GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 16, 2024

Nakia Woods
Iyana's A.F.C. INC.
1117 Adams
Saginaw, MI 48602

RE: License #: AS730398654
Investigation #: 2024A0572016
Iyana's A.F.C. INC.

Dear Nakia Woods:

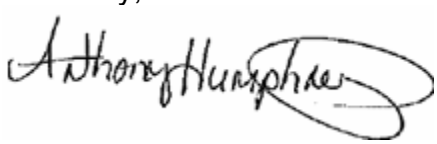
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730398654
Investigation #:	2024A0572016
Complaint Receipt Date:	12/18/2023
Investigation Initiation Date:	12/19/2023
Report Due Date:	02/16/2024
Licensee Name:	Iyana's A.F.C. INC.
Licensee Address:	1117 Adams Saginaw, MI 48602
Licensee Telephone #:	(989) 332-4130
Administrator:	Nakia Woods
Licensee Designee:	Nakia Woods
Name of Facility:	Iyana's A.F.C. INC.
Facility Address:	1117 Adams Saginaw, MI 48602
Facility Telephone #:	(989) 332-4130
Original Issuance Date:	08/13/2020
License **Status:**	REGULAR
Effective Date:	02/13/2023
Expiration Date:	02/12/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 10/16/2023, Resident A had not received prescribed medications for weeks. The Pharmacy was notified by the nurse and the pharmacy verified that Iyana's AFC Home had not been picking up the resident's medications.	No
Medications administration records are not being initialed correctly.	Yes
The medication door was left unlocked and Resident A had access to Resident A's medications and handed them to the nurse.	No
Additional Findings	Yes

III. METHODOLOGY

12/18/2023	Special Investigation Intake 2024A0572016
12/18/2023	APS Referral APS made referral.
12/19/2023	Special Investigation Initiated - Telephone
01/19/2024	Inspection Completed On-site Staff, Ronda Tyler.
01/31/2024	Contact - Face to Face Licensee, Nakia Woods, Resident A, Resident B and Resident C.
02/08/2024	Inspection Completed-BCAL Sub. Compliance
02/09/2024	Contact - Telephone call made Staff, John Choyce.
02/09/2024	Contact - Telephone call made Staff, John Choyce.
02/09/2024	Contact - Telephone call made Staff, LaPorsha Thompson.
02/12/2024	Contact - Telephone call made

	Staff, John Choyce.
02/12/2024	Contact - Telephone call made Staff, John Choyce.
02/13/2024	Contact - Telephone call made Staff, John Choyce.
02/13/2024	Contact - Telephone call made Staff, John Choyce.
02/15/2024	Exit Conference Licensee, Nakia Woods.
02/16/2024	Contact - Telephone call made Hope Network Nurse, Dawn Garrett.
02/16/2024	Contact - Telephone call made Resident A's Case Manager, Shanice Brown.
02/16/2024	Contact – Document Received Genoa Pharmacy.

ALLEGATION:

- On 10/16/2023, Resident A had not received prescribed medications for weeks. The Pharmacy was notified by the nurse and the pharmacy verified that Iyana's AFC Home had not been picking up the resident’s medications.
- Medication Administration Records are not being initialed correctly.

INVESTIGATION:

On 12/18/2023, the local licensing office received a complaint for investigation. Adult Protective Services referred the complaint to licensing for further investigation.

On 12/19/2023, contact was made with the Complainant. The Complainant informed that the allegations were true and had direct knowledge of the incident. In speaking with the Licensee, Nakia Woods indicated that they have cameras in the common area which proves that the medications were being administered.

On 01/19/2024, I made an unannounced onsite at Iyana's AFC Home, located in Saginaw County Michigan. Staff, Ronda Tyler was present for an interview.

