GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2026

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

RE: License #: AS630418556
Investigation #: 2026A0991013
Nannies Inn By Golden Grace

Dear Huma Shahid:

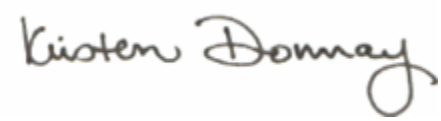
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable 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 (248) 972-9136.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630418556
Investigation #:	2026A0991013
Complaint Receipt Date:	02/19/2026
Investigation Initiation Date:	02/19/2026
Report Due Date:	04/20/2026
Licensee Name:	Nannies Inn By Golden Grace
Licensee Address:	3050 Spring Street West Bloomfield Twp, MI 48322
Licensee Telephone #:	(248) 431-8586
Licensee Designee/ Administrator:	Huma Shahid
Name of Facility:	Nannies Inn By Golden Grace
Facility Address:	3050 Spring Street West Bloomfield Twp, 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 TRAUMATICALLY BRAIN INJURED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The residents at Nannies Inn by Golden Grace are being neglected. Katrina refuses to change Resident A's briefs at night and leaves him soaked throughout her shift.	Yes
Staff, Katrina, refused to give Resident A water. Staff refuse to give Resident B solid food, giving her only Ensure when she is not prescribed a special diet.	No
Resident C is prescribed blood pressure medication every six hours. Staff give him the medication without checking his blood pressure first.	No
Additional Findings	Yes

III. METHODOLOGY

02/19/2026	Special Investigation Intake 2026A0991013
02/19/2026	Special Investigation Initiated - Telephone Contacted Adult Protective Services (APS)- assigned worker, Candid Jamerson
02/19/2026	APS Referral Received from Adult Protective Services (APS)
02/19/2026	Contact - Document Received Received additional allegations from APS re: resident not being fed solid food
02/19/2026	Contact - Telephone call made To Uzair Shahid
02/19/2026	Contact - Document Received Text message exchange between Uzair Shahid and terminated staff, assessment plans, resident care notes and checklists
02/19/2026	Contact - Document Sent Emailed instructions for Workforce Background Check to Uzair Shahid
03/04/2026	Inspection Completed On-site

	Unannounced onsite inspection- interviewed staff and residents
03/04/2026	Contact - Telephone call made Left message for Uzair Shahid
03/05/2026	Contact - Telephone call made To licensee designee, Huma Shahid re: concerns from onsite inspection
03/09/2026	Contact - Document Received Employee file for temp employee
03/17/2026	Contact - Telephone call made Left message for hospice agency
03/17/2026	Contact - Telephone call made Left message for staff, Michelle Neal
03/18/2026	Contact - Telephone call received From APS worker, Candid Jamerson
04/02/2026	Contact - Document Received Text from Uzair Shahid- Resident B passed away
04/13/2026	Contact - Telephone call made To Resident B's guardian
04/13/2026	Contact - Telephone call made To Resident B's hospice nurse
04/16/2026	Exit Conference Via telephone with licensee designee, Huma Shahid

ALLEGATION:

The residents at Nannies Inn by Golden Grace are being neglected. Katrina refuses to change Resident A's briefs at night and leaves him soaked throughout her shift. Staff, Katrina, refused to give Resident A water. Staff refuse to give Resident B solid food, giving her only Ensure when she is not prescribed a special diet.

INVESTIGATION:

On 02/19/26, I received a complaint alleging that the residents at Nannies Inn By Golden Grace are not being properly cared for. The complaint alleged that direct care worker, Katrina, was not changing Resident A and left him urine soaked throughout the night. The complaint also stated that Katrina refused to give Resident A water, and that Resident B was not being given solid food despite not being prescribed a special diet. I initiated my investigation on 02/19/26 by contacting the assigned Adult Protective Services (APS) worker, Cadid Jamerson. Ms. Jamerson stated that she went to the home early this morning and saw Resident A and Resident B. Both residents had clean appearances. The staff on shift denied the allegations. None of the residents reported any concerns. The licensee designee's son, Uzair Shahid, who oversees the home, stated that he recently fired a staff person, who threatened to call APS.

