GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

Jasper Mukwada
Zimshine LLC
7483 W Q Ave
Kalamazoo, MI 49009

RE: License #: AS390409454
Investigation #: 2023A0581029
Zimshine LLC

Dear Mr. Mukwada:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390409454
Investigation #:	2023A0581029
Complaint Receipt Date:	04/06/2023
Investigation Initiation Date:	04/06/2023
Report Due Date:	06/05/2023
Licensee Name:	Zimshine LLC
Licensee Address:	7483 W Q Ave Kalamazoo, MI 49009
Licensee Telephone #:	(269) 267-9739
Administrator:	Dinah Mukwada
Licensee Designee:	Jasper Mukwada
Name of Facility:	Zimshine LLC
Facility Address:	7483W Q Ave Kalamazoo, MI 49009
Facility Telephone #:	(269) 267-9739
Original Issuance Date:	03/11/2022
License Status:	REGULAR
Effective Date:	09/11/2022
Expiration Date:	09/10/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 04/05/2023, a direct care staff abused and threatened Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

04/06/2023	Special Investigation Intake 2023A0581029
04/06/2023	Special Investigation Initiated - On Site Interviewed staff and residents. Obtained some resident documentation.
04/06/2023	APS Referral APS received the allegations but denied investigating.
04/06/2023	Contact - Telephone call made Left voicemail with license designee, Jasper Mukwada
04/07/2023	Exit Conference with Licensee Designee, Jasper Mukwada
04/13/2023	Inspection Completed-BCAL Sub. Compliance
04/14/2023	Contact – Document Sent Email correspondence with Portage Police Department.
04/17/2023	Contact – Document Sent Email correspondence with Kalamazoo Sheriff's Department.
04/18/2023	Contact – Document Received Received Kalamazoo Sheriff's Department Incident Report # 2023-00011001.

ALLEGATION:

On 04/05/2023, a direct care staff abused and threatened Resident A.

INVESTIGATION:

On 04/06/2023, I received this complaint through the Bureau of Community Health Systems online complaint system. The complaint alleged Resident A, who is a 55 year old male with COPD, high blood pressure, a bad heart and bad back, requested police assistance on 04/05/2023 on or around 3:10 pm because a male direct care staff was abusing and threatening him; however, no details were provided. The complaint alleged a direct care staff, identified as "Martin", also contacted police a few minutes after Resident A did to report Resident A was "okay". The complaint alleged the police were dispatched to the facility.

On 04/06/2023, I conducted an unannounced investigation. I interviewed direct care staff, Khalil Marlowe, who stated he also went by "Martin". Mr. Marlowe stated he had been the only direct care staff working on 04/05/2023 when the incident with Resident A occurred. He stated that at approximately 2:30 pm on 04/05/2023, Resident A became upset with his wife, Resident B, for only purchasing one bag of tobacco while she was at the store. Mr. Marlowe stated Resident A briefly left the facility on foot and when he returned Mr. Marlowe indicated Resident A was "even more angry". Mr. Marlowe stated Resident A wears a "panic button" around his neck that is linked to a phone that will call a security control center in the event of an emergency. Mr. Marlowe stated Resident A continually pushed the panic button, which caused the phone to ring in Resident A's bedroom as the security center was checking on Resident A. Mr. Marlowe stated he told the security control center emergency services were not needed for Resident A because he (Mr. Marlowe) was handling Resident A's behaviors and that Resident A and Resident B were just arguing. Mr. Marlowe stated Resident A then pressed his panic button again and when the security control center contacted the phone again, Resident A told them that one of the direct care staff had a gun in the home. Mr. Marlowe stated this prompted the police to arrive to the facility.

Mr. Marlowe stated that since he was on the only direct care staff working that day, there wouldn't have been another direct care staff Resident A was referring to as having a gun other than Mr. Marlowe. Mr. Marlowe stated in addition to police arriving, an ambulance and the fire department also showed up. Mr. Marlowe stated Resident A was "belligerent", calling Mr. Marlowe a "niger" and asking police to send Mr. Marlowe to jail. Mr. Marlowe stated Resident A's vitals were checked by emergency personnel, who asked Resident A if he wanted to go to the Emergency Room (ER); however, Resident A stated he didn't want to go. Mr. Marlowe denied abusing or threatening Resident A on or around 04/05/2023.

