GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 25, 2025

Huma Shahid
Golden Grace LLC
6449 Rutledge Park Dr.
West Bloomfield, MI 48322

RE: License #: AS630417897
Investigation #: 2025A0612022
Golden Grace, LLC

Dear Ms. Shahid:

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 (248) 972-9136.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630417897
Investigation #:	2025A0612022
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/09/2025
Report Due Date:	09/05/2025
Licensee Name:	Golden Grace LLC
Licensee Address:	3840 Manchester Ct. Bloomfield Hills, MI 48302
Licensee Telephone #:	(248) 431-8588
Administrator:	Huma Shahid
Licensee Designee:	Huma Shahid
Name of Facility:	Golden Grace, LLC
Facility Address:	6449 Rutledge Park Dr. West Bloomfield, MI 48322
Facility Telephone #:	(248) 431-8588
Original Issuance Date:	02/06/2024
License Status:	REGULAR
Effective Date:	08/06/2024
Expiration Date:	08/05/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff Preola Jenkins stole Resident A's medications and was under the influence while at work. As a result, Resident A did not get her medications as prescribed.	Yes
Resident A is bedbound. While direct care staff Preola Jenkins was under the influence of Resident A's medication, she got Resident A out of bed and sat her in her wheelchair at the kitchen table.	No
The home does not have adequate staffing.	No
Residents are given "horrible food."	No

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0612022
07/08/2025	APS Referral Referral received from Adult Protective Services (APS). APS denied the referral for investigation.
07/09/2025	Special Investigation Initiated - Telephone Telephone interview completed with Golden Grace director of operations, Uzair Shahid.
07/09/2025	Contact - Document Received Facility documentation received via text message from Golden Grace director of operations, Uzair Shahid: proof of Preola Jenkins drug test results, Ms. Jenkins termination notice, Incident Report, and Resident A's Medication Administration Records.
07/10/2025	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed Safe Hands Hospice LPN Lisa Akins, direct care staff Alissa Hayes, Resident A, Resident B, Resident C, and Resident D.
07/21/2025	Contact - Document Received Facility documentation received via text message from Golden Grace director of operations, Uzair Shahid: Resident assessment plans and fire drills.

07/22/2025	Contact – Telephone call made Telephone interview completed with Safe Hands Hospice director of nursing, Kristy Doyle.
07/24/2025	Contact – Telephone call made Telephone call to direct care staff Preola Jenkins. The phone numbers provided are out of service.
07/24/2025	Exit Conference I placed a telephone call to licensee designee Huma Shahid to conduct an exit conference.

ALLEGATION:

- **Direct care staff Preola Jenkins stole Resident A's medications and was under the influence while at work. As a result, Resident A did not get her medications as prescribed.**
- **Resident A is bedbound. While direct care staff Preola Jenkins was under the influence of Resident A's medication, she got Resident A out of bed and sat her in her wheelchair at the kitchen table.**

INVESTIGATION:

On 07/08/25, I received a referral from Adult Protective Services (APS). APS denied the referral for investigation. The referral indicates Resident A resides in a group home. Resident A has bone cancer; she is declining and on hospice. The group home does not have adequate staffing. Due to this Resident A is not getting adequate care. For a while, Resident A was not getting her medication due to the lack of staffing and staff stealing her medication. On numerous occasions, direct care staff Preola Jenkins was high from taking Resident A's medication that is used to calm her. As a result of Ms. Jenkins taking Resident A's medication Resident A was not getting her medication until she was in constant pain. Three months ago, it was decided that Resident A would not get out of bed due to her cancer causing her pain. While Ms. Jenkins was under the influence of Resident A's medication, she got Resident A out of bed and had her sitting up in her wheelchair at the kitchen table. Resident A has been in pain ever since. Ms. Jenkins was fired from the group home. Resident A is given horrible food, such as dollar store steaks. Resident A does not eat the food because it is terrible so her family must take her food.