On 02/19/26, I interviewed Uzair (Ozzy) Shahid via telephone. Mr. Shahid stated that they recently fired a staff person, Michelle, and he felt that she retaliated by making a complaint to APS. He stated that he had text messages sent by the terminated staff person, in which she threatened to call APS. Mr. Shahid stated that Resident B is on hospice. She is not on a special diet and receives regular meals. She eats solid food. Mr. Shahid stated that Resident B gets snacks and Ensure. He was not aware of any staff denying Resident B food. Mr. Shahid stated that he visits the home nearly every day. He never observed that any of the residents were dirty or had not been changed. He stated that staff are providing proper care and are changing and feeding the residents as required; however, it is not always properly documented. He stated that they are working on improving the documentation. Mr. Shahid stated that staff on the night shift are required to check and change the residents. It is expected that residents are changed and toileted as needed throughout the night. Staff are not permitted to sleep during the night shift.

On 03/04/26, I conducted an unannounced onsite inspection at Nannies Inn By Golden Grace. I interviewed direct care worker, Katrina McGhee. Ms. McGhee stated that she has worked in the home since October 2025. She stated that she is a live-in staff and works twelve-hour shifts at the home. Ms. McGhee stated that Resident B is on hospice. She is not prescribed a special diet and eats regular food like everyone else. Ms. McGhee stated that Resident B's food must be cut up, but she eats solid food. Resident B eats breakfast, lunch, and dinner. She also gets Ensure every morning. Resident B is able to eat on her own and does not require staff to feed her. Ms. McGhee stated that she was not aware of any staff not feeding Resident B solid food and making her only drink Ensure.

Ms. McGhee stated that she always ensures that all of the residents in the home get their fluids. Resident A has a big red cup that she keeps filled with water. She stated that they need to make sure the residents keep fluids in their system in order to prevent urinary tract infections. Ms. McGhee stated that there was never a time when she

refused to give Resident A water. Ms. McGhee stated that she changes Resident A every two hours or more often if needed. There has never been a time when she refused to change Resident A. Resident A does not have any rashes or wounds on his bottom. Ms. McGhee stated that there was another staff, Michelle Neal, who recently got fired from the home. Ms. McGhee stated that Ms. Neal had a problem with her and made up these allegations. She stated that Ms. Neal was the one who was not providing proper care. She stated that “Michelle walked up out of here and did not change (Resident A).” She stated that Ms. Neal also “left (Resident B) pissy and shitty.”

On 03/04/26, I interviewed Resident A. Resident A stated that staff in the home are pretty good. He stated that staff change his brief when he needs to be changed, and they help him get cleaned up. He stated that he does not have any sores or wounds. Resident A stated that he always has water to drink when he wants it. Resident A stated that there is nothing he would change about the home.

On 03/04/26, I attempted to interview Resident B. Resident B had limited verbal and cognitive abilities, and she had difficulty participating in an interview. She stated that she could not remember what she ate today. She stated that she is able to eat on her own and she gets solid foods. I observed a bowl of fruit on the bedside table in Resident B’s room.

On 03/04/26, I interviewed Resident D. Resident D stated that staff check on him often and help him when he needs assistance. He stated that he did not have any complaints about staff, Katrina McGhee. He stated that she is the best staff at the home, and does the best changes, making sure that he is clean. Resident D stated that he has a call button to use if he needs staff. They usually respond within a minute or two.

During the onsite inspection, I observed that the residents had water cups in their rooms. There was an adequate supply of food in the home. The residents appeared to have good hygiene, and there were no odors in the home.

On 04/13/26, I interviewed Resident B’s guardian via telephone. Resident B’s guardian stated that Resident B passed away on hospice at the home on 03/26/26. He stated that he was mostly happy with the care that she was receiving at Nannie’s Inn, as it was much better than the facility where she had been living previously. Resident B’s guardian stated that there were some issues when Resident B first moved into the home. She stated that Resident B had a specialized moisture sensor that would beep and alert staff if she was wet. There was at least one occasion when Resident B was soaked, and her brief had not been changed. He stated that the sensor was not on, so staff were not alerted that she was wet. Staff addressed the issue right away and put the sensor on Resident B. Resident B’s guardian stated that there were a few incidents like this when Resident B first moved into the home. Resident B’s guardian stated that he did not have any concerns about staff, Katrina McGhee. He stated that Resident B

was able to eat solid food and was not on a special diet. He was not aware of Resident B being fed Ensure only.

