GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 4, 2024

Esther Mwankenja
Zanzibar Adult Foster Care, LLC
5806 Outer Drive
Bath, MI 48808

RE: License #: AS330406614
Investigation #: 2024A0790015
Zanzibar Adult Foster Care, LLC

Dear Esther Mwankenja:

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. If I am unavailable and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330406614
Investigation #:	2024A0790015
Complaint Receipt Date:	03/25/2024
Investigation Initiation Date:	03/25/2024
Report Due Date:	05/24/2024
Licensee Name:	Zanzibar Adult Foster Care, LLC
Licensee Address:	5806 Outer Drive Bath, MI 48808
Licensee Telephone #:	Unknown
Administrator:	Esther Mwankenja
Licensee Designee:	Esther Mwankenja
Name of Facility:	Zanzibar Adult Foster Care, LLC
Facility Address:	520 S. Holmes Street Lansing, MI 48912
Facility Telephone #:	(517) 885-0716
Original Issuance Date:	02/17/2021
License Status:	REGULAR
Effective Date:	08/17/2023
Expiration Date:	08/16/2025
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's room has feces on the wall and Resident A smells like urine.	Yes
The residents' needs are not being met and there was no food in the refrigerator on 03/21/2024.	No
Resident A has not been getting his medications as prescribed. Resident A has not been taken to get his blood drawn, his mental health injections, or to his medication clinic appointments in months.	No

III. METHODOLOGY

03/25/2024	Special Investigation Intake 2024A0790015
03/25/2024	APS Referral not necessary because APS is investigating the allegations.
03/25/2024	Special Investigation Initiated - On Site
03/25/2024	Inspection Completed On-site- Interviewed licensee designee Esther Rupia Mwankenja, Resident B, and Resident C.
03/26/2024	Contact - Telephone call received from AFC area manager Dawn Timm. Case conference.
03/26/2024	Contact - Telephone call made to interview adult protective services (APS) worker Robert Lindley via phone on 01/26/2024. I left a voicemail message requesting a return call.
03/26/2024	Contact - Telephone call made to interview Guardian A1 via phone on 03/26/2024. I left a voicemail message requesting a return call.
03/26/2024	Contact - Telephone call made to interview case manager Eric Baraga from Clinton-Eaton-Ingham (CEI) Community Mental Health (CMH). I left a voicemail message requesting a return call.
03/26/2024	Contact - Telephone call made. Interviewed licensee designee Esther Mwankenja.
03/26/2024	Contact – Telephone call received. Interviewed APS worker Robert Lindley.

03/26/2024	Contact – Telephone call received. Interviewed case manager Eric Baraga from CEI-CMH.
03/27/2024	Contact - Telephone call received from case manager Eric Barringer from CMH requesting consultation and technical assistance regarding the viability of Resident A returning to the facility. Consultation and technical assistance were provided.
03/27/2024	Contact - Telephone call received from Sparrow Hospital Behavioral Health requesting consultation and technical assistance regarding the viability of Resident A returning to the facility. Consultation and technical assistance were provided.
03/27/2024	Contact - Telephone call received. Interviewed Guardian A1.
03/27/2024	Inspection Completed On-site. Interviewed Ms. Mwankenja and Resident A.
03/27/2024	Exit Conference with licensee designee Esther Mwankenja.
04/02/2024	Inspection Completed-BCAL Sub. Compliance.
04/02/2024	Corrective Action Plan Requested and Due on 04/17/2024.

ALLEGATION: Resident A's room has feces on the wall and Resident A smells like urine.

INVESTIGATION:

I reviewed an Adult Protective Services (APS) referral dated 03/22/2024. The referral stated Resident A is diagnosed with schizophrenia, mild cognitive impairments, high blood pressure, and borderline diabetes. Resident A ambulates independently. The referral indicated Resident A's public guardian (Guardian A1) had difficulty seeing Resident A despite going to the home on 03/13 and 03/15, and 03/19/2024. When visiting Resident A on 03/21/2024, the home was filthy, Resident A smelled of urine, feces, and bad body odor. Resident A's hair and beard was matted to his face and head. According to the referral, Resident A could not remember the last time he had showered. The referral also indicated Resident A's bedroom had feces all over the walls and throughout the room. There was no bedding or pillows in Resident's room, and there was only a mattress cover on the bed. The room was in complete disarray.

