GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 30, 2021

Josephine Uwazurike
Kevdaco Human Services LLC
PO Box 4199
Southfield, MI 48037

RE: License #: AS820282017
Investigation #: 2021A0121013
Kevdaco Westland I

Dear Ms. Uwazurike:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS820282017
Investigation #:	2021A0121013
Complaint Receipt Date:	08/11/2021
Investigation Initiation Date:	08/12/2021
Report Due Date:	10/10/2021
Licensee Name:	Kevdaco Human Services LLC
Licensee Address:	23999 Northwestern Hwy, Suite 200 Southfield, MI 48075
LicenseeTelephone #:	(248) 722-5004
Administrator:	Josephine Uwazurike, Designee
Name of Facility:	Kevdaco Westland I
Facility Address:	1900 Martin Street Westland, MI 48185
Facility Telephone #:	(248) 722-5004
Original Issuance Date:	07/18/2006
License **Status:**	REGULAR
Effective Date:	06/01/2021
Expiration Date:	05/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Workers at the home overmedicated a resident while in their care.	No
On 7/16/21, the home had a bad smell. It is unclear if the smell is from poor resident hygiene or a lack of cleaning at the facility. Feces left all over the toilet and not cleaned every 2 hours as required.	No
Additional Findings	Yes

III. METHODOLOGY

08/11/2021	Special Investigation Intake 2021A0121013
08/12/2021	Special Investigation Initiated - On Site Interview with Home Manager, Ursula Ajaero
09/29/2021	Contact - Telephone call made Call to Relative 1
09/30/2021	Referral - Recipient Rights Online referral
10/14/2021	Contact - Telephone call received N. Louie, Rights Investigator
10/15/2021	Contact - Telephone call made Follow up call to Relative 1
11/10/2021	Contact - Telephone call made Call to licensee designee
11/15/2021	Contact - Face to Face Meeting with Area Manager, Lanetria Gibson
11/17/2021	Contact - Document Received ORR status report
11/18/2021	Contact - Telephone call made

	Call to Pharmacist, Dr. Tony Akande
11/19/2021	Contact - Telephone call received Follow up call from Dr. Akande
11/19/2021	Contact - Telephone call made Call to Home Manager
11/22/2021	Contact - Telephone call made Nerissa Louie, Office of Recipient Rights
11/22/2021	Contact - Telephone call made Ms. Gibson
11/22/2021	Exit Conference J. Uwazurike
11/23/2021	Contact – Telephone call made Ms. Ajaero
11/23/2021	Contact – Telephone call made Phone interviews with Resident B and C

ALLEGATION: Workers at the home overmedicated a resident while in their care.

INVESTIGATION: On 8/12/21, I completed an onsite inspection at the facility. I reviewed Resident A's closed file. Resident A was discharged from the facility on or around 7/18/21 per Home Manager, Ms. Ursula Ajaero. Resident A's psychiatric evaluation dated 2/18/21 indicates her primary diagnosis is Schizophrenia, paranoid type and secondary diagnosis is Bipolar I disorder, single manic episode, unspecified. Resident A is prescribed multiple psychiatric medications to treat her mental illness. When she was placed at the facility, Resident A was taking Risperdal to treat her illness. Ms. Ajaero said she informed Relative 1 that Resident A's behavior had not improved since placement. According to Ms. Ajaero, the family was hopeful, Resident A would gain improved social skills by being around other residents in the home. However, Resident A continued to display manic behaviors like, talking to herself in an aggressive tone, bulging eyes, and erratic hand gestures. Ms. Ajaero reported Resident A's behavior made the other residents in the home so fearful, they started eating their meals in a hurry to get away from Resident A. Therefore, Ms. Ajaero determined Resident A was not a good fit for the home in her current state. She suggested the doctor consider making changes to Resident A's medication.

On 9/29/21 and 10/15/21, I spoke to Relative 1 by phone. Relative 1 was adamant the home overmedicated Resident A during her short stay there. According to Relative 1, Dr. Tanya McCauley discontinued the use of Risperdal because "it wasn't working", so she switched Resident A to Invega 6mg. Relative 1 stated she goes to the home one time monthly to review Resident A's medication. She reported this is when she noticed workers at the home had been administering the Invega pills, along with the Risperdal which should have been discontinued. Specifically, Relative 1 reported, "I saw the Invega samples had been popped out", suggesting the medication had been dispensed. She did not provide an explanation as to why she thought the Risperdal was being dispensed as well. However, she believes the action of the Staff contributed to the resident's close encounter with a "stroke" based upon Resident A's high blood pressure reading ("222/11") at the time of discharge.

