GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 10, 2024

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

RE: License #: AS730398654
Investigation #: 2025A0623003
Iyana's A.F.C. INC.

Dear Nakia Woods:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan was required. On October 29, 2024, you submitted an acceptable written corrective action 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 (517) 643-7960.

Sincerely,

Cynthia Badour

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(517) 648-8877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730398654
Investigation #:	2025A0623003
Complaint Receipt Date:	10/18/2024
Investigation Initiation Date:	10/18/2024
Report Due Date:	12/17/2024
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?
Resident A was not receiving their medication after their last hospitalization.	Yes

III. METHODOLOGY

10/18/2024	Special Investigation Intake 2025A0623003
10/18/2024	APS Referral
10/18/2024	Special Investigation Initiated - Telephone Contact with APS Jessire Ramos
10/29/2024	Inspection Completed On-site Observation and Interviews
10/29/2024	Inspection Completed-BCAL Sub. Compliance
10/29/2024	Exit Conference with Licensee Nakia Woods
10/29/2024	Corrective Action Plan Received
10/29/2024	Corrective Action Plan Approved.
12/03/2024	Contact - Telephone call made I contacted Training and Treatment Innovations (TTI) case manager Kelly Kadlec

ALLEGATION: Resident A was not receiving their medication after their last hospitalization.

INVESTIGATION: On 10/18/2024, I contacted APS (Adult Protective Services) worker Jessire Ramos. APS Ramos stated that Resident A was hospitalized in September 2024. APS Ramos stated that there was miscommunication between the AFC home and the pharmacy and Resident A did not have their prescriptions when they were sent home. Resident A did not get their prescription until 9/26/2024. The change in the script was for Keppra to be increased 500 mg to 750 mg. APS is substantiating for neglect as the AFC homeowner failed to follow up with the pharmacy. APS Ramos stated that Resident A likes the home and wants to stay.

On 10/29/2024, I conducted an unannounced onsite inspection of Iyana's AFC home. I interviewed Resident A, direct care worker Ronda Tyler and interviewed Licensee Nakia Woods separately.

On 10/29/2024, I interviewed Resident A at the dining room table. Resident A appeared clean, neatly groomed and dressed for the weather. Resident A was found to be alert and oriented to person, place, and time. I observed Resident A was able to ambulate throughout the home without adaptive equipment. Resident A denied having a guardian, however they do have a payee. Resident A also stated that they were hospitalized due to having balance issues and falling. Resident A stated the medication didn't get delivered to the home. Resident A was unable to remember what medication was not delivered. Resident A did not have their discharge paperwork and stated they did not remember what they did with it. Resident A stated that the home staff give them their medication. Resident A stated that they do not have any medical complications due to not having the medication. Resident A stated that the staff at the home are good people, and they would like to continue to reside in the home.

On 10/29/2024, I interviewed direct care worker (DCW) Ronda Tyler. DCW Tyler stated that they were not working when the mix-up with the medication delivery occurred. DCW Tyler stated that usually it isn't a problem. DCW Tyler stated that Resident A usually takes their medication without any issue.

On 10/29/2024, I interviewed Licensee Designee (LD) Nakia Woods. LD Woods stated that Resident A has lived at the home for 2 years, after being placed by a TTI case manager. LD Woods stated that Resident A attends the day program Friends for Recovery every day except Wednesday. Licensee Woods stated that there was miscommunication with Genoa pharmacy which sent the script Keppra to the hospital instead of the AFC home once Resident A was released. Licensee Woods stated that Resident A was taken to the physician for follow up on 10/21/2024 and the prescription was renewed. LD Woods stated they have set up a plan with the pharmacy for better communication measures. Genoa Pharmacy will email if there are any medications that need refills.

On 10/29/2024, I observed the medication log for Resident A. The prescription renewal confirmed. The Keppra prescription is 250 mg tablets: take 3 tablets (total 750 mg) by mouth twice a day. Resident A was discharged from Covenant Hospital in Saginaw on 9/18/2024. Resident A's dosage was corrected on 9/26/2024.

On 12/3/2024, I contacted TTI case manager (CM) Kelly Kadlec. CM Kadlec stated that Resident A has been doing well at the home. CM Kadlec stated that she checks monthly on Resident A. CM Kadlec reported that Resident A had not reported any concerns with the home. I informed CM Kadlec of the miscommunication with the

medication. CM Kadlec expressed that they would make a point of checking on Resident A's medication during monthly visits.

On 10/29/2024, I conducted an exit conference with Licensee Designee (LD) Woods. I explained my findings and the rule violation. A corrective action plan was completed on site. I also observed pharmacy delivery to the home while completing the onsite investigation. LD Woods stated that the home would be more proactive in ensuring their residents' medications are filled and up to date.

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:	I interviewed Resident A, (LD) Woods, and home staff. I consulted with APS and TTI case manager. Resident A was prescribed in September to take 250 mg Keppra. 3 tablets by mouth twice a day. Resident A was discharged from the hospital on 9/18/2024 and the proper dose of medication was not administered until 9/26/2024. The home failed to administer the correct dosage following the discharge of Resident A from the hospital. (LD) Woods admitted to miscommunication between the home and the pharmacy which resulted in Resident A temporarily not having their prescription sent to the AFC home. I observed the pharmacy delivering medications to the AFC home showing this issue has been resolved. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

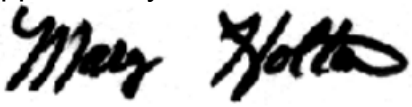
II. RECOMMENDATION

An approved written corrective action plan has been received. I recommend that the status of this facility's license remain unchanged.

12/10/2024

Cynthia Badour Date
Licensing Consultant

Approved By:



12/10/2024

Mary E. Holton Date
Area Manager