GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 25, 2023

Wycliffe Opiyo
Mercy Homes Assisted Living LLC
2901 Asbury St.
Kalamazoo, MI 49048

RE: License #: AS390380979
Investigation #: 2023A1024049
Mercy Homes Assisted Living

Dear Mr. Opiyo:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 9/18/2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390380979
Investigation #:	2023A1024049
Complaint Receipt Date:	08/04/2023
Investigation Initiation Date:	08/07/2023
Report Due Date:	10/03/2023
Licensee Name:	Mercy Homes Assisted Living LLC
Licensee Address:	2901 Asbury St. Kalamazoo, MI 49048
Licensee Telephone #:	(817) 781-6512
Administrator:	Wycliffe Opiyo
Licensee Designee:	Wycliffe Opiyo
Name of Facility:	Mercy Homes Assisted Living
Facility Address:	2901 Asbury St. Kalamazoo, MI 49048
Facility Telephone #:	(817) 781-6512
Original Issuance Date:	09/26/2016
License Status:	REGULAR
Effective Date:	03/24/2023
Expiration Date:	03/23/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff members provided Resident A with medications for a home visit but did not ensure another person would use the medication resulting in Resident A's Xanax medication being stolen.	Yes

III. METHODOLOGY

08/04/2023	Special Investigation Intake 2023A1024049
08/07/2023	Special Investigation Initiated – Telephone with Recipient Rights Officer (RRO) Andrea Gummer
08/08/2023	Inspection Completed On-site with direct care staff members Hubert Majalliwa and Asende Ecasa
08/14/2023	Contact - Telephone call made with licensee designee Wycliffe Opiyo
09/18/2023	Exit Conference with licensee designee Wycliffe Opiyo
09/18/2023	Inspection Completed-BCAL Sub. Compliance
09/18/2023	Corrective Action Plan Requested and Due on 10/3/2023
09/18/2023	Corrective Action Plan Received
9/18/2023	Corrective Action Plan Approved
09/21/2023	APS Referral-does not meet criteria

ALLEGATION: Direct care staff members provided Resident A with medications for a home visit but did not ensure another person would use the medication resulting in Resident A's Xanax medication being stolen.

INVESTIGATION:

On 8/4/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged direct care staff members provided Resident A with medications for a home visit but did not ensure a

responsible person took control of the medication resulting in Resident A's Xanax medication being stolen.

On 8/7/2023, I conducted an interview with Recipient Rights Officer (RRO) Andrea Gummer who stated Resident A is his own guardian and does not have a behavior treatment plan. Andrea Gummer stated Resident A requested to go on a visit to spend time with his family for ten days which he is allowed to do. Andrea Gummer stated the family visit was approved by Resident A's mental health case worker. Andrea Gummer stated direct care staff members prepared a 10-day supply of medications for Resident A to take with him on his visit. Andrea Gummer stated Resident A left for his visit however returned to the facility two hours later and stated that he no longer wanted to go on the visit. Andrea Gummer stated Resident A then disclosed that he left his 10-day supply of Xanax that was given to him by staff members in the car with a person that was providing transportation for him to his family visit. Andrea Gummer stated Resident A stated he did not know the person who was driving and stated he changed his mind about going on a family visit which is why he returned to the facility after only five hours. Andrea Gummer stated he returned all medications back to the facility except for the Xanax therefore it is believed Resident A gave this medication away or had it stolen. Andrea Gummer believes direct care staff appropriately prepared Resident A's medications for his 10-day family visit. Andrea Gummer stated she has no concerns direct care staff members took the medication.

On 8/8/2023, I conducted an onsite investigation at the facility with direct care staff members Hubert Majalliwa and Asende Ecasa. Asende Ecasa stated she does not handle any medications in the facility when she works during her shift rather direct care staff member Hubert Majalliwa is responsible for preparing medications for residents when they go on family home visits. Asende Ecasa stated she believes Resident A has only been on a family home visit once and it is not a routine occurrence.