On 11/18/21 and 11/19/21, I spoke to Dr. Tony Akande with Save Life Pharmacy. Dr. Akande stated he does not believe Resident A was overmedicated while at the facility. According to Dr. Akande, Resident A's health insurance would not cover the cost of the Invega medication without prior authorization. He explained Risperdal is the approved drug. It is comparable to Invega, but Invega is proven to be more effective. Dr. Akande further explained the pharmacy could not release Invega unless the insurance company agreed to pay (which they did not). So, as a courtesy Dr. Akande stated he provided Resident A with a 3-day supply of Invega in hopes of getting approval from the insurance company. These samples were hand delivered to the home with instructions for Resident A to take them 1 time daily. Ms. Ajaero confirmed Resident A took all the samples. Per Ms. Ajaero, any unused medication was returned to the pharmacy after Resident A was discharged from the home.

Dr. Akande verified the home returned all unused portions of Resident A's medication. He reported he's been working with the home since 2014 or 2016. Dr.

Akande stated the workers at the home are knowledgeable when it comes to resident medications. He reported feeling confident the workers would not overmedicate Resident A. I asked Dr. Akande if he believed Resident A could suffer a stroke if given Risperdal and Invega simultaneously. He said the answer is "subjective", but he believes there is no correlation between the two drugs.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's prescription for Invega 6mg was not filled because her insurance wouldn't cover the costs. The pharmacy provided Resident A with a short supply of Invega as a courtesy to the home. The pharmacist vouched for the workers at the home stating they are competent to pass medication; he's been working with this facility for many years. Relative 1 provided statements based on speculation and not facts. Therefore, there is insufficient evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 7/16/21, the home had a bad smell. It is unclear if the smell is from poor resident hygiene or a lack of cleaning at the facility. Feces left all over the toilet and not cleaned every 2 hours as required.

INVESTIGATION: I conducted an unannounced onsite inspection at the facility on 8/12/21. Due to the Covid-19 pandemic, I limited my face-to-face contacts in the Staff office to reduce risk of exposure to the virus. I could not smell any odors because I wore a mask inside of the facility. I did not observe the home to be in disarray or unclean. I interviewed Resident B and C by phone on 11/24/21. They both reported the home is generally well kept. Resident B and C reported Staff clean the home, daily. This includes the bathrooms. Ms. Ajaero reported the home has 4 bathrooms available for resident use. Ms. Ajaero is adamant the house keeping standards are maintained in accordance with the rule requirements.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable clean, and orderly appearance.
ANALYSIS:	Resident B and C presented as credible witnesses. They have resided at the home 3 years or more. Resident B and C denied the home is unclean. They reported the home, including the bathrooms are well kept.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: I reviewed Resident A's medication administration record (MAR) for the month of July 2021. I observed Resident A's Risperdal 4mg tablets were signed out as having been administered at 8:00 a.m. 7/1/21 - 7/21/21. The Risperdal 4mg tablets were also signed out as having been administered at 8:00 p.m. 7/1/21 – 7/20/21. This medication was discontinued on the MAR after those dates. According to the home's Resident Register, Resident A was discharged from the facility on 7/23/21. Ms. Ajaero acknowledged Resident A was given multiple doses of Invega as a substitute for the Risperdal at the request of her doctor. However, there are no recordings on Resident A's MAR to document the use of Invega. I made a follow up call to Ms. Ajaero on 11/19/21 to verify these findings. Ms. Ajaero could not provide documentation of the Invega having been administered. She suspects the Staff may have failed to document the medication because sample packets were used.

On 11/22/21, I completed an exit conference with Ms. Uwazurike to report my findings of the investigation. Ms. Uwazurike reported she would have the direct care workers retrained on proper documentation as it relates to medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Ms. Ajaero acknowledged Resident A was administered Invega, but there is no documentation to follow. To date, it is unclear how many Invega pills the resident was given because workers failed to record each passing of this medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

11/24/21

_____

Kara Robinson Date
Licensing Consultant

Approved By:

11/30/21

_____

Ardra Hunter Date
Area Manager