The referral indicated direct care staff members (DCSMs), and licensee designee Esther Mwankenja had instructed Resident A to defecate in a white bucket. DCSMs would then take the bucket outside and dispose of the feces in the backyard.

I reviewed a *Health Facility Complaint* form dated 03/22/2024. The form stated Resident A resides at Zanzibar Adult Foster Care and has a legal guardian. The form indicated Resident A suffers from schizoaffective disorder bipolar type. Resident A's room has feces on the wall and Resident A smells like urine. The feces on the wall are old and have been cleaned up. There are concerns Resident A is not being taken care of. The form indicated law enforcement (LE) was dispatched to the facility on 03/21/2024. The licensee designee Esther Mwankenja was not present when LE visited the facility, but her son Patrovah Mazara was present. This form stated Ms. Mwankenja works 12-hour shifts and is often away from the facility leaving direct care staff member Patrovah Mazara in charge. The form alleged Mr. Mazara did not appear to know what was going on or was capable of caring for residents.

I conducted an unannounced onsite investigation on 03/25/2024. I interviewed licensee designee Esther Rupia Mwankenja who stated she is almost always at the facility. Ms. Mwankenja said she received her licensed practical nurse (LPN) license recently and had worked a shift in Grand Rapids, MI on 03/21/2024. Ms. Mwankenja said Guardian A1 made an unannounced visit on 03/21/2024 while she was working and found feces in one corner of Resident A's bedroom. She stated Resident A had also wiped the feces all over the walls of his room.

Ms. Mwankenja said her son Patrovah Mazara, who is also trained as a direct care staff member, was at the facility caring for the residents on 03/21/2024 when Guardian A1 arrived. She stated Guardian A1 was concerned because Mr. Mazara would not communicate with Guardian A1, did not appear to know what was going on, nor how to properly care for the residents. Ms. Mwankenja stated she has subsequently informed her son he can no longer work at the facility and has begun the process of hiring qualified DCSMs to work at the facility. She said she told Patrovah Mazara he must speak to professionals who come to the facility and answer all their questions.

Ms. Mwankenja stated Resident A's guardian was also upset because Resident A was unshaven, dirty, and disheveled. She said Resident A refuses to shave when it is cold outside because it makes him feel too cold. Ms. Mwankenja said Resident A refuses to shower and complete other activities of daily living (ADLs) associated with overall hygiene. She stated Resident A often refuses to brush his teeth, comb his hair, shave, etc.

Ms. Mwankenja admitted there was feces all over the floor and the walls in Resident A's bedroom on 03/21/2024 when Guardian A1 arrived. She also admitted Resident A smelled of urine, feces, was dirty, unkempt, and unshaven because he refused to participate in ADL associated with overall hygiene. Ms. Mwankenja said she was not at the facility to clean up the feces in Resident A's bedroom on 03/21/2024, and direct care staff member Patrovah Mazara told her he was overwhelmed with making breakfast, lunch, dinner, and all the other daily tasks involved when caring for the residents and was unable to clean up the feces in Resident A's room at the time.

Ms. Mwankenja said Resident A urinates in his room. She stated Resident A has been urinating in his room since he was admitted to the facility. Ms. Mwankenja explained this is a known behavior for Resident A and Resident A's Community Mental Health (CMH) case manager Eric Barriger is aware of this behavior. She said Resident A will take all his clothing out of the drawers and cupboards in his room, throw them on the floor in his closet, and then urinate on all of them. Ms. Mwankenja stated she is constantly washing his clothes because of this behavior.

Ms. Mwankenja stated she recently gave Resident A a urinal to use when he needs to urinate while in his bedroom. She said Resident A complained it was too small and refused to use it. Ms. Mwankenja admitted that on 03/06/2024 she put a black bucket in Resident A's room for him to urinate in because Resident A told her he could not make to the bathroom to use the toilet in time even though the bathroom is right next to Resident A's room.

