GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 23, 2023

Susan Simwenyi
Sasse AFC LLC
5972 Par View Dr
Ypsilanti, MI 48197

RE: License #: AS810399293
Investigation #: 2023A0122012
Sasse Brooks House

Dear Ms. Simwenyi:

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 (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810399293
Investigation #:	2023A0122012
Complaint Receipt Date:	01/05/2023
Investigation Initiation Date:	01/05/2023
Report Due Date:	03/06/2023
Licensee Name:	Sasse AFC LLC
Licensee Address:	5972 Par View Dr Ypsilanti, MI 48197
Licensee Telephone #:	(734) 476-8781
Administrator:	Susan Simwenyi
Licensee Designee:	Susan Simwenyi
Name of Facility:	Sasse Brooks House
Facility Address:	7368 E Brooks Ypsilanti, MI 48197
Facility Telephone #:	(734) 476-8781
Original Issuance Date:	06/24/2019
License **Status:**	REGULAR
Effective Date:	06/24/2022
Expiration Date:	06/23/2024
Capacity:	5
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff members did not respond appropriately to a medical emergency involving Resident A on 12/13/2022.	Yes
Resident A had medication on her possession.	Yes

III. METHODOLOGY

01/05/2023	Special Investigation Intake 2023A0122012 APS Referral Denied
01/05/2023	Special Investigation Initiated - Telephone Washtenaw County Community Mental Health. Kelley Van Gemergt - Crisis department. Will have representative contact me to complete an interview.
01/09/2023	Inspection Completed On-site Completed interview with Susan Simwenyi, Licensee Designee. Reviewed Resident A's file.
01/10/2023	Contact – Telephone call received Completed interviews with Jonathan Allen and Tim Kolbasa, Washtenaw County Community Mental Health – Crisis Workers.
01/12/2023	Contact – Telephone call received Completed interview with staff member, Courage Kapuyanyika.
01/16/2023	Contact – Telephone call received Completed interview with Dr. Marjorie Almeda, PACE Program.
01/17/2023	Exit Conference Discussed findings with Susan Simwenyi, Licensee Designee.

ALLEGATION: Staff member did not respond appropriately to a medical emergency involving Resident A on 12/13/2022.

INVESTIGATION: On 01/09/2023, I completed an interview with Susan Simwenyi, Licensee Designee. Ms. Simwenyi reported on 12/13/2022, staff member, Courage Kapuyanyika, contacted her and reported that Resident A claimed that she had taken pills, Excedrin, that she had in her purse. Per Ms. Simwenyi, Mr. Kapuyanyika asked how may pills she had taken but received no answer. Mr. Kapuyanyika reported that Resident A started vomiting and he called a representative from the PACE program.

Ms. Simwenyi stated a representative whom she believed was from the emergency PACE program (but later found out they were representatives from Washtenaw County Community Mental Health) came to the facility, observed Resident A, and contacted emergency medical personnel by calling 911. Ms. Simwenyi stated that Mr. Kapuyanyika did not contact emergency personnel as she had been directed by PACE representative for any emergencies with Resident A to contact the PACE program.

Ms. Simwenyi gave the following history of Resident A. That a representative from the PACE program contacted her for admission on 12/09/2022 stating that Resident A was verbalizing suicidal thoughts and they did not want her to go home. Resident A was under the impression that she would be picked up from the facility by a PACE representative on Monday, December 12, 2022, however, she became upset when Ms. Simwenyi reported that she would be picked up on Wednesday, December 14, 2022. Ms. Simwenyi reported that Resident A took the pills on Tuesday, December 13, 2022, as she was angry that she wasn't going to be picked up until Wednesday.

On 01/10/2023, I completed interviews with Jonathan Allen and Tim Kolbasa, Washtenaw County Community Mental Health – Crisis Intervention Workers. Both reported the following: on 12/13/2022, they arrived at the Sasse Brooks House adult foster care home, observed Resident A on the floor, and immediately called 911 for medical assistance. Mr. Allen stated when he approached Resident A she was crying, breathing rapidly, and had been vomited. Per Mr. Allen, Resident A was unable to answer questions regarding medications she might have ingested but repeated that she wanted to die. Both Mr. Allen and Mr. Kolbasa stayed with Resident A until emergency personnel arrived.

