



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 25, 2025

Betty Mackie  
Henry's Inc.  
P.O. Box 81733  
Rochester, MI 48308

RE: License #: AS820273992  
Investigation #: 2025A0119016  
Henry's Inc. Paradise Home

Dear Ms. Mackie:

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,

A handwritten signature in cursive script that reads "Shatonla Daniel". The ink is dark and the signature is fluid.

Shatonla Daniel, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 919-3003

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820273992
<b>Investigation #:</b>	2025A0119016
<b>Complaint Receipt Date:</b>	01/31/2025
<b>Investigation Initiation Date:</b>	02/03/2025
<b>Report Due Date:</b>	04/01/2025
<b>Licensee Name:</b>	Henrys Inc.
<b>Licensee Address:</b>	P.O. Box 81733 Rochester, MI 48308
<b>Licensee Telephone #:</b>	(313) 910-2951
<b>Administrator:</b>	Sheila Hawkins
<b>Licensee Designee:</b>	Betty Mackie
<b>Name of Facility:</b>	Henry's Inc. Paradise Home
<b>Facility Address:</b>	30935 Pennsylvania Romulus, MI 48174
<b>Facility Telephone #:</b>	(313) 363-7018
<b>Original Issuance Date:</b>	06/07/2005
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/20/2023
<b>Expiration Date:</b>	11/19/2025
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED MENTALLY ILL DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED

## II. ALLEGATION(S)

	Violation Established?
Resident A's medication log was not signed by Staff- Azsha Franks.	Yes
Resident A's blood pressure not monitored by staff in the event Resident A's medication needed to be adjusted.	Yes
Additional Findings	Yes

## III. METHODOLOGY

01/31/2025	Special Investigation Intake 2025A0119016
01/31/2025	Referral - Recipient Rights Received
01/31/2025	APS Referral Received
02/03/2025	Special Investigation Initiated - Telephone call made Recipient Rights Investigator Avery Barnett
02/04/2025	Contact - Telephone call made Administrator- Shelia Hawkins
02/05/2025	Contact - Telephone call made Complainant
02/07/2025	Inspection Completed On-site Staff- Samatha Grace and Angelique Childs
02/07/2025	Contact- Telephone call made Staff- Azsha Franks, Left message
03/12/2025	Contact- Document Received Staff- Azsha Franks' Training Document and Written Reprimand
03/13/2025	Contact- Telephone call made Staff- Azsha Franks, unable to leave a message voice mail full

03/13/2025	Contact- Document Received Resident A's Individual Plan of Service
03/13/2025	Exit Conference Licensee Designee- Bettie Mackie

### **ALLEGATION:**

**Resident A's medication log was not signed by Staff- Azsha Franks.**

### **INVESTIGATION:**

On 02/03/2025, I telephoned and interviewed Recipient Rights Investigator- Avery Barnett regarding the above allegations. Mr. Barnett stated the staff were not initialing the medication administration records for January 2025 but Resident A did receive his medications. Mr. Barnett stated he was still completing his investigation.

On 02/04/2025, I telephoned and interviewed Administrator- Sheila Hawkins regarding the above allegations. She stated Staff- Azsha Franks did dispense the medications to Resident A but did not sign the medication administration record for January 2025. Mrs. Hawkins stated Resident A attends the day program daily.

On 02/05/2025, I telephoned and interviewed the complainant regarding the above allegations. The complainant stated she observed five or six days on Resident A's medication administration record that were not initialed by various staff not just Ms. Franks for January 2025. The complainant stated she was visiting the home on 01/28/2025.

On 02/07/2025, I completed an onsite inspection and interviewed Staff- Samatha Grace and Staff- Angelique Childs regarding the above allegations. Ms. Grace stated when she notices that the resident medication record is not initialed by another staff, she will inform that staff person. She stated all residents are given their medications by staff and has not noticed any blank spaces on Resident A's medication logs.

Ms. Child stated when she notices that the resident medication record was not initialed by other staff, she will inform that staff person. She stated she has observed missing staff initials on Resident A's medication log for January 2025.

While out at the facility, I observed Resident A's medication administration records to not have any missing staff initials for the month of December 2024 and January 2025.

On 3/12/2025, I received documentation that Staff- Azsha Franks was retrained with Detroit Wayne Connects (DWC) in medication administration refresher course dated 02/10/2025.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (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. (vi) A resident's refusal to accept prescribed medication or procedures.
<b>ANALYSIS:</b>	Administrator- Sheila Hawkins, Recipient Rights Investigator- Avery Barnett, Staff- Angelique Childs, and the complainant stated the staff were not initialing on Resident A's medication administration record for January 2025.  Therefore, staff failed to complete Resident A's medication administration record by initialing at the time medication was given.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Resident A's blood pressure not monitored by staff in the event Resident A's medication needed to be adjusted.**

**INVESTIGATION:**

On 02/03/2025, I telephoned and interviewed Recipient Rights Investigator Avery Barnett regarding the above allegations. Mr. Barnett stated Resident A's blood pressure and blood sugar was not being logged daily for January 2025. He stated that Resident A's individual plan of service indicated that Resident A was to have his

blood pressure and blood sugar levels check daily in the event he needs additional medications based on these readings.