Ms. Mwankenja stated Resident A began urinating and defecating in the bucket she placed in his room, so she removed it. She said he urinated and defecated in the bucket on 03/19/2024. She said after the incident on 03/19/2024 she explained to Resident A he could not defecate in the bucket because it was not the purpose of the bucket. Ms. Mwankenja told Resident A the bucket was only to be used for urination. Ms. Mwankenja said she later removed the bucket from Resident A's room on 03/19/2024.

I observed Resident A's room to be clean and clutter free. I did not smell any unpleasant odors in Resident A's bedroom. I observed clean sheets, a blanket, and pillow with a pillowcase on Resident A's bed.

I reviewed Resident A's *Assessment Plan for AFC Residents.* I found under the section titled, 'Toileting' it documented, "[Resident A] flushes wipes and other materials into toilet which has caused overflow." I found under the section titled, 'Bathing, Grooming (hair care, teeth, nails, etc.), Dressing, and Personal Hygiene' it documented, "[Resident A] needs prompting to complete these tasks." I found under the section titled, 'Moves Independently in Community', it documented, "[Resident A] requires supervision, transportation to appointments, and has a history of getting lost in the community."

I reviewed Resident A's Treatment Plan from CMH and found nothing mentioned regarding urinating and/or defecating on the floor in his bedroom, nor about smearing feces on walls. Ms. Mwankenja was adamant these are known behaviors Resident A has historically displayed and she is unsure why they are not mentioned in his Treatment Plan.

I reviewed Resident A's *Health Care Appraisal* and confirmed all the diagnoses listed for him above in the APS referral and Health Facility Complaint Form. The *Health Care Appraisal* also indicated Resident A is overweight and a tobacco smoker.

I attempted to interview Guardian A1 via phone on 03/26/2024. I left a voicemail message requesting a return call.

I interview CMH case manager Eric Barriger via phone on 03/26/2024. Mr. Barriger stated he spoke with Guardian A1 on 03/21/2024 after her visit to the facility and was informed of the concerns found relating to Resident A's personal care. He confirmed the allegations to be accurate and comprehensive based on his knowledge of what was found on 03/21/2024. Mr. Barriger stated Resident A does have an issue with incontinence and has been diagnosed with polydipsia which is defined as an excessive thirst or compulsive water drinking. He said Resident A has had this issue for at least a year and he has been attempting to get services in place to assist with this diagnosis and behaviors involved. Mr. Barriger said the polydipsia diagnosis is not currently listed in Resident A's CMH Treatment Plan because he has not been able to get Resident A's primary care physician (PCP) from Visiting Physicians to write it in Resident A's Treatment Plan, provide a bladder restriction plan, and refer Resident A to a behavioral health treatment therapist for counseling and treatment. Ms. Barriger stated he is going to continue to try and get Resident A assistance with this. He said it is complicated waiting for the PCP to add the diagnosis to Resident A's Treatment Plan.

Mr. Barriger said in the meantime he and Ms. Mwankenja have been attempting to get Resident A to wear adult briefs. He stated Resident A was embarrassed to wear them, but Ms. Mwankenja had informed him she had gotten him to wear adult briefs sometimes with underwear over them so no one would know he was wearing them.

Mr. Barriger said Resident A does not always comply with his Treatment Plan and he has had to initiate a court order appointment because of noncompliance. Mr. Barringer said he was also concerned when hearing from Guardian A1 about Resident A being allowed to leave the facility alone and walk to a local convenience store. He said Resident A requires assistance with all activities of daily living (ADL) and needs supervision when in the community.

I interviewed adult protective services (APS) worker Robert Lindley via phone on 03/26/2024. Mr. Lindley stated he conducted an unannounced onsite investigation on 03/22/2024 and found licensee designee Esther Mwankenja had the facility cleaned up, including Resident A's bedroom. He said he did not witness feces on the floor and/or walls in Resident A's room. Mr. Lindley said the bathroom and other areas of the facility had also been cleaned up and organized. He had no concerns regarding the cleanliness or organization of the facility during his onsite investigation.