On 07/09/25, I initiated my investigation by interviewing Golden Grace director of operations, Uzair Shahid via telephone. Mr. Shahid stated Resident A is on hospice and she is showing signs of transitioning. Mr. Shahid stated on an unknown date, Resident A told Safe Hands Hospice director of nursing, Kristy, that she suspected direct care staff Preola Jenkins was stealing her medications and was under the influence while at work. Mr. Shahid stated they reviewed the cameras in the home and did not observe

any theft. On 05/30/25, Ms. Jenkins was sent in for drug testing and placed on a two-week suspension. Mr. Shahid stated Ms. Jenkins declined to be observed while completing the drug test at the testing facility. The drug test came back clear. Mr. Shahid stated on 06/27/25, it was discovered that four of Resident A's medication bottles were missing from her medication basket. Ms. Jenkins was called in for questioning. Ms. Jenkins went to the medication basket and suddenly two of the four missing medications appeared. Ms. Jenkins was terminated immediately. Mr. Shahid stated Ms. Jenkins was a direct care staff and a member of the household, she was asked to move out of the facility the same day that she was terminated. Mr. Shahid stated at the time of the termination he overheard Ms. Jenkins vomiting in the restroom, he suspects that she could have consumed some of the medications and she was vomiting them up. Mr. Shahid stated when Ms. Jenkins was administering medications, she was completing Resident A's Medication Administration Record indicating that the medication was administered and therefore, this issue was not immediately identified. Mr. Shahid provided facility documentation related to this allegation.

On 07/09/25, I reviewed facility documentation received via text message from Golden Grace director of operations, Uzair Shahid: proof of Preola Jenkins drug test results, Ms. Jenkins termination notice, Incident Report, and Resident A's Medication Administration Record (MAR). In summary, Ms. Jenkins took a urine drug screen at Quest Diagnostics on 05/30/25. There results were "uneventful." Incident Report dated 06/27/25 indicated that four of Resident A's medication bottles were missing from her medication basket. Ms. Jenkins was called in for questioning. Ms. Jenkins went to the medication basket and suddenly two of the four missing medication bottles appeared. This was witnessed by licensee designee Huma Shahid, director of operations Uzair Shahid, direct care staff Alissa Hayes, and Safe Hands Hospice Nurse Kristy. Ms. Jenkins was terminated. I also reviewed Resident A's April 2025 – May 2025 MAR. All medications are marked as if they were administered to Resident A as prescribed. Resident A is prescribed Lorazepam (Ativan) 1 mg – take 1 tablet every 8 hours and MS Contin 15 mg – take twice daily. Lastly, I reviewed Resident A's assessment plan which indicates Resident A is bedbound and uses a hoyer lift to transfer.

On 07/10/25, I completed an unscheduled onsite investigation. I interviewed Safe Hands Hospice LPN Lisa Akins, direct care staff Alissa Hayes, Resident A, Resident B, Resident C, and Resident D. While onsite I observed that all resident medications are secured and locked in a medication cabinet. The facility has cameras and there is a camera near the medication cabinet.

On 07/10/25, I interviewed direct care staff Alissa Hayes. Ms. Hayes stated direct care staff Preola Jenkins stole a bottle of Resident A's MS Contin (morphine). As such, Resident A did not receive her medications as they are prescribed. Resident A is experiencing pain because she has gone without her medications. Ms. Hayes explained on 06/27/25, four of Resident A's medications were missing from her medication basket. Ms. Jenkins was called in for questioning. Ms. Jenkins immediately went to the medication basket and suddenly two of the four missing medication bottles appeared. These medications were not there before Ms. Jenkins came in. Ms. Hayes stated she

suspects Ms. Jenkins was under the influence while on shift. Ms. Hayes stated she would see Ms. Jenkins at shift change and she appeared to be under the influence. Her moods were up and down, and she smelled of marijuana. Ms. Hayes stated Resident A is on hospice and it was recommended that she stay in bed due to her pain. She was told by another resident that Ms. Jenkins was getting Resident A out of bed.

On 07/10/25, I interviewed Safe Hands Hospice LPN Lisa Akins. Ms. Akins stated Resident A's medications were stolen by a direct care staff. Resident A's assigned hospice nurse, Kristy, has additional details on the specific medications that were taken. Ms. Akins stated as a result of not having her medications as prescribed Resident A is miserable and crying in pain.

On 07/10/25, I observed Resident A laying in bed. Safe Hands Hospice LPN Lisa Akins had just administered medication to Resident A for pain. Resident A was unable to be interviewed.

On 07/10/25, I interviewed Resident B. Resident B stated her medications are administered to her as prescribed she reports no issues.

On 07/10/25, I observed Resident C in bed asleep. Resident C could not be interviewed.