On 01/19/2024, I interviewed Staff, Ronda Tyler regarding the allegation. Ronda Tyler informed that she was not working the day of the incident but believes that

Resident A is getting its meds timely. Ronda Tyler is trained in administering medication as well as the other staff. Ronda Tyler believes that Resident A may have told the nurse that Resident A was not getting meds, but Resident A also is known to hallucinate and say that people are taking Resident A's meds, when they are not. When asked if there was a time when Resident A was missing medications or ran out due to not picking them up, Ronda Tyler informed that she does not recall a time when Resident A ran out of medication. This could have happened when one of the other staff were working as they are live-in staff. Ronda Tyler informed that the home does not pick up the medications because the pharmacy drops them off.

On 01/19/2024, I reviewed the current med sheet and it appeared to be accurate. Med sheets were reviewed from 01/01/2024 to 01/19/2024.

On 01/31/2024, I interviewed Licensee Designee, Nakia Woods regarding the allegation. Nakia Woods informed that they have never picked up medications since the home opened. The pharmacy has always delivered the medications to the home. Nakia Woods informed that the pharmacy had tried to contact the doctor to renew the script but did not get an answer, so the pharmacy contacted her to see if she could contact the doctor. Nakia Woods indicated that there was no way for them to pick up the medications that ran out for Resident A because they needed a script. When the pharmacy called and asked her to call the doctor, she did and the doctor said that they had sent it already, but the pharmacy wasn't getting it on their end. Also, Resident A wasn't getting the Clozapine anymore because the insurance wouldn't cover it.

On 01/31/2024, I reviewed all of the residents' current med sheets and they appeared to be accurate. While reviewing Resident A's file, the med sheets for October and November were missing. There were also two separate December 2023 med sheets for Resident A. One appeared to be used from 12/01/2023 to 12/14/2023 and the other starts on 12/15/2023 through 12/31/2023.

On 01/31/2024, I asked Licensee Designee, Nakia Woods about the 2 separate medication sheets for Resident A for December 2023. Nakia Woods informed that Resident A had several medications that were on the previous medication administration records that were discontinued, which looks confusing to whoever is viewing the med sheets and is not familiar with what Resident A is currently prescribed, so she asked the Pharmacy to print them an updated medication administration record without all of the discontinued medications on the med sheet. According to the medication administration record, Resident A is being administered prescribed medication.

On 01/31/2024, I reviewed an email from the pharmacy to Licensee Designee, Nakia Woods that states, "Hello, I have already sent multiple requests to the doctor for these meds. Please call the doctor and let them know these consumers need refills."

On 01/31/2024, I reviewed the staff files, and all staff are documented as trained in administering medications. I observed all of the verifications of training for each staff member.

On 01/31/2024, I interviewed Resident A regarding the allegation. Resident A informed that the nurse said there were some missing medications and was going to find out why. Resident A has recently switched doctors and the current doctor is trying to figure out which medications Resident A should be taking and which medications to discontinue. Resident A indicated that the new doctor has changed some of the medications and will make more changes as the doctor becomes more knowledgeable about Resident A. Resident A denied that staff were missing any medications and informed that the medications that weren't given, Resident A was not supposed to get those medications anymore.

On 01/31/2024, I interviewed Resident B regarding medications. Resident B is administered medications and always gets them on time. Resident B denied there has ever been a time when staff missed administering medications.

On 01/31/2024, I interviewed Resident C regarding medications. Resident C informed that staff always administered medications timely. Resident C is called downstairs to the main floor to take meds.

On 02/09/2024, I made my first of several phone calls to Staff, John Choyce and did not receive answer or a call back.

On 02/09/2024, I called Staff, LaPorsha Thompson regarding the allegation. LaPorsha Thompson informed that she was not working at the time, so she does not know anything about missing medications, but indicated that Resident A gets medications timely. LaPorsha Thompson indicated that the pharmacy makes the request to have the meds filled and they have to wait for the doctor to approve the refills. There are times when the meds are not filled timely, so they have to wait for them to be filled. Staff do not pick up meds as the pharmacy drops the meds off to the home.

