GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 20, 2024

Tema Pefok
Precious AFC Home, Inc.
7435 Silver leaf Lane
West Bloomfield, MI 48322

RE: License #: AS820414983
Investigation #: 2024A0101024
Merritt

Dear Mrs. Pefok:

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.

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820414983
Investigation #:	2024A0101024
Complaint Receipt Date:	04/10/2024
Investigation Initiation Date:	04/19/2024
Report Due Date:	06/09/2024
Licensee Name:	Precious AFC Home, Inc.
Licensee Address:	7435 Silver leaf Lane West Bloomfield, MI 48322
Licensee Telephone #:	(248) 506-5329
Administrator:	Tema Pefok
Licensee Designee:	Tema Pefok
Name of Facility:	Merritt
Facility Address:	32116 Merritt Drive. Westland, MI 48185
Facility Telephone #:	(734) 956-6420
Original Issuance Date:	04/20/2023
License **Status:**	REGULAR
Effective Date:	10/20/2023
Expiration Date:	10/19/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was being discharged from the hospital. Resident A does not want to return to the Merritt Adult Foster Care Home because staff had been physical with him.	No
Resident A is not getting his medication properly.	Yes
Resident A is not getting enough food.	No

III. METHODOLOGY

04/10/2024	Special Investigation Intake 2024A0101024
04/19/2024	Special Investigation Initiated - Telephone LD left message
04/19/2024	Adult Protective Services (APS) Referral Received from APS Office of Recipient Rights (ORR) Referral made
04/19/2024	Contact - Telephone call made direct care staff Katlyn Lassier
04/19/2024	Contact - Telephone call received APS worker Martina Franklin
04/19/2024	Contact - Telephone call received Recipient Rights Investigator (RRI) Lexus Davis
05/17/2024	Inspection Completed Interviewed Home Manager Kia Flowers Observed food supply Reviewed Resident A assessment plan
06/05/2024	Contact – Documents received Resident A's medication logs. Incident reports on Resident A
07/09/2024	Contact- Telephone call made Resident A's caseworker Stella Amakeme

07/10/2024	Contact – Telephone call received Ms. Amakeme
07/10/2024	Contact – Telephone call made Resident A's case worker Alex Lindsay
07/10/2024	Exit Conference Ms. Pefok, Left message
07/11/2024	Contact – Telephone call received Ms. Pefok message left
07/11/2024	Contact – Telephone call made Ms. Pefok message left
07/11/2024	Contact – Telephone call received Mr. Lindsay voice message left
07/12/2024	Contact – Telephone call made Ms. Pefok – Conducted exit conference

ALLEGATION: Resident A was being discharged from the hospital. Resident A does not want to return to the Merritt Adult Foster Care Home because staff had been physical with him.

INVESTIGATION: On 04/19/2024, I received a telephone call from the Adult Protective Services Worker, Martina Franklin. Ms. Franklin stated she was at the hospital interviewing Resident A and he has changed his story. Resident A is now stating it is the hospital staff that is physical with him. He is denying that the group home staff had been physical with him.

On 04/19/2024, I spoke with the Recipient Rights Investigator, Lexus Davis. Ms. Davis stated she spoke with Resident A before he left the hospital. Ms. Davis stated Resident A denied the allegation that direct care staff at the group home had been physical with him.

On 05/17/2024, I conducted an onsite in inspection the expectation of interviewing Resident A. However, according to the Home Manager, Kia Flowers, when Resident A was discharged from the hospital he did not return to the Merritt AFC Home and his whereabouts are unknown. Ms. Flowers further stated Resident A did not have a guardian.

On 05/17/2024, I interviewed Ms. Flowers. Ms. Flowers stated the staff have never been physical with Resident A. However, there was an incident when Resident A

assaulted a staff. Resident A picked up a chair and chased direct care staff Oliver Taliaferro out of the home.

I also reviewed Resident A's treatment plan on 05/17/2024. Resident A's treatment plan indicates "he will swing on others."

On 07/11/2024, I received a voice message from Resident A's caseworker. Mr. Lindsay stated he really doesn't know Resident A. Mr. Lindsay stated he met with Resident A on one occasion and during that meeting Resident A announced, "You're pissing me off." According to Mr. Lindsay Resident A refused to work with Mr. Lindsay and he refused the services Lincoln Behavioral Services offer.

On 07/12/2024, I conducted an exit conference with Ms. Pefok. Ms. Pefok agreed with the findings regarding this allegation.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner. (e) Withhold food, water, clothing, rest, or toilet use. (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats. (g) Refuse the resident entrance to the home. (h) Isolation of a resident as defined in R 400.14102(1)(m). (i) Any electrical shock device.

ANALYSIS:	There is no evidence to determine that the group home staff was physical with Resident A. On 04/19/2024, I received a telephone call from APS Worker, Martina Franklin. Ms. Franklin stated that Resident A has changed his story. He is now stating it is the hospital staff that is physical with him. On 04/19/2024, I received a telephone call from the RRI, Lexus Davis. Ms. Davis stated she spoke with Resident A before he left the hospital and he denied the allegation that staff was physical with him. On 05/17/2024, I interviewed the home manager Kia Flowers. Ms. Flowers stated that staff have never been physical with Resident A. On 05/17/2025, I conducted an onsite investigation with the intention of interviewing Resident A. According to Ms. Flowers the group home staff do not know the whereabouts of Resident A. According to Resident A former caseworker, Mr. Linsday, Resident A refused to worker with him, and he also refused the services Lincoln Behavioral Services offer.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is not getting his medication properly.

