GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 12, 2026

Huma Shahid
Nannies Inn By Golden Grace
3050 Spring Street
West Bloomfield Town, MI 48322

RE: License #: AS630418556
Investigation #: 2026A0611008
Nannies Inn By Golden Grace

Dear Ms. Shahid:

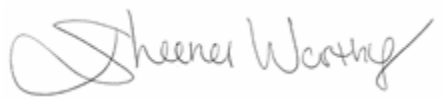
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418556
Investigation #:	2026A0611008
Complaint Receipt Date:	12/22/2025
Investigation Initiation Date:	12/23/2025
Report Due Date:	02/20/2026
Licensee Name:	Nannies Inn By Golden Grace
Licensee Address:	3050 Spring Street West Bloomfield Town, MI 48322
Licensee Telephone #:	(248) 431-8586
Administrator:	Huma Shahid
Licensee Designee:	Huma Shahid
Name of Facility:	Nannies Inn By Golden Grace
Facility Address:	3050 Spring Street West Bloomfield Town, MI 48322
Facility Telephone #:	(248) 562-7966
Original Issuance Date:	08/01/2024
License Status:	REGULAR
Effective Date:	02/01/2025
Expiration Date:	01/31/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
A resident with dementia and diabetes at Nannies Inn has reportedly suffered severe neglect, including pressure ulcers and poor hygiene, leading to significant health decline since February 2025.	Yes

III. METHODOLOGY

12/22/2025	Special Investigation Intake 2026A0611008
12/23/2025	Special Investigation Initiated - Letter I sent the reporting source an email asking for the name of the resident who the allegations are about. The reporting source provided this information shortly after receiving my email.
01/02/2026	Inspection Completed On-site I completed an unannounced onsite. I spoke to staff member Alana Caver and the owner Ozzy Shahid via telephone.
01/06/2026	APS Referral I made an Adult Protective Services (APS) referral.
01/06/2026	Contact - Telephone call made I made a telephone call to Resident M's guardian. The allegations were discussed.
01/06/2026	Contact - Document Received I received copies of Resident M assessment plan, personal care checklist, incident report, and hospital discharge paperwork.
01/13/2026	Contact - Telephone call made I made a telephone call to Ozzy Shahid regarding clarification about the personal care checklist.
01/13/2026	Contact - Telephone call made I made a telephone call to staff member Katrina McGhee. The allegations were discussed.
01/13/2026	Contact - Telephone call made I left a voice message for staff member Shaunita Vanzant requesting a call back.

01/13/2026	Contact - Telephone call received I received a return phone call from staff member Shaunita Vanzant. The allegations were discussed.
01/13/2026	Contact - Telephone call made I made a telephone call to Adult Protective Services worker Gene Evans. Mr. Evans had not started his investigation as of yet. However, Mr. Evans advised that Resident M was moved to Macomb County.
01/14/2026	Contact - Telephone call received I received a return phone call from Dr. Shivakumar Deva. The allegations were discussed.
01/15/2026	Contact - Document Received I completed a Workforce Background Check for the AFC group home. There were no background checks found for any employees.
01/15/2026	Contact - Telephone call made I left a voice message for staff member Angel Evans requesting a call back.
01/15/2026	Contact - Document Received I received copies of the employees background checks.
01/16/2026	Contact - Telephone call made I made a telephone call to staff member Angel Evans. The allegations were discussed.
01/27/2026	Contact - Telephone call made I made a telephone call to the Adult Protective Services worker Gene Evans. Mr. Evans provided an update regarding his investigation.
01/27/2026	Exit Conference I completed an exit conference with the licensee designee Huma Shahid via telephone.

ALLEGATION:

A resident with dementia and diabetes at Nannies Inn has reportedly suffered severe neglect, including pressure ulcers and poor hygiene, leading to significant health decline since February 2025.

INVESTIGATION:

On 12/22/25, a complaint was received and assigned for investigation alleging that whenever the family visits Resident M, she would be lying in bed alone in her room. Staff did not appear to be moving Resident M, and she has developed advanced pressure ulcers/bed sores. Family has repeatedly observed Resident M to have dirty nails, body odor, and poor overall hygiene. They report facility staff fail to keep Resident M clean and regularly bathed. Resident M has resided at Nannies Inn by Golden Grace since February 2025 and family has seen a drastic decline in Resident M health during this time.