Mr. Lindley stated he interviewed Guardian A1 and found out Guardian A1 and police were at the facility on 03/21/2024 and witnessed feces on the floor and walls in Resident A's bedroom. Mr. Lindley stated Resident A was filthy and unkempt on 03/21/2024 according to Guardian A1. Guardian A1 said Resident A's hair had not been washed and was matted to his head, his beard had not been trimmed, he smelled of urine, feces, and bad body odor.

Mr. Lindley said he interviewed Ms. Mwankenja on 03/22/2024. He stated Ms. Mwankenja disclosed she had been out of the state receiving oral surgery for a few days and admitted direct care staff member Patrovah Mazara let things go while she was gone. Mr. Lindley stated Ms. Mwankenja admitted the allegations were true regarding the condition of Resident A and Resident A's bedroom on 03/21/2024. He said based on Ms. Mwankenja's admission and the evidence obtained, and condition of the facility observed by Guardian A1 and police on 03/21/2024, he is going to substantiate both Ms. Mwankenja and direct care staff member Mr. Mazara for neglect.

I interviewed Guardian A1 via phone on 03/27/2024. Guardian A1 said on 03/21/2024 direct care staff member (DCSM) Patrovah Mazara, who is the licensee designee Esther Mwankenja's son, was at the facility and answered the door. Guardian A1 stated Mr. Mazara came up from the basement when answering the door and appeared to have just woken up. Guardian A1 said she does not have any evidence indicating Mr. Mazara had just woken up but it appeared like Mr. Mazara had just woken up.

Guardian A1 stated Resident A appeared disoriented, was filthy, and smelled of urine when observed at the facility on 03/21/2024. She said the facility smelled like marijuana, appeared filthy, and extremely cluttered. Guardian A1 said there was dirty water and dishes in the kitchen sink and there was a film around the dishes which made it appear like the dishes had been in there for a very long time. Guardian A1 said Resident A was reluctant to allow anyone access to his bedroom but eventually consented. She stated there was urine and feces all over the wood floor and walls in Resident A's bedroom. Guardian A1 said there was a bucket with a mop beside it in his bedroom and the mop head was covered in feces and looked as if it had been used to try and clean up the feces.

Guardian A1 stated Resident A has a history of incontinence and urinating in his bedroom, but she was not aware of him doing so while at the three previous Adult Foster Care (AFC) facilities he resided at. Guardian A1 stated there was only a mattress with a plastic cover over it and a balled-up blue comforter on Resident A's bed.

Guardian A1 said Resident A indicated licensee designee Esther Mwankenja told him he could go to the bathroom in the corner of his bedroom and gave him the bucket and mop to clean up after doing so.

Guardian A1 said Resident A was encouraged to shower in the facility's sit-down tub and shower. She stated soap could not be located and Resident A stated Ms. Mwankenja said she was bringing soap home for him and the other residents after work.

I reviewed pictures taken on 03/21/2024 of the facility and confirmed the pictures were of Resident A's bedroom within this facility and that there was feces found all over the wood floor and smeared on the walls in Resident A's bedroom.

I reviewed a Renewal Licensing Study Report dated 08/15/2023 and completed by Adult Foster Care (AFC) licensing consultant Jana Lipps. The report cited Rule 400.14403.

(1) due to this same resident's bedroom smelling of urine and having a thick layer of dirt on the baseboards, windows coverings, and floors. This same resident's mattress was observed to be soiled with urine and not in good condition. The corrective action plan documented the room would be cleaned and the mattress replaced.