Mr. Allen also stated upon arrival there was one staff member present who allowed them entry into the adult foster care facility. Once Resident A was transported to the hospital the staff member showed them the locked medication cabinet where Resident A's medication was kept. However, he observed an Excedrin 200 pill bottle taken from Resident A's possession. Mr. Allen noted there was approximately 50 pills left in the bottle.

On 01/12/2023, I completed an interview with staff member, Courage Kapuyanyika. Mr. Kapuyanyika confirmed that he provided care to Resident A during the incident on 12/13/2022. Per Mr. Kapuyanyika, Resident A had been upset that she had not been picked up by a PACE representative for two days and came to him on 12/13/2022 stating that she had taken some pills. Mr. Kapuyanyika stated that Resident A was also speaking to a PACE representative as well when she informed him that she had ingested pills.

Mr. Kapuyanyika reported that he spoke briefly with the PACE representative, they stated they would call back with a plan, and Resident A left the room. He went to check on Resident A, she showed him an Excedrin 200 count pill bottle with pills missing, and he gave her water. Per Mr. Kapuyanyika, Resident A began crying, stating she wanted to die, and spitting out water. During this time representatives from Washtenaw County Community Mental Health arrived and observed Resident A. The representatives from Washtenaw County Community Mental Health contacted emergency personnel by calling 911.

On 01/16/2023, I completed an interview with Dr. Marjorie Almeda, PACE Program. Dr. Almeda stated that Resident A had been placed in the Sasse Brooks adult foster care facility to receive adult foster care services and to assist with medication compliance and isolation by having social interaction with other residents within the facility. Dr. Almeda reported that Resident A had in her personal possession a bottle of Excedrin pills that staff members of the adult foster care group home had no knowledge of and neither did the staff members of PACE.

Dr. Almeda further stated that providers of adult foster care group homes are directed to contact staff members of the PACE program if residents affiliated with the program encounter an emergency. Per Dr. Almeda this directive is given to avoid unnecessary ambulance calls and hospitalizations. Dr. Almeda confirmed that Susan Simwenyi was given this directive regarding Resident A when she was admitted into the Sasse Brooks adult foster care facility. Dr. Almeda reported that Resident A died several days later.

On 01/17/2023, I completed an exit conference with Susan Simwenyi, Licensee Designee. Ms. Simwenyi was in agreement with my findings as discussed and stated she would submit a corrective action plan to address established licensing rule violations.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	On 12/13/2022, Resident A informed staff member, Courage Kapuyanyika, that she had ingested an unknown amount of Excedrin pills that she had in her possession. On 01/12/2023, Courage Kapuyanyika, confirmed that Resident A told him that she had ingested Excedrin pills. Mr. Kapuyanyika stated he gave Resident A some water and observed her spit the water out. On 01/10/2023, Jonathan Allen reported when he went to the facility to assess Resident A, he observed that she was crying, breathing rapidly, and had vomited. On 01/10/2023 and 01/12/2023, respectively both Jonathan Allen and Courage Kapuyanyika stated that Mr. Allen contacted emergency personnel by calling 911 on 12/13/2022. Based upon my investigation I find that staff member, Courage Kapuyanyika, did not respond appropriately to Resident A's medical emergency as he did not obtain needed care immediately, he did not contact emergency personnel when he observed Resident A's adverse change in her physical condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A had medication on her possession.

INVESTIGATION: On 01/09/2023, Susan Simwenyi, confirmed that Resident A had the medication, Excedrin pills, in her possession, and she took more than the recommended dosage which caused a medical emergency for Resident A.

On 01/12/2023, staff member, Courage Kapuyanyika, confirmed that Resident A had Excedrin pills in her possession and reported that she had ingested an unknown amount.

On 01/17/2023, I completed an exit conference with Susan Simwenyi, Licensee Designee. Ms. Simwenyi was in agreement with my findings as discussed and stated she would submit a corrective action plan to address established licensing rule violations.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 01/09/20232 and 01/12/2023, respectively both Susan Simwenyi and Courage Kapuyanyika confirmed that Resident A had Excedrin pills in her possession. Based upon my investigation I find that Resident A's medication was not kept in a locked cabinet or drawer. Therefore, she was able to ingest an unknown amount of the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change to the status of the license.

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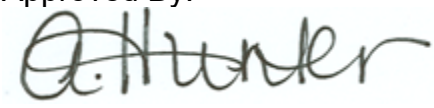
Vanita C. Bouldin
Licensing Consultant

Date: 01/19/2023

Approved By:



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Ardra Hunter
Area Manager

Date: 01/23/2023