On 01/02/26, I completed an unannounced onsite. I spoke to staff member Alana Caver and the owner Ozzy Shahid via telephone. Ms. Caver stated there are currently five residents in the AFC group home. Ms. Caver stated she does not have access to the resident register because it is locked up inside the office.

On 01/02/26, Mr. Shahid stated Resident M was discharged from the AFC group home on 12/08/25. Resident M was admitted into Golden Grace LLC (AS630417897) which is another AFC group home owned by the same company. Mr. Shahid stated Resident M only resided at Golden Grace LLC for one or two days before she was admitted into Henry Ford hospital. Resident M was discharged from Henry Ford Hospital and returned to Golden Grace LLC for one day before she was admitted to Roya Oak Beaumont as the family was not happy with the care Resident M received at Henry Ford hospital. Resident M was sent to the hospital because she was unresponsive, her blood sugar was dropping, and her blood pressure was dropping despite the fact that she was eating and receiving her insulin. Mr. Shahid stated on 12/15/25, he received a written notice from Resident M guardian stating she will not be returning to Golden Grace LLC and to discharge her at the end of the month.

Mr. Shahid stated Nannies Inn by Golden Grace has a shower schedule and every resident receives a bath on Monday’s and Wednesday’s and sometimes Saturday’s. Mr. Shahid stated Resident M was somewhat bed ridden but she would be transferred into her wheelchair to eat in the dining area or when her family came over to visit. Mr. Shahid does not recall Resident M having any bed sores. Resident M was seen by Dr. Deva at the AFC group home once a week for routine checks. Dr. Deva would also prescribe Resident M’s medications. Mr. Shahid stated there was nothing documented with regards to rotating Resident M while she was in bed. Resident M would get out of bed about three times a week.

On 01/06/26, I made a telephone call to Resident M guardian. Regarding the allegations, the guardian stated while visiting Resident M at the AFC group home, she noticed that Resident M was not being thoroughly bathed nor was she being taken out of bed. Resident M would just lay in bed watching T.V. Resident M would complain about her butt hurting. The guardian stated she witnessed about 3-4 bed sores on Resident M's butt around October 2025. The staff did treat the bed sores and they were healed a month later. There was a nurse by the name of Shanita who would visit Resident M and bathe her once a week. The guardian stated Resident M's hands would still be dirty as there would be dark spots on her fingers. The staff informed the guardian that Resident M had a skin condition. At the beginning of December, the guardian wanted to discharge Resident M however; she was told that per policy she had to pay for the month of December. The guardian was offered to transfer Resident M to Golden Grace LLC. Once Resident M was admitted to Golden Grace LLC, she was admitted into Henry Ford hospital on 12/12/25. Resident M returned to Golden Grace LLC on 12/16/25 but, was admitted into Royal Oak Beaumont hospital on 12/17/25. Resident M was initially hospitalized because she didn't eat and became unresponsive. While Resident M was at Henry Ford hospital, her blood sugar was dropping. The guardian stated she and her family were not pleased with the care that Resident M received at Henry Ford hospital and decided to take her to Royal Oak Beaumont hospital.

The guardian stated it was discovered at Royal Oak Beaumont hospital that Resident M had a UTI and a blood clot in her right lung. Resident M was discharged from the hospital over a week ago and she was admitted into a different AFC group that she use to live in prior to living at Nannies Inn by Golden Grace.

The guardian provided three short videos of Resident M's hands. In the first video it was evident that Resident M had some discoloration on her hand. The second video did not show any discoloration. The third video you could see a small bowl with water that appeared to have skin in it from the guardian cleaning Resident M's hands before doing her nails.

On 01/06/26, I received copies of Resident M assessment plan, personal care checklist, incident report, hospital discharge paperwork, and the resident register. Resident M was admitted on 03/01/25 and discharged on 12/08/25. The personal care checklist has several columns entitled AM mouth care, PM mouth care, Hair groom, Shave, AM wash, PM wash, Skin care, Feet, Shower or Bath, Hair wash, and Bowel movement. The staff are expected to initial in the appropriate am or pm columns indicating when the task has been completed.

According to the month of March, Resident M received 15 bed baths. Resident M's skin care was completed on 18 days out of the month.