On 04/13/26, I interviewed Resident B's nurse through Trinity Hospice. The nurse stated that the care provided by Nannie's Inn By Golden Grace was "not very great." She stated that the staff at the home were not skilled in taking care of residents who were on hospice or who had wounds. She trained staff on how to care for Resident B's wounds, but they did not always follow the instructions, including floating her heels and repositioning her. She also communicated with the owner's son, Uzair Shahid, but she felt that there was a disconnect and discord among the employees in the home. She stated that the staff in the home often tried to place blame on one another rather than focusing on what they needed to do to meet the needs of the residents. The hospice nurse stated that Resident B was always soiled when she saw her. On some occasions, there was a time written on Resident B's brief showing when it was last changed. The nurse stated that she did not feel that the residents were being neglected; however, she often observed that Resident B's bed sheets and clothing were soiled with old stool and/or food. She stated that hospice staff always changed Resident B's bed sheets when they came to the home, because staff at the home were not doing it. Resident B's hospice nurse stated that the care in the home improved over time, but it was difficult to get staff on the same page to do what was asked of them. She stated that it took staff at least a month to get on board with providing the care that Resident B required. Staff eventually began repositioning Resident B. The wound on Resident B's coccyx did not heal, but it was stable. The wounds on Resident B's heels healed once staff began to float her heels as required. Resident B's hospice nurse stated that staff could have done a better job with maintaining Resident B's hygiene. She stated that Resident B was feisty and could refuse assistance at times, but she felt staff could have continued to prompt Resident B throughout the day and could have paid more attention to her. Resident B was bed bound and required more one on one attention. Resident B's hospice nurse stated that she was not aware of staff only feeding Resident B Ensure. She stated that she observed Resident B eating solid food, including scrambled eggs and French toast. She felt staff were feeding Resident B appropriately. There were times that Resident B would sleep through meals, but staff were not supposed to force Resident B to eat since she was on hospice.

I received and reviewed Resident B's personal care documentation, which included staff notes regarding Resident B's care during each shift. The notes indicate that Resident B was being offered meals including solid food and Ensure. Some of the staff documented when they were changing Resident B and repositioning her; however, this was not consistently documented on every shift.

I requested a copy of Resident B's assessment plan and hospice care plan from the owner, Uzair Shahid. Mr. Shahid stated that they did not have a copy of the hospice

care plan and indicated that he would request the plan from hospice. The assessment plan and hospice plan were not provided during the investigation.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (e) Withhold food, water, clothing, rest, or toilet use.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff withheld water or solid food from the residents. All of the residents who were interviewed stated that they received food. Resident B's guardian and hospice nurse denied any knowledge of Resident B receiving only Ensure for meals. I observed solid food and water on Resident B's bed tray during my onsite inspection. All of the residents had water cups during my onsite inspection.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 my investigation, there is sufficient information to conclude that personal care was not provided per Resident B's assessment plan. Resident B's hospice nurse stated that staff were not following Resident B's wound care plan and were not floating her heels and repositioning her as required. The hospice nurse stated that it took over a month for staff to get on board with providing the required care to Resident B. She frequently observed Resident B's sheets and clothing to be soiled with feces and food. Resident B's briefs were often soiled when the hospice nurse visited the home. Staff were not consistently documenting the care provided to Resident B or her wound care. Direct care

	worker, Katrina McGhee, stated that she always makes sure residents are changed; however, she stated that another staff, Michelle Neal, left Resident B wet and soiled. In addition, a copy of Resident B's hospice care plan was not included as an addendum to her assessment plan and was not maintained in her resident record.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C is prescribed blood pressure medication every six hours. Staff give him the medication without checking his blood pressure first.

INVESTIGATION:

The complaint also alleged that Resident C is prescribed blood pressure medication, and staff give him the medication without checking his blood pressure first. The complaint noted that typically when blood pressure medication is prescribed, staff must check the resident's blood pressure and only give the medication if needed.

On 03/04/26, I conducted an unannounced onsite inspection at Nannie's Inn By Golden Grace. I interviewed direct care worker, Katrina McGhee. Ms. McGhee stated that Resident C is prescribed blood pressure medication, including Amolodipine. She stated that the midnight staff take Resident C's blood pressure; however, there are no parameters to hold Resident C's blood pressure medication if his blood pressure is above or below a certain level.