On 02/05/2025, I telephoned and interviewed the complainant regarding the above allegations. The complainant stated she was at the home on 01/28/2025 and she stated there were at least 10 entries in December for blood pressure monitoring and there was no log for January 2025.

On 02/07/2025, I telephoned and interviewed Administrator- Sheila Hawkins regarding the above allegations. Mrs. Hawkins stated they staff have begun keeping a record of Resident A's blood pressure and sugar levels. Ms. Hawkins stated she could not provide an explanation as to why the staff had not been recording Resident A's blood pressure and sugar levels for the past two months.

On 02/07/2025, I completed an onsite inspection and interviewed Staff- Samatha Grace and Staff- Angelique Childs regarding the above allegations. Ms. Grace stated staff have not been documenting Resident A's blood pressure and sugar levels in December 2024 and January 2025, however, they have begun doing it for the month of February.

Ms. Childs stated she had no knowledge of Resident A having a log to document his blood pressure and blood sugar levels for January 2025. Ms. Childs stated she recently stated working in the facility.

While out at the facility, I did not observed log that records Resident A's blood pressure and/or sugar levels for December 2024 and January 2025.

On 3/12/2025, I received a written reprimand for Staff- Azsha Franks for not recording blood pressure on 02/01/2025.

On 03/13/2025, I received Resident A's Individual Plan of Service dated 12/18/2024 from Community Living Services which indicated in the heading "Medication Instruction Skills" and "Health & Safety / Medical Complexity" that Resident A needs assistance with monitoring his blood pressure and blood glucose levels from AFC staff.

<b>APPLICABLE RULE</b>	
<b>R 400.14310</b>	<b>Resident health care.</b>
	(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: (a) Medications. (b) Special diets.

	<p>(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.</p> <p>(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.</p>
<b>ANALYSIS:</b>	<p>Recipient Rights Investigator Avery Barnett Staff- Angelique Childs stated Resident A blood pressure and blood sugar was not being logged daily for January 2025.</p> <p>Administrator- Sheila Hawkins, the complainant, and Staff- Samatha Grace stated staff have not documenting Resident A's blood pressure and sugar levels in December 2024 and January 2025. Ms. Childs stated she had no knowledge of Resident A having a log to document his blood pressure and blood sugar levels</p> <p>While at the facility there were not records of Resident A's blood pressure and/or sugar levels for December 2024 and January 2025 available for review.</p> <p>Resident A's Individual Plan of Service dated 12/18/2024 from Community Living Services which indicated in the heading "Medication Instruction Skills" and "Health &amp; Safety / Medical Complexity" that Resident A needs assistance with monitoring his blood pressure and blood glucose levels from AFC staff.</p> <p>Therefore, the licensee did not ensure that staff followed the instructions and recommendations of other health care professional with regard maintaining a log of Resident A's blood pressure and sugar levels.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **ADDITIONAL FINDINGS:**

#### **INVESTIGATION:**

On 02/05/2025, I telephoned and interviewed the complainant regarding the above allegations. The complainant stated Staff- Azsha Franks did not know how to read the medical instruction provided on the medication administration record for Resident A. The complainant stated Ms. Franks was not able to differentiate between the greater than or less than symbol in order to provide Resident A additional medications if needed based on his blood pressure readings.



On 02/07/2025, I completed an onsite inspection and I reviewed Resident A's medication administration log sheet which indicated Resident A's blood pressure should be checked weekly and continue taking Zestril and Toprol daily if SBP< 100 or DBP< 60. Hold BP meds if SBP>190 or DBP >110. Recheck in 5 minutes if still elevated and call the clinic.

Staff- Samatha Grace and Staff- Angelique Childs were interviewed about Resident A's medication instructions. Ms. Grace was able to differentiate between greater than and less than symbol for Resident A's medication instructions.

Ms. Childs was not able to differentiate between greater than and less than symbol in order for Resident A's medication instructions.

On 02/07/2025, I telephoned and interviewed Administrator- Sheila Hawkins regarding the above allegations. Ms. Hawkins stated the staff have been trained on how to properly dispense medications, check blood pressures, sugar levels, and follow special medication procedures. I informed Ms. Hawkins that during the onsite inspection, the staff did not appear sure and was not able to communicate with me their knowledge.

On 03/13/2025, I received Resident A's Individual Plan of Service dated 12/18/2024 from Community Living Services which indicated in the heading "Medication Instruction Skills" and "Health & Safety / Medical Complexity" that Resident A needs assistance with monitoring his blood pressure and blood glucose levels.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	(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 §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

<b>ANALYSIS:</b>	<p>The complainant stated Staff - Azsha Franks was not able to differentiate between the greater than or less than symbol and Staff- Angelique Childs was not able to demonstrate to me that she can differentiate between the greater than or less than symbol in order to provide Resident A additional medications if needed based on his blood pressure readings.</p> <p>Resident A's Individual Plan of Service dated 12/18/2024 from Community Living Services indicates staff should assist in monitoring Resident A's blood pressure.</p> <p>Based on the above, facility staff was not able to apply special medical procedures as prescribed by a licensed physician.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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

*Shatonla Daniel*

03/24/2025

Shatonla Daniel  
Licensing Consultant

Date

Approved By:

*A. Hunter*

03/25/2025

Ardra Hunter  
Area Manager

Date