According to the month of April, Resident M received 1 shower and 27 bed baths. Resident M's skin care was completed the first 28 days out of the month.

With regards to the month of May, Resident M received 30 bed baths. Resident M skin care was completed every day during the month of May.

With regards to the month of June, Resident M received 23 bed baths. Resident M skin care was completed every day for the first 27 days out of the month of June.

According to the month of July, Resident M received 13 bed baths. Resident M skin care was completed 24 days out of the month of July.

According to month of August, Resident M received 10 bed baths. Resident M skin care was completed 29 days out of the month of August.

With regards to the month of September, Resident M received 22 bed baths. Resident M skin care was completed 26 days out of the month of September.

With regards to the month of October, Resident M received 20 bed baths. Resident M skin care was completed everyday during the month of October except for 8 days. Resident M was hospitalized for 3 days in October.

According to the month of November, Resident M received 27 bed baths. Resident M skin care was completed everyday during the month of November except for 9 days.

Resident M's assessment plan indicate that she has a wheelchair, hospital bed with rails, shower chair, and hoyer lift. Under the section entitled physical limitations, it is written that Resident M is bed bound. The assessment plan was completed on 03/01/25. The assessment plan does not provide any instructions regarding wound care or rotating Resident M.

The incident report dated 06/16/25 was written by staff member Shaunita Vanzant. The incident report states that Resident M reported that she was not feeling well and that she had a UTI. Resident M was transported to the emergency room and returned to the AFC group home the next day.

The discharge paperwork from Henry Ford hospital dated 06/16/25 states that Resident M was diagnosed with Hypertensive urgency. There is no documentation indicating that Resident M had any bed sores for either hospital visit.

I received hospital discharge paperwork when Resident M was taken to Henry Ford hospital while she was in the care of her guardian on 10/10/25. According to the paperwork, Resident M admission diagnosis was Hypomagnesemia and a mental health problem.

On 01/13/26, I made a telephone call to Ozzy Shahid regarding clarification about the personal care checklist. Mr. Shahid stated if a staff member wrote "wash" under the shower/bed bath column it also means the resident received a bed bath. Resident M would often refuse to receive a shower because she did not want to get out of bed. Mr.

Shahid clarified that the skin care column mean Resident M face was washed and/or her body was moisturized. Mr. Shahid could not give a definitive answer as to why Resident M's bed baths declined during the months of July and August 2025. Mr. Shahid stated he has made a request to receive Dr. Deva's notes from every visit with Resident M.

On 01/13/26, I made a telephone call to staff member Katrina McGhee. Regarding the allegations, Ms. McGhee stated staff member Shaunita Vanzant always gave Resident M bed baths on a regular basis as she was bed ridden. Resident M did develop a bed sore but the wound was not open. Ms. McGhee stated she and other staff members would rotate Resident M from side to side while she laid in bed. Ms. McGhee stated Resident M was feisty and she would make sure staff would rotate her. Resident M received the bed sore in October 2025 and it was healed about a month later as it was being treated with cream. Ms. McGhee stated the staff did change Resident M's brief as needed.

Ms. McGhee stated Resident M had long finger nails and she would not allow staff to cut her finger nails. Resident M would allow staff to clean underneath her finger nails. Resident M did allow her granddaughter to do her nails. Ms. McGhee denied Resident M having a body odor but her bowl movements did have a strong smell. Ms. McGhee stated some staff may not have cleaned Resident M's buttock thoroughly after a bowel movement.

On 01/13/26, I received a return phone call from staff member Shaunita Vanzant. Ms. Vanzant stated she was laid off from the AFC group home on 12/5/25. Ms. Vanzant was told that since Resident M is moving to another group home, there wasn't enough funds to pay her. Ms. Vanzant stated she worked at the AFC group home for 15 years and it seemed strange that she would be laid off. Ms. Vanzant stated Resident M did develop three bed sores because the midnight staff would not change her briefs on a regular basis. One of the bed sores were open. Resident M complained about her bed sores every day. The bed sores started to form around July or August. Ms. Vanzant stated in December the bed sores were not healed. Ms. Vanzant advised Resident M's guardian to move her out. Ms. Vanzant stated the midnight staff would wait to change Resident M's brief at 6:00am because they knew she would arrive to work at 7:00am. With the exception of staff member Angel, Ms. Vanzant could not provide names for the midnight staff as the group home has a high turnover rate and a lot of staff would be terminated.