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 gathered during this special investigation through review of documentation and interviews with licensee designee Ms. Mwankenja, APS worker Mr. Lindley, CMH case manager Mr. Baraga, Guardian A1, and Resident A there was sufficient evidence found indicating Ms. Mwankenja did not adequately maintain Resident A's bedroom in a manner which provided for Resident A's health, safety, and well-being. Ms. Mwankenja admitted there was feces all over the floor and the walls in Resident A's bedroom on 03/21/2024. She also admitted on 03/06/2024 she put a black bucket in Resident A's bedroom for him to urinate in.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE RENEWAL LICENSING STUDY REPORT AND CORRECTIVE ACTION PLAN BOTH DATED 08/15/2023].**

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with licensee designee Ms. Mwankenja, APS worker Mr. Lindley, CMH case manager Mr. Baraga, Guardian A1, and Resident A there was sufficient evidence found indicating Ms. Mwankenja failed to afford to Resident A the opportunity and instructions for daily bathing, oral, and personal hygiene. Ms. Mwankenja failed to ensure Resident A was bathing at least weekly. Ms. Mwankenja admitted Resident A smelled of urine, feces, was dirty, unkempt, and unshaven when observed on 03/21/2024 because he refused to participate in activities of daily living (ADL) associated with overall hygiene.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The residents' needs are not being met, the facility was filthy, and there was no food in the refrigerator on 03/21/2024.

INVESTIGATION:

The APS referral dated 03/22/2024 indicated the facility smelled of marijuana. The referral also indicated Resident A was very confused, disheveled and was hungry. The referral stated there was only molded lettuce, four tomatoes, and a tiny bit of orange juice in the refrigerator.

The referral indicated there was dirty water in the kitchen sink with dirty dishes. The bathroom had dried feces and urine all over the place. There was no toilet paper, towels, or soap.

The referral stated Resident A left the home because he was confused and agitated. There was concern Resident A has been panhandling to get food because the home does not have any food.

The *Health Facility Complaint* form dated 03/22/2024 indicated nothing is being done at the facility to meet Resident A's needs. There was no food in the refrigerator.

At the time of my unannounced onsite investigation on 03/25/2024 the facility appeared relatively clean and organized throughout. I observed Resident A's room to be clean and clutter free. I did not smell any unpleasant odors when in Resident A's bedroom. I observed clean sheets, a blanket, and pillow with a pillow sheet on Resident A's bed. I observed the bathroom to be clean and clutter free. I observed individual towels in the bathroom. I did not smell any unpleasant odors permeating from the bathroom.

I inspected the entire facility during the unannounced onsite investigation on 03/28/2024. I looked in the refrigerator where there was pizza, various produce, condiments, and several things to drink. The freezer was completely full of meat and boxes of food items. Ms. Mwankenja said she had much more food in her vehicle and carried in three full boxes of food she had brought to the facility from another home she owns in Lansing, MI.

The kitchen sink was empty and clean. There were no dirty dishes witnessed in the kitchen.

I interviewed Resident B and Resident C who both stated they like living at the facility and had no concerns. Resident B and Resident C both said they have always been provided three meals a day plus snacks while residing at the facility.

During my interview with Guardian A1 on 03/27/2024, she said she asked to visit with Resident A and Mr. Mazara consented and headed back downstairs to the basement. She stated attempts were made by knocking on the basement door to get Mr. Mazara to come back up later during the visit but he never responded to the knocks or came back up.

Guardian A1 said the only things found in the refrigerator on 03/21/2024 were two wilting lettuce leaves, condiments, and a small amount of orange juice in the bottom of the jug. She stated there were four bowls of Kellogg's Froot Loop cereal with a banana, a cup of milk beside each bowl of cereal and in front of each chair around the kitchen table. Guardian A1 said it was approximately 10:45 a.m. and the food had not been touched.

Guardian A1 said Resident A left the facility. She stated Resident A has gone out in the community on his own and she does not believe he should be able to do so. She said Resident A was once found with other unknown individuals in Frandor and she has previously found him lying on the ground in front of a convenience store putting on one of his shoes.

Guardian A1 said police were called to the facility after Resident A left the home. She said the police spoke to Mr. Mazara while he was boiling hotdogs for the residents. Mr. Mazara told the police Resident A is probably out begging. Mr. Mazara said Resident A does that.