On 07/10/25, I interviewed Resident D. Resident D stated her medications are given to her daily as they are prescribed. She has no issues or concerns.

On 07/22/25, I interviewed Safe Hands Hospice director of nursing, Kristy Doyle via telephone. Ms. Doyle informed me that Resident A died on 07/20/2025. Ms. Doyle stated Resident A was losing her frontal lobe and she could not always openly communicate. However, Resident A told her that she was not getting her medications at night. Ms. Doyle remarked, Resident A was in a great deal of pain. Ms. Doyle stated she began doing medication counts every two to three weeks. The home watched the cameras, and they waited to find any suspicious activity. Ms. Doyle stated one day she came in to compete a medication count and medication bottles were missing. Ms. Doyle contacted the pharmacy, and she was informed that the medication was delivered to the home and signed for by direct care staff Preola Jenkins.

Ms. Doyle stated with licensee designee Huma Shahid, director of operations Uzair Shahid, and direct care staff Alissa Hayes, Ms. Jenkins was called in for questioning. Ms. Doyle asked Ms. Jenkins where the medications were and further informed her that if she did not produce the medications the police would be contacted immediately. Ms. Jenkins went to Resident A's medication basket and suddenly the missing medications appeared. Ms. Jenkins was terminated immediately. The medication bottles that were missing, but returned by Ms. Jenkins, were one bottle of MS Contin (morphine)15 mg and two bottles of Lorazepam 1 mg. MS Contin is an extended-release pain medication and without it, Resident A was suffering and uncomfortable. Following this incident Resident A's medications were switched to bubble packages. Ms. Doyle stated she is

unable to determine how many doses of medication Resident A did not receive as prescribed.

Ms. Doyle stated the first time she met direct care staff Preola Jenkins. She suspected that she was high due to the way her eyes looked and the way she responded when spoken to. Ms. Doyle stated she suspected Ms. Jenkins used marijuana, she never thought she would steal the resident's medications. Upon meeting Ms. Jenkins, Ms. Doyle stated that she notified the hospice team to watch out for her as she suspected that she was under the influence.

Ms. Doyle stated she had no knowledge of Ms. Jenkins putting Resident A into her wheelchair and sitting her at the table. Ms. Doyle remarked Resident A was in a lot of pain and could not tolerate getting out of bed anymore. Ms. Doyle stated Resident A's son wanted Resident A out of bed because he felt she was declining laying in bed. Ms. Doyle stated that she explained to him that Resident A is in a great deal of pain, and she cannot tolerate it anymore. However, the family insisted that they wanted her out of bed. So, Ms. Doyle stated that she had Safe Hands Hospice physical therapist come to the home and teach staff how to use the Hoyer lift with Resident A. This training was completed with the live in staff at the time, Peggy. Ms. Doyle stated Peggy eventually left the company and Ms. Jenkins moved in. Ms. Doyle stated she has no knowledge of any staff getting Resident A out of bed after this instance.

Ms. Doyle stated the home provides quality care. They are attentive and go above and beyond to meet the needs of the residents. Ms. Doyle remarked that she does not feel that they could have done anything differently to prevent this from happening.

On 07/24/24, I interviewed licensee designee Huma Shahid. Ms. Shahid stated Ms. Jenkins was called in for questioning regarding Resident A's missing medication. Ms. Jenkins went to the medication basket and suddenly the bottles of missing medications appeared. Ms. Jenkins was terminated immediately. The medication bottles that were missing were one bottle of MS Contin (morphine)15 mg and two bottles of Lorazepam 1 mg. Ms. Shahid stated Resident A was bedbound. However, her family requested that she be taken out of bed and sat in her wheelchair. Ms. Shahid stated she and the hospice provider continuously explained to the family that Resident A could no longer tolerate getting out of bed, but they persisted. Ms. Shahid stated they sat Resident A up in her wheelchair upon the family's request and within five minutes she was screaming that she wanted to go back to bed. Ms. Shahid stated this occurred two to three months ago, she cannot recall the name of the staff who was on shift when they got Resident A out of bed however, indicates that it was not Ms. Jenkins.

