GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2024

Happiness Nwaopara
Divine Care Inc.
6400 Royal Pointe Drive
West Bloomfield, MI 48322

RE: License #: AS820415477
Investigation #: 2024A0901028
Divine Care: Bennett

Dear Happiness Nwaopara:

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 (313) 456-0380.

Sincerely,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820415477
Investigation #:	2024A0901028
Complaint Receipt Date:	03/25/2024
Investigation Initiation Date:	03/27/2024
Report Due Date:	05/24/2024
Licensee Name:	Divine Care Inc.
Licensee Address:	6400 Royal Pointe Drive West Bloomfield, MI 48322
Licensee Telephone #:	(248) 346-4397
Administrator:	Happiness Nwaopara
Licensee Designee:	Happiness Nwaopara
Name of Facility:	Divine Care: Bennett
Facility Address:	27129 Bennett Redford, MI 48240
Facility Telephone #:	(313) 543-3033
Original Issuance Date:	06/07/2023
License Status:	REGULAR
Effective Date:	12/07/2023
Expiration Date:	12/06/2025
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

I. ALLEGATION(S)

	Violation Established?
Resident A was left at the hospital by staff.	Yes
Resident A had numerous bed sores.	No

II. METHODOLOGY

03/25/2024	Special Investigation Intake 2024A0901028
03/27/2024	Special Investigation Initiated - Telephone Licensee Designee
03/29/2024	APS Referral
03/29/2024	Referral - Recipient Rights
04/01/2024	Contact - Document Received Email
04/02/2024	Contact - Telephone call made Sister A
04/03/2024	Contact - Document Received Fax
04/03/2024	Contact - Telephone call made Case Manager
04/17/2024	Contact - Telephone call made Nurse
04/22/2024	Contact - Telephone call made Resident A
05/17/2024	Exit Conference

	Licensee Designee
05/17/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was left at the hospital by staff.

INVESTIGATION:

On 03/27/2024, I made a telephone call to the licensee designee, Happiness Nwaopara. Happiness stated she had given Resident A a 30-day discharge notice and the 30 days had passed. Resident A's sister, Sister A, did not want her to move and was holding up the discharge by finding fault with other placements. When Resident A was admitted to the hospital in February 2024, the social worker was not sure how long she would be there. Happiness discussed with the social worker about finding Resident A a new placement upon discharge because she was not taking her back. She stated Resident A was in the hospital for a week or more and that she also informed Resident A's case manager that she was not accepting her back. Resident A does not have a guardian. Sister A is her Power of Attorney.

On 04/01/2024, I received an email from Happiness. It consisted of a 30-day discharge notice that was dated for 12/20/2023. It indicated that the case manager, Genetta Campbell, from Community Living Services (CLS), was notified 12/20/2023 and that the reason for discharge was that Sister A was too much to deal with due to pressure and fault finding. Happiness also sent a copy of a text message she sent Sister A on 02/03/204 informing her that Resident A was in the hospital and that she was not accepting her back because her 30-day discharge notice was over.

On 04/02/2024, I made a telephone call to Sister A. She reported Resident A received a discharge notice. They were receiving placement referrals and was in the process of trying to find a new placement when Resident A was abruptly discharged from the facility. Sister A stated she received a call from the hospital informing her that staff was not picking Resident A up. Due to the short notice, she had to place Resident A in a home she was not satisfied with.

On 04/03/2024, I made a telephone call to Genetta. She explained that Happiness felt Sister A was too much to deal with so she gave Resident A a 30-day discharge notice. During the residential assessment on 01/30/2024, Happiness asked the CLS assessor if Resident A was admitted to the hospital could she leave her there. They explained to her she could not do that. When Resident A was admitted to the hospital in February, Happiness initially said she would take her back, but changed her mind and left Resident A there. She felt Sister A was taking too long to find a new placement.

On 05/17/2024, I conducted an exit conference with Happiness. She disagreed with my investigative findings. She felt justified in the way she handled the discharge, due to Sister A prolonging discharge by finding fault with other placements.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge.** **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency** **or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Based on the information obtained during this investigation, Resident A was improperly discharged from the home. The Department's discharge procedures were not followed. Although a written 30-day discharge notice was given and the 30 days were exceeded, Resident A was discharged before another appropriate placement was obtained.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had numerous bed sores.

INVESTIGATION:

On 03/27/2024, I made a telephone call to the licensee designee, Happiness Nwaopara. She denied the allegations. She stated Resident A came from her previous placement with bed sores. She also stated she was bed bound and they transferred her daily to her wheelchair. In addition to this, she was receiving wound care from a nurse that came to the home.

On 04/01/2024, I received an email from Happiness. It included a copy of her assessment plan that indicated she received wound care from nurse Andrea. There were also copies of a medical consultation forms verifying she was receiving wound care at her previous placement prior to being placed in the above facility on 11/29/2024.

On 04/02/2024, I made a telephone call to Sister A. She stated while at the hospital, Resident A had numerous bed sores from not being rotated at the AFC home.

On 04/03/2024, I made a telephone call to Genetta Campbell, Resident A's case manager from CLS. She was not aware of Resident A having any bed sores. The only hole she was aware of was the one from the catheter. She suggested I contact Nurse Andrea and gave me her number.

On 04/03/2024, I received a copy of Resident A's hospital discharge paperwork from Resident A's current placement. She was admitted to Beaumont hospital 02/03/2024-02/08/2024. It indicated she had a stage III pressure ulcer of sacral region and an unstageable pressure ulcer of left buttock.

On 04/17/2024, I made a telephone call to Nurse Andrea, from Beaumont Home Health. She stated Resident A already had bed sores on her sacral area prior to placement and was receiving wound care. She stated Resident A did not have any wounds on her buttock and if she had any upon discharge from the hospital they likely occurred while in the hospital. Andrea stated staff at the AFC home provided really good care, some of the best she has seen, and that her wounds actually got better. She also stated Resident A was highly suspectable to getting bed sores, even with being rotated.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's

	physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegations. There is no indication that staff did not follow medical instructions as it pertains to providing proper care to Resident A. Documentation was obtained verifying that Resident A had bed sores prior to placement in the home. In addition to this, her wound care nurse verified that staff provided good care when it came to attending to her wounds and her wounds got better. She also verified Resident A did not have a wound on her buttock while at the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan. I recommend the status of the license remains unchanged.

_____05/17/2024

Regina Buchanan
Licensing Consultant

Date

Approved By:

05/20/2024

_____

Ardra Hunter
Area Manager

Date