I reviewed pictures provided to me and taken on 03/21/2024 of the facility. I confirmed the pictures were of the facility but could not confirm the entire facility was filthy.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with licensee designee Ms. Mwankenja, Resident B, Resident C, APS worker Mr. Lindley, CMH case manager Mr. Baraga, Guardian A1, and Resident A, and my own observation during an unannounced onsite investigation, there was insufficient evidence found indicating the residents' needs are not being met, the facility was filthy, or there was no food for the residents to eat on 03/21/2024. On 03/21/2024 four bowls of Kellogg's Froot Loop cereal were observed with a banana and a cup of milk sitting beside them on the kitchen table. Mr. Mazara was later observed boiling hotdogs for the residents. Resident B and Resident C said they have always been provided three meals a day plus snacks since residing at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A has not been getting his medications as prescribed. Resident A has not been taken to get his blood drawn, his mental health injections, or to his medication clinic appointments in months.

INVESTIGATION:

The APS referral dated 03/22/2024 stated the DCSMs, and Ms. Mwankenja had not taken Resident A for monthly blood draws, his mental health injections, or medication clinic appointments.

The referral went on to indicate Resident A's medications were nowhere to be found in the facility and only one of his allergy medications were located on the counter in the kitchen.

During the unannounced onsite investigation on 03/25/2024, Ms. Mwankenja stated Resident A remained in the hospital. She said Guardian A1 had Resident A admitted to the hospital on 03/24/2024 but she was not certain why. Ms. Mwankenja said she has

been getting calls from physicians and other medical professionals at the hospital stating Resident A does not have a medical or acute mental health issues requiring hospitalization and should be discharged. She stated she has no issues with Resident A returning to the facility but referred to the physicians and medical professionals to Guardian A1 and Resident A's CMH case manager for approval to discharge Resident A and transport him back to the facility.

Mr. Barriger said Resident A missed three appointments with his psychiatrist on the following dates 01/09, 02/20, and 03/11/2024. He stated the appointments are over Zoom so he is not sure why Resident A missed these appointments. Mr. Barringer said Resident A does not like any doctors and requires a lot of assistance and encouragement to get him to speak with and visit a physician and/or psychiatrist.

Mr. Barringer said he is unaware and has no knowledge of Resident A not being taken to get his blood drawn, his mental health injections, or to his medication clinic appointments in months. He stated he is unaware of Resident A requiring injections for any mental health diagnosis. Mr. Barringer said he knows the psychiatrist was able to meet over Zoom with Resident A on 02/13/2024 for 13 minutes and psychiatrist did not document anything about Resident A's blood levels. Mr. Barringer said he cannot not find any documentation regarding Resident A's blood levels since 07/12/2023 and he is unsure if Ms. Mwankenja has medication at the facility for Resident A given this information.

Mr. Barringer said Resident A's psychiatrist does need to know Resident A's blood levels every quarter to continue to prescribe and refill medications. He stated he does not see any new notes from the psychiatrist documenting Resident A's blood levels.

Mr. Barringer said given his conversation with Guardian A1 he believes Resident A requires additional support to ensure he attends his appointments with his PCP and psychiatrist, gets his blood drawn when necessary, and more direct care when it comes to getting his hair cut, beard trimmed, fingernails/toenails clipped, bathed, teeth brushed, etc.

APS Specialist Mr. Lindley said Guardian A1 informed him Resident A had not been receiving his medications as prescribed and DCSM Patrovah Mazara was unable to locate Resident A's medications when Guardian A1 conducted an unannounced visit on 03/21/2024. Mr. Lindley said Guardian A1 was going to petition the court to have Resident A hospitalized for medical evaluation and medication review given he had not been receiving his medications.

I interviewed licensee designee Esther Mwankenja via phone on 03/26/2024. Ms. Mwankenja said Resident A has always received his medication per doctor's orders. She said he has never failed to receive medication as ordered. Ms. Mwankenja said Resident A has had his blood drawn monthly as ordered. She stated Resident A has never missed getting his blood drawn. Ms. Mwankenja said Resident A cannot receive medication refills without getting his blood drawn every month. She said she would

provide documentation demonstrating Resident A has had his blood drawn every month and received all his prescribed medications per doctor's orders.