Hubert Majalliwa stated Resident A recently requested to go visit with family in Jackson, MI which was approved by his mental health case worker and licensee designee Wycliffe Opiyo. Hubert Majalliwa stated Resident A requested to go visit with his family for 10 days and stated that a family member would pick him up for the visit. Hubert Majalliwa stated on the day he left for the family home visit, Resident A was provided with a 10-day supply of all his medications in its original prescription package that included written instructions on how much and what time he should take each medication. Hubert Majalliwa stated he talked to Resident A who verbally stated he understood the medication instructions. Hubert Majalliwa stated he did not speak to the responsible family member who Resident A was going to be staying with for 10 days nor did he speak to the person who picked Resident A up for the family home visit. Hubert Majalliwa stated Resident A left the facility with his bags packed along with his medications at around 2pm however Hubert Majalliwa did not walk outside with Resident A to contact the person who picked up Resident A. Consequently, Hubert Majalliwa did not know who transported Resident A for the visit or what type of car they were in. Hubert Majalliwa also stated he did not have any contact information for any family members Resident A was going to visit. Hubert Majalliwa stated later in the day,

around 7pm, Resident A returned to the home and stated that he no longer wanted to visit with his family, and that he accidentally left his Xanax medication in the car with the person who dropped him off. Hubert Majalliwa stated Resident A stated it was a friend who dropped him off however did not want to disclose the name of the friend or any contact information for his friend. Hubert Majalliwa stated after he counted Resident A's medications, he discovered that Resident A's Xanax medication was missing from the 10 day supply of medication that was prepared for him. Hubert Majalliwa stated he then called administrator/licensee designee Wycliff Opiyo to inform him of the missing medication. Hubert Majalliwa stated administrator/licensee designee Wycliff Opiyo advised him to make a police report. Hubert Majalliwa further stated he also immediately notified Resident A's mental health case manager and the office of recipient rights. It should be noted Resident A refused to be interviewed.

While at the facility, I observed Resident A's August 2023 *Medication Administration Record* (MAR) and reviewed Resident A's medications in their original bubble packaging and found all were consistent with Resident A's MAR. According to Resident A's MAR and original prescription packages Resident A is prescribed the following: Alprazolam (Xanax) 1mg to take three times a day, Metoprolol Tartrate 25 mg to take twice daily, Warfarin Sodium 3 mg to take once daily, Sertraline HCL 50 mg take once daily, Spironolactone 25 mg to take once daily, and Aripiprazole 20mg to take one a day.

On 8/14/2023, I conducted an interview with administrator/licensee designee Wycliffe Opiyo who stated that Resident A is his own guardian and requested to visit with his family in Jackson, MI for 10 days. Wycliffe Opiyo stated after discussing this request with Resident A's case manager, the request was approved. Wycliffe Opiyo stated he was advised by Office of Recipient Rights that Resident A has the right to visit with family when they reside in an adult foster care setting therefore direct care staff members assisted Resident A with packing his clothes and prepared his medications for him to take for 10 days. Wycliffe Opiyo stated he did not specifically know who Resident A was visiting however believes he has a brother who lives in Jackson MI. Wycliffe Opiyo stated he spoke with Resident A prior to him leaving for his visit and Resident A informed him that he had all his belonging and had all his medications with instructions provided for him to take while on his visit. Wycliffe Opiyo stated a few hours later after Resident A left to go on his family home visit, he received a call from a direct care staff member stating Resident A returned to the facility but left his Xanax medication in the car with an unknown driver who transported him back to the facility. Wycliffe Opiyo stated he thought this was very unusual and believed someone may have taken advantage of Resident A to obtain his Xanax medication. Wycliff Opiyo stated he contacted and made a police report of the missing medication. Wycliffe Opiyo stated he also immediately contact Resident A's mental health case manager and the office of recipient rights. Wycliffe Opiyo stated Resident A denied the medication was stolen from him and claims to have lost the medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation which included interviews with (RRO) Andrea Gummer, direct care staff members Hubert Majalliwa, Asende Ecasa, administrator/licensee designee Wycliffe Opiyo, and my review of Resident A's MAR, there is evidence direct care staff members provided Resident A with medications for a home visit but did not take reasonable precautions to ensure the medications were not used/taken by another person leading to Resident A's Xanax being missing/stolen. Both Hubert Majalliwa and Wycliffe Opiyo stated no direct care staff member discussed the management of Resident A's medications with any responsible person nor did any staff member make any effort to contact any family members or responsible person to discuss the management of Resident A's medications, prior to allowing Resident A to leave the facility with 10 days of medication. Subsequently, Resident A returned to the facility missing one of his medications, a 10-day supply of Xanax. Therefore, the licensee did not ensure Resident A's prescription medications were not used by a person other than the resident for whom the medication was prescribed**.**
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/18/2023, I conducted an exit conference with licensee designee Wycliffe Opiyo. I informed Wycliffe Opiyo of my findings and allowed him an opportunity to ask questions or make comments.

On 9/18/2023, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore, I recommend the current license status remain unchanged.

9/21/2023

Ondrea Johnson
Licensing Consultant

Date

Approved By:

9/25/2023

_____

Dawn N. Timm
Area Manager

Date