Ms. Vanzant stated she would give Resident M and the other residents bed baths every Tuesday and Friday. Ms. Vanzant stated no other staff member was giving any of the residents bed baths. Ms. Vanzant stated the shower schedule is falsified by Mr. Shahid as he is the only person who has been completing the paperwork for the past six months. Ms. Vanzant stated she will provide a calendar that she kept that outlines the days she worked. Ms. Vanzant stated she circled the days on the calendar that she gave the residents bed baths. Ms. Vanzant stated she either worked three days (Tuesday, Wednesday, Thursday) a week or four days a week (Tuesday, Wednesday, Thursday, Friday). Ms. Vanzant stated when she would return to work on Tuesday's

Resident M would smell musty and like urine. Ms. Vanzant would inform Mr. Shahid but nothing would change. Ms. Vanzant stated she and Ms. McGhee would rotate Resident M while she was in bed.

Ms. Vanzant provided copies of her work schedule for the month of October 2025 and November 2025. According to the calendar for October 2025, Ms. Vanzant provided bed baths for Resident M and the other residents on the following days:

- 10/1 (Wednesday)
- 10/8 (Wednesday)
- 10/10 (Friday)
- 10/14 (Tuesday)
- 10/21 (Tuesday)
- 10/24 (Friday)
- 10/29 (Wednesday)

Ms. Vanzant provided bed baths for Resident M and the other residents during the month of November 2025 on the following days:

- 11/5 (Wednesday)
- 11/7 (Friday)
- 11/11 (Tuesday)
- 11/19 (Wednesday)
- 11/21 (Friday)
- 11/25 (Tuesday)
- 11/27 (Thursday)

After reviewing the dates provided by Ms. Vanzant and comparing them to the information provided on the personal care checklist for the months of October and November, I found some discrepancies. With regards to the month of October, the personal care checklist indicates that Ms. Vanzant provided personal care on 10/2, 10/15, 10/16, 10/22, 10/23, 10/28, and 10/30. However, these dates do not match the above-mentioned dates provided by Ms. Vanzant.

With regards to the month of November, the personal care checklist indicates that Ms. Vanzant provided personal care on 11/4, 11/6, 11/12, 11/13, 11/18, and 11/20. However, these dates do not match the above-mentioned dates provided by Ms. Vanzant. Furthermore, Ms. Vanzant stated she worked on 11/25 and 11/27 however, these dates are not reflected on the personal care checklist for Ms. Vanzant.

On 01/14/26, I received a return phone call from Dr. Shivakumar Deva. Regarding the allegations, Dr. Deva stated the last time he saw Resident M at the AFC group home was on 12/08/25 which was after she was discharged from the hospital and in the process of moving to another AFC group home (Golden Grace LLC). Prior to Resident M being discharged from the AFC group home, Dr. Deva would visit her every six weeks. Resident M was bed bound and her left leg was amputated. Dr. Deva described Resident M as a difficult resident as she would refuse to take her medication and spit her pills out of her mouth. Resident M would also fight and argue with staff members.

Resident M is also delusional. Dr. Deva stated Resident M had skin irritation on her buttock but she did not have any wounds and/or bed sores. Resident M's buttock would become irritated from sitting in urine. Dr. Deva confirmed that Resident M's hygiene was definitely an issue as she would smell like urine. Dr. Deva could not give a reason as to why Resident M smelled like urine when he would examine her. Dr. Deva did not know if staff were changing Resident M's briefs on a regular basis. Dr. Deva stated in general a lot of residents go into the hospital and come home with bed sores.

Dr. Deva has worked with the AFC group home for 15 years. Dr. Deva stated there has been a lack of care since new management has taken over the AFC group home. Dr. Deva could not answer to whether or not the staff is doing their jobs. Dr. Deva stated the staff are not negligent but, he would not answer definitively if he had any concerns.