I reviewed a copy of Resident C's March 2026 administration record (MAR) and his medications. The MAR shows that Resident C is prescribed Amlodipine Besylate 5mg PO Tab- take one tablet by oral route for 30 days, Diltiazem Hydrochloride 30mg PO Tab- take one tablet every six hours by oral route for AFIB/HTN (atrial fibrillation/ hypertension), and Metoprolol Tartarate 100mg PO Tab- take one tablet twice a day by oral route for HTN. I reviewed the prescription and label instructions for these medications that are prescribed for blood pressure. There were no instructions from the doctor indicating that staff must take Resident C's blood pressure or hold the medication under certain parameters.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff did not follow the physician instructions for Resident C's blood pressure medications. All of the medications are prescribed on a scheduled basis, and there were no instructions from the physician to hold the medications based on Resident C's blood pressure reading.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation I reviewed the information in the Michigan Workforce Background Check System for Nannies Inn By Golden Grace. I noted that there were no employees fingerprinted and linked to Nannies Inn By Golden Grace. On 02/19/26, I spoke with Uzair Shahid and informed him that there were no employees fingerprinted for Nannies Inn By Golden Grace (AS630418556). Mr. Shahid stated that some of the employees were fingerprinted under a different license, as he was not able to access the Workforce Background Check System for Nannies Inn By Golden Grace.

On 02/19/26, I provided Mr. Shahid with the username and reset the password to provide access to the Workforce Background Check System for Nannies Inn By Golden Grace. I advised Mr. Shahid that all staff must be linked to each home where they are working and any staff with regular, direct access to the residents at Nannies Inn By Golden Grace must have an eligibility letter that states they are eligible to work at Nannies Inn By Golden Grace (AS630418556). As of 04/13/26, there were no staff linked to Nannies Inn By Golden Grace in the Workforce Background Check System.

I confirmed that the staff working in the home, Katrina McGhee, Angel Evans, and Michele Thomas, were in the Workforce Background Check System, fingerprinted under Golden Grace, LLC (AS630417897).

During the onsite inspection on 03/04/26, I arrived at the home around 12:30pm, as direct care worker, Nkiruka (Stacey) Crook, was also arriving at the home. The direct

care worker on shift, Katrina McGhee, stated that she was not feeling well and had called off work for the rest of the day. Ms. Crook would be covering the remainder of the afternoon shift until the next staff arrived at 7:00pm. This was the first shift Ms. Crook was working in the home. Following the onsite inspection, I contacted Uzair Shahid and Huma Shahid. They stated that Stacey Crook was a staff from a temp agency, Quinable, who was providing emergency coverage in the home. Mr. Shahid stated that Ms. Crook was trained and fingerprinted through the temp agency. Mr. Shahid provided a background screening report from Quinable, Inc. noting that no reportable records were found in a national criminal database search. There was no verification provided showing that Ms. Crook completed fingerprints through the Workforce Background Check System.

On 03/04/26, I searched the Michigan Workforce Background Check System for Nkiruka Stacey Crook. Ms. Crook did not have fingerprints linked to Nannies Inn By Golden Grace or Quinable, Inc. in the system.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to

	another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the staff at Nannies Inn By Golden Grace did not have fingerprints in the Michigan Workforce Background Check System that were linked to Nannies Inn By Golden Grace. Uzair Shahid was given instructions and guidance on how to link employees to the home in the system; however, as of 04/13/26, there were no employees with fingerprints linked to the facility. In addition, Nannies Inn By Golden Grace employed staff from a temp agency, Nkiruka Stacey Crooks, without obtaining verification that fingerprinting was completed through the Michigan Workforce Background Check System.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference renewal licensing study report dated: 03/11/25; CAP Dated: 03/13/25**

INVESTIGATION:

During the onsite inspection on 03/04/26, I arrived at the home as direct care worker, Nkiruka (Stacey) Crook, was also arriving at the home. The direct care worker on shift, Katrina McGhee, stated that she was not feeling well and had called off work for the rest of the day. Ms. Crook was a new staff who was coming in to cover for Ms. McGhee. She had not worked any previous shifts in the home. I observed as Ms. McGhee walked Ms. Crook through the home and introduced her to the residents. She provided minimal information and instructions regarding the needs of the residents and the care that should be provided. For example, she told Ms. Crook that Resident B is on hospice and needs to be turned every two hours, but she always ends up in the same position. She stated that Resident A has arthritis in his knees and could not get up from the toilet yesterday. He uses a wheelchair, but he does not have a Hoyer lift. Resident D is bed bound. She provided some information regarding the food preferences of the residents in the home. For example, Resident C does not eat fish and Resident D does not like chicken. She told Ms. Crook that if she wanted Resident B to eat, she had to cut up her

food. She did not provide any detailed instructions regarding how to transfer the residents, administer medications, or provide care to them. Ms. Crook stated that she has worked in other facilities and knows how to provide care. Ms. McGhee told Ms. Crook that the midnight staff would be arriving at 7:00pm, so she would not have to pass medications.