INVESTIGATION: On 05/17/2024, I interviewed Ms. Flowers. Ms. Flowers stated that during the month of April Resident A resided in the Merrit Home from April 1 thru 11. Resident A was sent to the hospital on the evening of 04/12/2024, because he was nonresponsive.

On 07/09/2024, I reviewed Resident A's April 2024, pharmacy supplied medication logs. I noticed Resident A did not receive his insulin injections. I also noticed Resident A's Divalproex medication 500 mg 1 tablet at 8:00 a.m. and 2 tablets at 5:00 p.m. had not been given. Furthermore, Resident A only received his Haloperidol medication 10 mg 1 tab at bedtime on April 10 and 11.

On 07/10/2024, I spoke with Ms. Flowers regarding Resident A's medication logs. Ms. Flowers stated that on 03/18/2024, Resident A was treated at Trinity Hospital for Hypoglycemia. At that time his insulin injection was discontinued, and Metformin 500 mg 1 tablet twice daily was prescribed. Ms. Flowers stated she did not know

why Resident A did not receive his Divalproex medication from April 1 thru 12. Ms. Flowers also stated she did not know why Resident A only received his Haloperidol medication on April 10 and 11. On 07/10/2024, Ms. Flowers forwarded me a copy of Resident A's discharge summary from Trinity Hospital which listed all of Resident A's current medications. Ms. Flowers also forwarded me the pharmacy supplied medication logs she had sent to me on 07/09/2024 and a handwritten medication log. The handwritten medication log indicated that Resident A had received his Metformin medication April 1 thru 12. The handwritten medication log also listed the Divalproex as being given April 1 thru 12. It was logical why the Metformin medication was on a handwritten log. It was a new medication. However, it made no sense why the Divalproex medication was on the handwritten medication log when it was already on the pharmacy supplied medication log. I asked Ms. Flowers why would staff put the Divalproex medication on the handwritten medication log when it was already on the pharmacy supplied log that was being used. Ms. Flowers stated staff did not understand the directions for use on the pharmacy supplied log. However, the directions for use were exactly the same on both logs. Resident A's April medication log indicates he was administered 5mg of Haloperidol April 1 thru 12, however, the list of Resident A's current medications did not indicate he was prescribed 5mg of Haloperidol.

On 07/10/2024, I contacted Ms. Pefok to conduct an exit conference, there was no answer. Therefore, I left a voice message stating that there was a violation. On 07/11/2024, Ms. Pefok left me a voice message indicating she was confused because the recipient rights investigator did not substantiate. On the same date I left Ms. Pefok a message stating that my investigation and the recipient rights investigation are independent. On 07/12/2024, I spoke with Ms. Pefok. Ms. Pefok stated she explained to staff that there should not be two medication logs. She stated the staff started a handwritten log because they did not see Divalproex on the pharmacy supplied medication log. I informed Ms. Pefok staff were signing for two other medications listed directly below the Divalproex entry on the medication log. Ms. Pefok further stated she could not remember what was going on with Resident A's Haloperidol medication.

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:	Some of Resident A's prescription medications were not given as prescribed. During the month of April 2024, Resident A resided in the Merritt Home for 12 days. Resident A was discharged from this home on April 12. Resident A is prescribed Haloperidol 10 mg 1 tab at bedtime. According to the pharmacy supplied medication log Resident A was only given this medication on April 10 and 11. From April 1 thru April 12 Resident A was given Haloperidol 5mg 1tablet daily. According to his current list of medications, Resident A's was not prescribed this medication. There are also concerns that Resident A did not receive his Divalproex medication from April 1thru 12. Resident A's pharmacy supplied medication log did not indicate this medication had been given. After this error was brought to the home manager's attention, she forwarded a handwritten medication log with this medication on it. However, she could not provide a reasonable explanation why this medication was on a handwritten log when it was already on the pharmacy supplied log that was being used. The handwritten logs are usually used when there is a medication change, for example a new medication was added during the month, or the pharmacy supplied log was lost or damaged. Ms. Pefok stated she explained to staff that there should not be two medication logs. She stated the staff started a handwritten log because they did not see Divalproex on the pharmacy supplied log. I informed Ms. Pefok staff were signing for two other medications being given direct below the Divalproex medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is not getting enough food.

INVESTIGATION: On 05/17/2024, I conducted an onsite visit. I observed the food supply. There was a sufficient amount of food available to provide three nutritious meals daily.

On 06/05/2024, I reviewed Resident A's weight record. Resident A was admitted into the Merritt AFC home on 09/23/2023. At the time of placement Resident A weighed

167 pounds. While residing in this home Resident A did not experience any significant weight loss. On 03/30/2024, Resident A weighed 165 pounds.

On 07/12/2024, I conducted an exit conference with Ms. Pefok. Ms. Pefok agreed with this finding.

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:	There is insufficient evidence to determine Resident A is not getting enough food. On 05/17/2024, I conducted an onsite visit. The licensee had a sufficient supply of food available in the facility to provide three nutritious meals daily. On 06/05/2024, I reviewed Resident A's weight record. Resident A was admitted into the Merritt AFC home on 09/23/2023. At the time of placement Resident A weighed 167 pounds. While residing in this home Resident A did not experience any significant weight loss. On 03/30/2024, Resident A weighed 165 pounds.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

07/31/2024

Edith Richardson
Licensing Consultant

Date

Approved By:

8/20/2024

Ardra Hunter
Area Manager

Date