On 07/24/25, I attempted to interview direct care staff Preola Jenkins via telephone. The facility provided multiple phone numbers that they had on file for Ms. Jenkins. All the phone numbers were out of service. As such, Ms. Jenkins was not interviewed for this investigation.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care staff Preola Jenkins was not suitable to meet the physical, emotional, intellectual, and social needs of each resident. Ms. Jenkins took one bottle of Resident A's MS Contin (morphine) 15 mg and two bottles of Resident A's Lorazepam 1 mg. This resulted in Resident A not receiving her medications as prescribed and experiencing increased pain. Safe Hands Hospice director of nursing Kristy Doyle, Golden Grace director of operations Uzair Shahid, and direct care staff Alissa Hayes consistently stated that they suspect Ms. Jenkins was under the influence while on shift. Although Ms. Jenkins completed a drug test on 05/30/25, that came back clear, she declined to be observed while completing the drug test at the testing facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that while direct care staff Preola Jenkins was under the influence of Resident A's medication, she got Resident A out of bed and sat her in her wheelchair at the kitchen table. Safe Hands Hospice director of nursing Kristy Doyle and licensee designee Huma Shahid consistently stated Resident A

	was bedbound. However, her family requested that she be taken out of bed and sat in her wheelchair. Ms. Shahid and the hospice provider stated that they continuously explained to the family that Resident A could no longer tolerate getting out of bed, but they persisted. After receiving training from Safe Hands PT on how to transfer Resident A using the hoyer, Resident A sat in her wheelchair upon the family's request. This lasted for approximately five minutes before Resident A requested to return to bed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A was not given her medication as prescribed. Resident A is prescribed Lorazepam (Ativan) 1 mg – take 1 tablet every 8 hours and MS Contin 15 mg – take twice daily. Direct care staff Preola Jenkins took one bottle of Resident A's MS Contin (morphine)15 mg and two bottles of Resident A's Lorazepam 1 mg. Safe Hands Hospice director of nursing, Kristy Doyle stated she is unable to determine how many doses of medication Resident A did not receive as prescribed. However, Ms. Doyle explained that MS Contin is an extended-release pain medication and without it, Resident A was uncomfortable and suffering. Safe Hands Hospice LPN Lisa Akins and direct care staff Alissa Hayes consistently remarked that as a result of not receiving her medication as prescribed Resident A was miserable and crying in pain.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The home does not have adequate staffing.

INVESTIGATION:

The referral indicates that the home does not have adequate staffing.

On 07/10/25, I completed an unscheduled onsite investigation. I interviewed Safe Hands Hospice LPN Lisa Akins, direct care staff Alissa Hayes, Resident A, Resident B, Resident C, and Resident D.

On 07/10/25, I interviewed direct care staff Alissa Hayes. Ms. Hayes stated the home has one staff on each shift. There are five residents who live in the home. Resident A and Resident D use a Hoyer to transfer. Resident C is bedbound. Resident B walks with a walker and Resident E uses a stand-up lift to transfer.

On 07/10/25, I interviewed Safe Hands Hospice LPN Lisa Akins. Ms. Akins stated she usually completes her visits in the morning there is usually one staff on shift.

On 07/10/25, I observed Resident A lying in bed. Safe Hands Hospice LPN Lisa Akins had just administered medication to Resident A for pain. Resident A was unable to be interviewed.

On 07/10/25, I interviewed Resident B. Resident B stated she had no concerns with staffing.

On 07/10/25, I observed Resident C in bed asleep. Resident C could not be interviewed.

On 07/10/25, I interviewed Resident D. Resident D stated she had no concerns with staffing.

On 07/22/25, I interviewed Safe Hands Hospice director of nursing, Kristy Doyle via telephone. Ms. Doyle stated the facility has one staff on shift, however 90% of the time when she completed her visits it was common for licensee designee Huma Shahid and/or director of operations Uzair Shahid to be onsite. Ms. Doyle stated that Ms. Shahid was hands on with Resident A; she would often find her in Resident A's bedroom talking to her or feeding her.

I reviewed Resident A, Resident B, Resident C, Resident D, and Resident E's assessment plans. The following is relevant information. Resident A is bedbound and uses a hoyer lift to transfer. Resident B uses a walker and requires standby assistance. Resident C is bedbound. Resident D is bedbound and uses a hoyer lift to transfer. Resident E uses a wheelchair and requires the use of a hoyer lift to transfer.