Following the onsite inspection, I contacted Uzair Shahid and Huma Shahid regarding my concerns about the staff's training and qualifications. Mr. Shahid stated that Stacey Crook was a staff from a temp agency, Quinable, Inc., who was providing emergency coverage in the home. He stated that Ms. Crook was trained and fingerprinted through the temp agency. Huma Shahid stated that Katrina McGhee lives in the basement of the home, so staff could always reach her if they had questions. Ms. Shahid acknowledged that Ms. McGhee would not be obligated to remain in the home if she had called off and was not scheduled to work.

Mr. Shahid forwarded the information provided from the temp agency for Nkiruka Stacey Crook. The documentation included a Nurse Aide Certificate of Registration for Nkiruka S Crook effective 06/26/24-06/26/26, as well as a resume that shows Ms. Crook worked as a Certified Nurse Assistant (CNA) in home care, assisted living, and memory care settings. There was no documentation in the file to show that Ms. Crook was trained and competent in the required areas including: reporting requirements, first aid, CPR, personal care, supervision, and protection, resident rights, safety and fire prevention, prevention and containment of communicable diseases, food safety, or nutrition and special diets.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases including recognizing signs of illness. (h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner. (i) Nutrition and special diets.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that there was no documentation on file to show that staff, Nkiruka Stacey Crook, was trained and competent in the required areas including: reporting requirements, first aid, CPR, personal care, supervision, and protection, resident rights, safety and fire prevention, prevention and containment of communicable diseases, food safety, or nutrition and special diets. Ms. Crook was brought in from a temp agency to provide emergency coverage in the home on 03/04/26, when the scheduled staff person called in sick. The temp agency only provided verification that Ms. Crook has a Nurse Aide Certification. Ms. Crook received minimal training and information from direct care worker, Katrina McGhee regarding the personal care and supervision needs of the residents prior to her providing coverage for a shift in the home.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference renewal licensing study report dated: 03/11/25; CAP Dated: 03/13/25**

INVESTIGATION:

During the onsite inspection on 03/04/26, staff Nkiruka Stacey Crook, was scheduled to cover the remainder of the afternoon shift for direct care worker, Katrina McGhee, who was ill. Ms. Crook was brought in from a temp agency, Quinable, Inc., to provide emergency coverage. I reviewed the documentation provided from the temp agency and noted that there was no health information for Ms. Crook, including a baseline screening for communicable disease.

APPLICABLE RULE	
R 400.631	**Health screenings.**
	(5) A licensee shall maintain documentation of a baseline screening for communicable diseases and records of illness on hiring. Staff who have direct physical contact with residents or resident food may perform those duties only when they are noninfectious or when proper precautions are taken to prevent the spread of a communicable disease. A licensee shall follow a staff's health care professional or local health department guidance on controlling the spread of a communicable disease when identified.

ANALYSIS:	On 03/04/26 staff, Nkiruka Stacey Crook, was brought in from a temp agency to provide emergency coverage of a shift at Nannies Inn By Golden Grace. There was no documentation provided from the temp agency to show that Ms. Crook had a baseline screening for communicable diseases.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 03/04/26, staff Nkiruka Stacey Crook, was scheduled to cover the remainder of the afternoon shift for direct care worker, Katrina McGhee, who was ill. Ms. Crook was brought in from a temp agency, Quinable, Inc., to provide emergency coverage. I reviewed the documentation provided from the temp agency which included a background screening report, resume, Nurse Aide Certificate of Registration, and Ms. Crook's profile on Quinable, Inc. which included ratings from previous facilities. The documentation did not include all of the required documents for a staff file, including: verification of age, verification of highest level of education completed and training, health information, or verification of the receipt of personnel policies and job descriptions.