On 01/15/26, I made a telephone call to the licensee designee Huma Shahid. Regarding the allegations, Mrs. Shahid denied Resident M having any bed sores. Mrs. Shahid described Resident M as aggressive and delusional. Resident M refused to allow Mrs. Shahid or any staff member to cut her nails. Resident M told Mrs. Shahid if she cut her nails she would "kill her". Mrs. Shahid asked Resident M's granddaughter for help regarding her nails. Resident M's granddaughter painted Resident M's nails red. Resident M would receive bed baths twice a week if she did not refuse. Resident M would often be verbally abusive towards staff as she thought they were trying to poison her.

Mrs. Shahid denied being aware of Resident M's brief not being changed or that she was smelling like urine. Mrs. Shahid stated the staff are good with changing all of the residents briefs and keeping them clean. There are three staff who work 12-hour shifts. Mrs. Shahid and Mr. Shahid also visit the home to help out. Mrs. Shahid stated her husband, Shahid Tahir only drops off food to the AFC group home. Mrs. Shahid stated she will provide background clearances for all of her employees.

On 01/15/26, I received copies of the Workforce Background Clearance check for the AFC employees, which are Angel Evans, Katrina McGhee, and Michelle Neal. Each background clearance states that the abovementioned employees are eligible for employment in a job that involves direct access or provides direct services to a resident. The background clearances were completed under Golden Grace LLC group home name.

On 01/16/26, I made a telephone call to staff member Angel Evans. Regarding the allegation, Ms. Evans stated she works the midnight shift. Ms. Evans stated she changes all of the residents briefs every 2-3 hours. Resident M did have a bed sore during the month of December 2025 before she was discharged from the AFC group home. Ms. Evans stated Resident M's bed sore was being treated by the other staff members. Resident M did receive bed baths but, Ms. Evans did not know how often. Ms. Evans stated Resident M would have a body odor when it was time to change her brief. Ms. Evans never waited more than 3 hours to change Resident M's brief. Ms. Evans stated she rotated Resident M every time she changed her brief.

On 01/27/26, I made a telephone call to the Adult Protective Services worker Gene Evans. Mr. Evans stated he sent a courtesy request to have a Macomb County worker visit Resident M in her new AFC group home. Mr. Evans was informed that Resident M was doing fine in the group home. Mr. Evans was also informed that Resident M did have a bed sore at the time of the visit however; there is no way to determined when she developed a bed sore. Mr. Evans stated he intends on transferring his investigation to Macomb County.

On 01/27/26, I completed an exit conference with the licensee designee Huma Shahid. Mrs. Shahid was informed that the allegations will be substantiated and a corrective action plan will be required.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information gathered through interviews, it is unclear if Resident M had any bed sores on her buttock while she resided at the AFC group home. Dr. Deva visited Resident M every six weeks and he never witnessed any bed sores. Dr. Deva stated Resident M had skin irritation on her buttock but she did not have any wounds and/or bed sores. Resident M was hospitalized on 06/16/25 and 10/10/25 and there was no documentation indicating that Resident M had any bed sores for either hospital visit. Resident M's assessment plan does not provide any instructions regarding wound care or rotating Resident M. Therefore, there is insufficient evidence to confirm that staff were not providing care based on what is specified in Resident M's assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(2) A licensee shall ensure the resident receives or has access to all of the following: **(a) Bathing at least weekly.**

	(c) Assistance with resident hygiene as needed.
ANALYSIS:	Based on the information above, there is sufficient information to confirm the allegations. Dr. Deva confirmed that Resident M's hygiene was definitely an issue as she would smell like urine. Dr. Deva stated Resident M's buttock would become irritated from sitting in urine. The guardian provided three short videos of Resident M's hands which confirmed that Resident M had some discoloration on her hands which the guardian was able to clean off. It was confirmed by staff that Resident M had a body odor. Ms. Vanzant stated whenever she would return to work, Resident M would smell musty and like urine. Despite the discrepancies found with Resident M's personal care checklist and what was reported by Ms. Vanzant, Resident M received at least one bed bath weekly. However, it seems as though she required more than one bed bath a week and/or a more thorough bed bath.
CONCLUSION:	**VIOLATION ESTABLISHED**

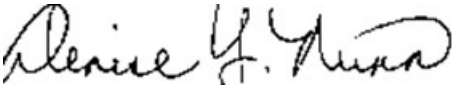
IV. RECOMMENDATION

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

02/05/26

Sheena Worthy — Date
Licensing Consultant

Approved By:



02/12/2026

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Denise Y. Nunn — Date
Area Manager