I interviewed Resident A, B, and C during my investigation. I attempted to interview Resident D; however, he was smoking and stated he didn't want to talk to me.

Resident A stated he “acted out” on or around 04/05/2023, which he attributed to discovering he has blood clots in his legs. He stated when he got back from the hospital, he and the licensee designee “got into it”. Resident A wasn’t able to elaborate on what that meant or what occurred, but stated a fire truck and police came to the facility. He stated he refused to go the ER but acknowledged being checked out by emergency personnel. Resident A stated he wasn’t assaulted or threatened by any direct care staff in the facility. He denied any direct care staff having a gun and threatening him with it. Resident A stated he and Mr. Marlowe are “fine” and get along.

Resident B stated Resident A was experiencing some health issues on or around 04/05/2023, which attributed to him experiencing behaviors. She stated he was making statements that weren’t true about direct care staff, Mr. Marlowe. She stated it was not true that Mr. Marlowe had a gun. She stated she had never observed or heard any direct care staff, including Mr. Marlowe, and the licensee designee, Mr. Mukwada, assault or threaten any residents, including Resident A. Resident B stated she felt safe within the facility.

Resident C stated that on 04/05/2023, he was at the store for approximately 45 minutes and when he returned to the facility there were cops and an ambulance present. He stated he wasn’t aware of any direct care staff having a gun. He also stated he had never observed or heard any direct care staff, including Mr. Marlowe, and the licensee designee, Mr. Mukwada, assault or threaten any residents, including Resident A.

On 04/18/2023, I received Kalamazoo Sheriff’s Department incident report # 2023-00011001, which indicated a “Care Center” contacted the police department on 04/05/2023 at 3:11 pm because staff were verbally abusing and threatening to Resident A. The incident report indicated the police assisted in the call; however, no additional information was in the report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based on my investigation, which included interviews with Resident A, Resident B, Resident C, direct care staff, Khalil Marlowe and licensee designee, Jaspar Mukwada, and my review of Kalamazoo County Sheriff's Department incident report # 2023-00011001, there is no evidence Resident A was assaulted or threatened by any direct care staff on or around 04/05/2023, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my investigation, I requested to review Resident A's and Resident B's *Health Care Appraisals* and *Assessment Plans for AFC Residents*; however, these documents were not available for review in the facility. Mr. Marlowe indicated these documents could have been taken out of the facility to be reviewed or updated by upper management; however, he was unable to locate them.

I informed both Mr. Marlowe and the licensee designee, Mr. Mukwada, the requirement of keeping resident records in the facility.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(f) Assessment plan.**

ANALYSIS:	Resident A's and Resident B's *Health Care Appraisal* and *Assessment Plan for AFC Residents* were not available for review during my unannounced onsite inspection, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my investigation, I interviewed the residents in an empty resident bedroom for privacy. Upon closing the bedroom door, I discovered the bedroom door had locking against egress hardware. I then checked every resident bedroom door and discovered each door had locking against egress hardware.

The licensee designee, Jasper Mukwada, stated Community Mental Health Summit Pointe agency had just conducted an inspection approximately one week prior and informed Mr. Mukwada that the doors needed to be locking against egress. Mr. Mukwada stated he changed the door hardware to be in compliance with Summit Pointe. Mr. Mukwada was informed residents may have locking door hardware; however, the hardware cannot be locking against egress. Mr. Mukwada stated he would change the hardware to be in compliance with the Department but would inform Summit Pointe of the violation.

On 04/25/2023, Mr. Mukwada sent me an email containing a picture of the changed door hardware indicating the hardware was now non locking against egress, as required.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, nonlocking-against-egress hardware.
ANALYSIS:	During my 04/06/2023 investigation, all the resident bedroom doors had locking against egress hardware.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/07/2023, I conducted an exit conference with the licensee designee, Jaspar Mukwada. Mr. Mukwada agreed with my findings but expressed frustration with community mental health's regulation of the door handle hardware.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

05/04/2023

Cathy Cushman — Date
Licensing Consultant

Approved By:

05/11/2023

Dawn N. Timm — Date
Area Manager