GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2022

Casmir Nnaji
Peace Home Michigan Inc.
28755 San Carlos Street
Southfield, MI 48076

RE: License #: AS820392529
Investigation #: 2022A0901048
Peace Home MI - Florence

Dear Mr. Nnaji:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820392529
Investigation #:	2022A0901048
Complaint Receipt Date:	09/20/2022
Investigation Initiation Date:	09/20/2022
Report Due Date:	11/19/2022
Licensee Name:	Peace Home Michigan Inc.
Licensee Address:	28755 San Carlos Street Southfield, MI 48076
Licensee Telephone #:	(313) 908-9433
Administrator:	Casmir Nnaji
Licensee Designee:	Casmir Nnaji
Name of Facility:	Peace Home MI - Florence
Facility Address:	26732 Florence St. Inkster, MI 48141
Facility Telephone #:	(313) 908-9433
Original Issuance Date:	12/05/2018
License Status:	REGULAR
Effective Date:	06/05/2021
Expiration Date:	06/04/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had an accident on herself, and staff refused to give her clean clothes. Resident A is responsible for cooking and other task.	No
Staff are verbally abusive. The home manager makes fun of Resident A. On an unknown date one of the staff members pushed Resident A.	No
Resident A gave another resident his medication.	No
The ramp is not stable. Resident A and another resident fell.	Yes

III. METHODOLOGY

09/20/2022	Special Investigation Intake 2022A0901048
09/20/2022	Special Investigation Initiated - On Site
09/20/2022	APS Referral
09/20/2022	Contact - Telephone call received Licensee Designee, Casmir Nnaji
09/23/2022	Referral - Recipient Rights
10/03/2022	Contact - Telephone call made Jill Josey, Henry Ford
10/04/2022	Contact - Telephone call made Resident A
10/10/2022	Exit Conference Licensee Designee, Casmir Nnaji

ALLEGATION:

Resident A had an accident on herself, and staff refused to give her clean clothes. Resident A is responsible for cooking and other task.

INVESTIGATION:

On 09/20/2022, I conducted an onsite inspection at the facility. I interviewed Resident A. She denied having to cook for herself. She indicated that staff cooks and provides them with 3 meals a day. When asked about what tasks she is responsible for, she indicated none, and that staff does everything. Resident A also denied not being given clean clothes. She explained that she did have an accident on herself, but she had clean underwear and changed herself. She further stated staff does their laundry weekly.

During the onsite inspection on 09/20/2022, I also interviewed Residents B and C separately. They each reported that staff does the cooking, cleaning, and laundry. Resident D was present but would not talk to me.

On 09/20/2022, while at the facility, I received a telephone call from the licensee designee, Casmir Nnaji. He denied the allegations. He stated staff does all the cooking as well as the cleaning and laundry. They encourage the residents to keep their bedrooms clean, but still assists them with all chores, unless it is a part of their treatment plan. Mr. Nnaji further stated, Resident A did not have a guardian or case manager. Her goal is to be independent. Therefore, they try to teach her different things when she is interested, but she is never forced to do anything.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegations. There is no indication that Resident A's personal care needs are not being met. She denied the allegations, as did everyone else interviewed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are verbally abusive. The home manager makes fun of Resident A. On an unknown date one of the staff members pushed Resident A.

INVESTIGATION:

On 09/20/2022, I conducted an onsite inspection at the facility. I interviewed Resident A. She stated Staff, Cowi and Regina, yells at her and the other residents and that they make fun of her and call her names. When asked to explain what she was saying, Resident A could not think of any examples or recall some of the things that were said. She denied being pushed by staff. She stated Resident C pushed her during a verbal altercation they had.

On 09/20/2022, I interviewed Resident B. He stated staff yelled at him once because he told them he was going to kill himself and they told him not to and called for help. He denied any knowledge of staff yelling at the other residents or hearing them make fun of anyone.

On 09/20/2022, I interviewed Resident C. She reported having no problems with staff. She stated she never witnessed staff being verbally abusive or mocking any of the residents. Resident C reported that the only verbal abuse she observed was done by Resident A. She explained that Resident A has anger issues and verbally abuses staff and the other residents, by yelling and calling everyone names. She also recalled an incident in which Resident A was in her face yelling at her and she had to push her away.

On 09/20/2022, I attempted to interview Resident D, but he would not talk to me.

On 09/20/2022, I interviewed staff, Cowi Barnes and Regina Nnaji, separately. They both denied the allegations and described Resident A as being problematic and always causing disturbances in the home.

During my onsite inspection on 09/20/2022, I received a telephone call from the licensee designee, Casmir Nnaji. He denied the allegations. He stated he has never observed staff talking inappropriately to the residents and that he is at the home almost daily, and Resident A has never complained to him.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to support the allegations. There is insufficient evidence to corroborate that Resident A is not being treated with dignity and her protection and safety is not being attended to. Although Resident A reported being verbally abused by staff and made fun of, staff denied it and there were no witnesses.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A gave another resident his medication.

INVESTIGATION:

On 10/03/2022, I made a telephone call to Jill Jossey, from Henry Ford Home Health Care. She was concerned that Resident A told her that she had to give another resident his medication. Ms. Jossey did not know when this occurred or the name of the resident.

On 10/04/2022, I made a telephone call to Resident A. She denied giving another resident his medication. She stated staff keeps the medications locked up and they are the only people who can get it and give it out.

On 10/10/2022, I made a telephone call to the licensee designee, Casmir Nnaji. He denied the allegations. He stated the medications are kept locked and only staff administers it.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegation. There is no indication that staff failed to supervise the administration of medication. Resident A denied the allegation. Mr. Nnaji also denied the allegation, and both indicated that the medications are kept locked and are administered by staff only.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The ramp is not stable. Resident A and another resident fell.

INVESTIGATION:

On 09/20/2022, I conducted and onsite inspection at the facility and interviewed Resident A. She reported falling in the past on the “small” ramp located on the rear deck that residents sit on to smoke. She stated since then, the ramp was fixed. I noticed Resident A had an unsteady gait, which she confirmed. She stated she was not steady on her feet due to having vision issues and health issues. When asked if she was sure she fell due to a problem with the ramp or could it had been due to her lack of steadiness, she stated she was not sure. The ramp in question appeared steady. I did not see any damage. She stated the other resident that fell is no longer there and she did not recall his name.

During my onsite inspection at the facility, I received a telephone call from the licensee designee, Casmir Nnaji. He recalled Resident A falling, but stated it had nothing to do with the ramp. It was due to her not being able to see well. He was not aware of anyone else falling.

On 09/20/2022, I interviewed staff, Cowi Barnes and Regina Nnaji, separately. They denied any knowledge of anyone falling on the ramps.

On 09/20/2022, I observed the ramps and the front and rear egress. The rear egress ramp had a bed frame stored on it. There was also debris on it and a blue tarp. In addition to this, some of the wooden slacks on the ramp were loose.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

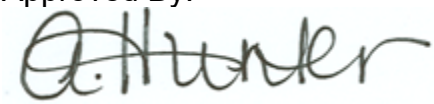
ANALYSIS:	Based on the information obtained during this investigation, the rear egress ramp was not adequately maintained for the safety and wellbeing of the residents. Items were observed on the ramp that obstructed egress. In addition to this, some of the wooden slacks on the ramp were loose, which posed a safety a hazard.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____10/10/2022
Regina Buchanan Date
Licensing Consultant

Approved By:



_____10/12/2022
Ardra Hunter Date
Area Manager