Ms. Mwankenja said Resident A does not get mental health injections. She stated Resident A does not have a doctor's order for mental health injections.

Ms. Mwankenja said she would provide me with copies of Resident A's monthly medication administration records (MARs) and medical documentation from Sparrow Laboratory showing Resident A has had his blood drawn monthly since moving into the facility.

Ms. Mwankenja said Resident A has only missed an appointment with his psychiatrist recently and it was on 03/11/2024. Ms. Mwankenja said she logged into the Zoom meeting with Resident A's psychiatrist, but the psychiatrist never logged in. She said the meeting was scheduled for 10:00 a.m. on 03/11/2024. Ms. Mwankenja said she contact CMH, and they encouraged Ms. Mwankenja and Resident A to remain logged in for a while because the psychiatrist could just be running late. Ms. Mwankenja said they remained on the Zoom meeting for approximately 30 minutes, but the psychiatrist did not show. She stated there was only one other time Resident A missed an appointment with his psychiatrist. Ms. Mwankenja said she could not locate Resident A because he had gone for a walk. She stated she logged into the Zoom meeting, but Resident A did not return home until much later so missed his appointment with the psychiatrist.

Guardian A1 stated before visiting with Resident A a request was made to review Resident A's *Resident Records.* She said Mr. Mazara disclosed he does not have access to Resident A's *Resident Records* only licensee designee Ms. Mwankenja has access to the residents' *Resident Records.*
Guardian A1 said a request was made to review Resident A's medications and *Medication Administration Record (MAR).* She said Mr. Mazara said licensee designee Ms. Mwankenja has the key to the cupboard where the medications and *MARs* are kept.

Guardian A1 stated she does not believe Resident A has been getting his medications or monthly blood draws. Guardian A1 said she does not have any evidence indicating Resident A has not been getting his medications or monthly blood draws.

Guardian A1 said a petition was filed and granted by Judge Garcia to have Resident A involuntarily hospitalized for medical evaluation and have his blood levels checked. Guardian A1 stated Resident A was involuntarily taken by police to Sparrow Hospital on 03/24/2024 and has not been incontinent while there. Resident A has had no accidents while at Sparrow Hospital.

I conducted an announced onsite visit on 03/27/2024 and reviewed Resident A's *MAR*s from 01/2024 through 03/2024. I compared Resident A's 03/2024 *MAR* with his medications which were in blister packs. There was no evidence found indicating Resident A did not receive his prescribed medication per doctor's orders.

I was unable to find a doctor's order for mental health injections.

I reviewed *Medical Expenses Reports* from Ascension MI Pharmacy from 06/2023 through 03/2024. There was no evidence found indicating Resident A did not receive monthly blood draws per doctor's orders.

Resident A returned to the facility when I was reviewing the above-mentioned documentation and stated he was happy to be back. Resident A stated he has no complaints living at the facility and indicated Ms. Mwankenja provides good care and meets his needs.

I conducted an exit conference with Ms. Mwankenja on 03/27/2024. I informed Ms. Mwankenja two rule violations were established because of this investigation and requested an acceptable Corrective Action Plan (CAP) be provided within the required timeframe.

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. **(2) Medication shall be given, taken, or applied pursuant to label instructions.**

ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with licensee designee Ms. Mwankenja, APS worker Mr. Lindley, CMH case manager Mr. Baraga, Guardian A1, and Resident A there was insufficient evidence found indicating Resident A has not been getting his medication administered as prescribed or getting his blood drawn monthly. Mr. Barringer said he is unaware and has no knowledge of Resident A failing to get his blood drawn monthly or his medication administered as prescribed. Mr. Baringer stated he is unaware of Resident A requiring injections for mental illness.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

04/02/2024

_____

Rodney Gill Date
Licensing Consultant

Approved By:

04/04/2024

_____

Dawn N. Timm Date
Area Manager