On 02/14/2024, I met with the Pharmacist and went over the allegation. The Pharmacist informed that she needed a little time to look Resident A's chart to see if there was ever an issue with regards to medications. The Pharmacist does not recall an issue with Iyana's AFC Home not getting medications for Resident A, but would need some time to review Resident A's file. The Pharmacist informed that she will try to give me the information sometime today.

On 02/14/2024, I emailed the Pharmacist my list of questions regarding the medications.

On 02/16/2024, I interviewed Hope Network Nurse, Dawn Garrett regarding the allegation. Nurse Garrett informed that in October 2023, some of the sections on the

medication administration sheets were blank and on 11/15/2023, there were two weeks of initials on the medication sheet for medications that were not sent to the home yet. In December, Nurse Garrett believes that Resident A was being administered medications, but the medication administration record was not being signed. Resident A now comes to the office with a copy of the medication administration record and now believes that the staff at Iyana's AFC are taking it seriously and making sure that the medication administration records (MARs) are being signed appropriately.

On 02/16/2024, I interviewed Resident A's Case Manager, Shanice Brown regarding the allegation. Shanice Brown was aware of the issues regarding Resident A's medications as she can see the notes from Nurse Garrett's chart. Resident A never mentioned to her that she was not being administered medication. Resident A is aware of the medications that is administered and sets up her own doctor's appointments and medication reviews. Shanice Brown informed that there have been some issues with staff not initialing the medication administration record. Shanice Brown has questioned staff about this, and they would respond that they forgot to sign. She would then ask Resident A if meds were administered, and Resident A would confirm that it was. Shanice Brown is not able to look at medications and count medications to confirm as she is not a nurse. Shanice Brown went to the home approximately two weeks ago and the medications were initialed.

On 02/16/2024, Genoa Pharmacy responded in a statement, "We have not had any issues with the Iyana's AFC Home not receiving their medications, however; due to the nature of prescription dispening, there are times when we cannot dispense a prescription, such as a prescription not having any refills to dispense. When a medication is out of refills, it is part of our process to contact the prescriber and request refills or a new prescription for the patient. We also notify the group home if the prescriber denies the refill request and requires the patient to make an appointment. Currently, we deliever medications to Iyana's AFC Home for patients who are residing in the home. The home has the option to pick up medications directly from the pharmacy, if needed. When medications were due to be refilled in September, the medications were out of refills. We requested refills from the prescriber. We communicated to the AFC Home that the medications were out of refills on 08/31/2023 and 09/28/2023. Since there were no refills remaining we did not receive refill authorization from the prescriber, we could not dispense the medications. On 10/17/2023, we received authorization to refill Resident A's medications. The medications were then dispensed and delievered to Resident A's group home. The following medications were authorized to be dispensed by the prescriber on 10/17/2023: Atorvastatin 80mg tablet and Omeprazole 20mg capsule.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	In speaking with staff, residents, pharmacist, nurse and case manager, there was not enough evidence to establish a violation. Resident A, B and C informed that they are being administered their medications daily and staff also indicated that the residents are receiving their medications. The pharmacist did not have any known issues regarding medications and informed that they currently deliver the medications to the home. Staff informed that they do not pick up medications as they are delivered to the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking if medication by a resident, he or she shall comply with all of the following information: **(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.**
ANALYSIS:	In speaking with nurse and case manager, there is enough evidence to establish a rule violation as staff are not properly initialing the med sheets. Nurse Garrett informed that there were two weeks of initials for medications that had yet to be delivered to the home and Case Manager, Shanice Brown also informed that in her review of the med sheets, staff were administering medications, but not initialing it on the medication sheet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
The medication door was left unlocked and Resident A had access to Resident A's medications and handed them to the nurse.

INVESTIGATION:
On 01/19/2024, I interviewed Staff, Ronda Tyler regarding the allegation. Ronda Tyler denied that Resident A would have access to the medications because staff keeps the door locked and keep the keys with them at all times. Ms. Tyler informed that she was not working that day, but she doubts that Resident A would go into the closet, because Resident A wouldn't know to try to open the door because it is always locked.

On 01/19/2024, Ronda Tyler was observed using her keys to get inside the medication closet to so that I could review the medications and med sheets.