I also reviewed fire drills dated 07/05/25, 06/05/25, and 05/03/25. The drills completed in June and July indicate that they were conducted by one staff. The drill completed in July took 7 minutes and 53 seconds to evacuate. The drills completed in May and June took 8 minutes to evacuate.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the home does not have sufficient direct care staff on duty for the supervision, personal care, and protection of residents. I reviewed Resident A, Resident B, Resident C, Resident D, and Resident E's assessment plans. There is no indication that any resident requires a two person assist to transfer. Fire drills are being conducted, and one staff can evacuate the residents from the home within 8 minutes.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents are given "horrible food."

INVESTIGATION:

The referral indicated Resident A is given horrible food, such as dollar store steaks. Resident A does not eat the food because it is terrible so her family must take her food.

On 07/10/25, I completed an unscheduled onsite investigation. I interviewed Safe Hands Hospice LPN Lisa Akins, direct care staff Alissa Hayes, Resident A, Resident B, Resident C, and Resident D. While onsite I observed that home had an adequate food supply including a variety of meat, dairy, fruits, vegetables, dry goods, and snacks. The home had a menu which included three meals per day. I did not observe any spoiled or expired foods. A lot of the food at the home appeared to have been purchased from Kroger.

On 07/10/25, I interviewed direct care staff Alissa Hayes. Ms. Hayes stated the food that is served to the residents is always fresh and never spoiled. Ms. Hayes remarked that she would never serve the residents food that she would not eat. My. Hayes stated she has no concern with the food at this home.

On 07/10/25, I interviewed Safe Hands Hospice LPN Lisa Akins. Ms. Akins stated she works with Resident A. Resident A does not eat food orally at this time, however, the food that is served in the home looks to be of good quality. Ms. Akins stated when

Resident A was eating food orally the staff would make her anything she wanted without issue.

On 07/10/25, I observed Resident A lying in bed. Safe Hands Hospice LPN Lisa Akins had just administered medication to Resident A for pain. Resident A was unable to be interviewed.

On 07/10/25, I interviewed Resident B. Resident B was observed eating lunch. Resident B stated the food she is served is good, she has no issues.

On 07/10/25, I observed Resident C in bed asleep. Resident C could not be interviewed.

On 07/10/25, I interviewed Resident D. Resident D stated she had a sandwich for lunch. Resident D stated she receives enough food a day, the food is of good quality, and she has no issues or concerns.

On 07/22/25, I interviewed Safe Hands Hospice director of nursing, Kristy Doyle via telephone. Ms. Doyle stated Resident A could not always consume food orally, there were times that her mouth would not open. However, the home always had food. Ms. Doyle remarked that they get fresh groceries daily. Anything that Resident A wanted to eat the home made for her, and hospice staff were welcomed into the kitchen and could get food for Resident A. Ms. Doyle stated she worked with Resident A for over a year and visited the home at all hour's day and night, she never observed any issues with the quality of food that was served.

On 07/24/25, I interviewed licensee designee Huma Shahid via telephone. Ms. Shahid stated most of their groceries are purchased from Kroger, Meijer, and sometimes Aldi. Resident A's family expressed dissatisfaction with this and expressed that they wanted the home to purchase the groceries from Costco. Ms. Shahid denied that any of the food served to the residents is "horrible", spoiled or unsafe for consumption.

On 07/24/25, I placed a telephone call to licensee designee Huma Shahid to conduct an exit conference and review my findings. Ms. Shahid was informed that a corrective action plan (CAP) would be required. Ms. Shahid acknowledged and verbally agreed to submit a CAP. Ms. Shahid informed me that Ms. Jenkins was terminated and no longer living at the home.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.

ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that residents were being served food that was spoiled or unsafe for consumption. While onsite I observed that home had an adequate food supply including a variety of meat, dairy, fruits, vegetables, dry goods, and snacks. I did not observe any spoiled or expired foods. Resident B and Resident D did not have any complaints about the food. Golden Grace staff and Safe Hands Hospice staff reported no concerns with the quality of the food that is served to residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

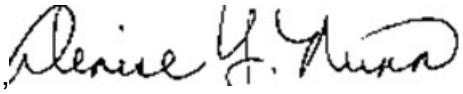
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change to the status of the license.

07/25/2025

Johnna Cade — Date
Licensing Consultant

Approved By:



07/25/2025

Denise Y. Nunn — Date
Area Manager