On 01/31/2024, I interviewed Licensee, Nakia Woods regarding the allegation. Nakia Woods informed that to her knowledge, the medication door is always locked. There would be no reason for the door to be left open.

On 01/31/2024, I checked to see if the door was locked, and it was. It does not appear to be accessible to any of the residents.

On 01/31/2024, I interviewed Resident A regarding the allegation. Resident A informed that the medication closet is always locked and denied ever having access to the medication and handing medications to the nurse. Resident A informed that you have to have a key to access the medication closet.

On 01/31/2024, I interviewed Resident B regarding access to the medication closet. Resident B informed that then medication door is always locked.

On 01/31/2024, I interviewed Resident C regarding access to the medication closet. Resident C stated, "No, the door is always locked, and the staff always has the key."

On 02/09/2024, I interviewed Staff, LaPorsha Thompson regarding the allegation. LaPorsha Thompson informed that she was not working that day but informed that the medication door is never left unlocked. LaPorsha Thompson then reiterated, "At least I can speak for myself. I never leave it unlocked."

On 02/16/2024, I interviewed Hope Network Nurse, Dawn Garrett regarding the allegation. Nurse Garrett informed that the medication closet was closed but left unlocked. Staff was on the front porch at the time. None of the residents went into the medication closet.

On 02/16/2024, I interviewed Resident A's Case Manager, Shanice Brown regarding the allegation. Shanice Brown informed that whenever she goes to the home, the medication closet is closed. She was at the home approximately 2 weeks ago and the door was closed and appeared to be locked but does not know with certainty because she doesn't go into the medication closet.

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 S333.1101 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:	In speaking with staff, residents, nurse and case manager, there was not enough evidence to establish a violation. All staff and residents interviewed indicated that the medication closet is kept locked at all times. Case Manager, Shanice Brown informed that the medication door is always closed and appeared to be locked but is not for certain. Nurse Dawn Garrett informed that the door was closed one day but was left unlocked. None of the residents went into the closet.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:
During both of my onsite visits on 01/19/2024 and 01/31/2024, staff could not find Resident A's medication administration records for October and November 2023.

INVESTIGATION:
On 01/19/2024, I reviewed the current medication administration sheet and it appeared to be accurate. Medication administration records were viewed from 01/01/2024 to 01/19/2024. When I asked Staff, Ronda Tyler for Resident A's med sheets for October and November, Staff Tyler checked the medication closet, and the office on the 2nd floor, but was unable to find them.

On 01/31/2024, while reviewing all of the residents' current medication administration records, I asked Licensee Designee, Nakia Woods for Resident A's October and November 2023 medication administration records. Nakia Woods initially looked in the closet and then she asked staff, Ronda Tyler if she knew where they were. Ronda Tyler informed that she had looked for them the last time and could not find them. Nakia Woods contacted Staff, LaPorsha Thompson over the phone and told her where they usually are kept, but they were not in that location.

On 02/09/2024, I contacted Staff, LaPorsha Thompson regarding the medication administration records (MARs). LaPorsha Thompson indicated that they usually keep the old medication administration records on the 2nd floor. She explained that sometimes staff will move things around and maybe it got misplaced, but hopefully not thrown away.

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.**
ANALYSIS:	Based upon my review of the medication sheets during both of my onsite visits, there is enough evidence to support a rule violation. During my visits to the home, October and November 2023 medication administration records were not in the home and staff were unable to locate them.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/15/2024, I held an Exit Conference with Licensee Designee, Nakia Woods regarding the results of the special investigation. Nakia Woods was informed that she would need to submit a corrective action plan within the next 15 days.

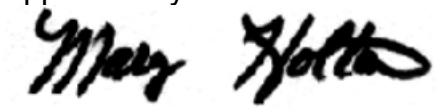
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (Capacity 1-6).

02/16/2024

Anthony Humphrey — Date
Licensing Consultant

Approved By:



02/16/2024

Mary E. Holton — Date
Area Manager