APPLICABLE RULE	
R 400.639	**Staff records.**
	(1) A licensee shall maintain a record for each staff that contains all of the following: (d) Verification of age. (e) Verification of experience, highest level of education completed, and training. (h) Health information as required by these rules. (i) Verification of the receipt by the staff of personnel policies and job descriptions.
ANALYSIS:	The documentation provided to the home from the temp agency for temp staff, Nkiruka Stacey Crook, did not include all of the required documents for a staff file, including: verification of age, verification of highest level of education completed and training, health information, or verification of the receipt of personnel policies and job descriptions.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference renewal licensing study report dated: 03/11/25; CAP Dated: 03/13/25**

INVESTIGATION:

During the onsite inspection on 03/04/26, direct care worker, Katrina McGhee advised the temporary staff, Nkiruka Stacey Crook, to prepare lunch for the residents. She told Ms. Crook that there was bread and meat to make sandwiches. Ms. McGhee stated that they do not follow a menu or any nutritional guidelines in the home. She stated that Resident C, Resident D, and Resident E are diabetic, but they are not prescribed a special diet. She stated, “We just don’t feed them sweets like candy, cakes, pies, and sugar.” There was no documentation in the residents’ files to show that they were prescribed a special diet. Ms. McGhee stated that they just feed the residents what they like and there is no set menu. Resident D does not eat chicken and Resident C does not like fish. During my interview with Resident D, he stated that the quality of the food is not very good. He stated that you can tell the food is low quality. He stated that he buys his own soup or snacks that he can eat, because sometimes he does not like “the crap they’re giving.” There were no menus posted in the home at the time of the onsite inspection.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(4) Meals must meet the nutritional allowances recommended by the United States Department of Agriculture and the United States Department of Health and Human Services in the Dietary Guidelines for Americans (DGA), 2020-2025. The Dietary Guidelines for Americans 2020-2025 are adopted by reference and available to be viewed or downloaded from the U.S. Department of Agriculture and the U.S. Department of Health and Human Services at https://www.dietaryguidelines.gov at no cost at the time of adoption of these rules. A copy of these guidelines is available for inspection and distribution from the Bureau of Community and Health Services, Department of Licensing and Regulatory Affairs, at 611 West Ottawa Street, P.O. Box 30664, Lansing, Michigan 48909 at a cost of 15 cents per page as of the time of the adoption of these rules.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff are not following the nutritional guidelines as required. Direct care worker, Katrina McGhee, stated that staff do not follow any menus or nutritional guidelines. They prepare food according to what the residents like. There was no documentation of meals served or menus available to review in order to determine if meals met nutritional standards.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that menus are not being written one week in advance and posted, and that substitutions are not being noted on the menus. Direct care worker, Katrina McGhee, stated that staff do not follow a menu. They prepare meals based on the preferences of the residents. There were no menus posted in the home at the time of the onsite inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 03/04/26, I reviewed Resident A's medications and March 2026 medication administration record (MAR). I noted the following:

- Resident A's March 2026 MAR was not initialed for 8:00am medications on 03/04/26. Direct care worker, Katrina McGhee, stated that she does not initial the MAR at the time medications are passed. She stated that she knows the residents' medications and does not use the medication book or MARs when she is passing medications. She goes back and initials the MARs later.
- Resident A's March 2026 MAR and the label instructions on the bubble pack note that Resident A is prescribed Aspirin Low Dose 81mg EC Tab- take one tablet by oral route once daily. "Every other day" was handwritten on the bubble pack, and the MAR was initialed indicating the medication was being passed every other

day. Direct care worker, Katrina McGhee, stated that the medication was changed to every other day, but there was no prescription or documentation on file regarding the change. Following the onsite inspection, Uzair Shahid provided an order from Resident A's physician dated 02/17/26, noting the medication change to every other day; however, the instructions on the MAR were not updated to reflect this change.

- There was no reason documented for the administration of Resident A's PRN medication Diclofenac Sodium 1% gel on 03/01/26, 03/02/26, or 03/03/26, or his PRN medication Tramadol Hydrochloride 50mg on 03/03/26.
- During the onsite inspection, I observed Resident A's Diclofenac Sodium Topical Gel 1% on a table in Resident A's bedroom.

During the onsite inspection on 03/04/26, I reviewed Resident B's medications and March 2026 medication administration record (MAR). I noted the following:

- Resident B's March 2026 MAR was not initialed for 8:00am medications on 03/04/26.
- Resident B's March 2026 MAR was not initialed for Metronidazole 250mg PO Tab (Flagyl)- crush one tablet (=250mg) and apply to wound bed with each dressing change. There was no documentation on file to show that the medication was discontinued.
- During the onsite inspection, there were two pills in a medication cup on Resident B's dresser. I observed the medications on the dresser after 2:00pm. Direct care worker, Katrina McGhee, stated that Resident B had refused her medication that morning and she left them there to administer later.
- During the onsite inspection, I also observed wound care supplies including wound cleanser, Medihoney, Triad cream, and Manukapli sterile honey wound dressing cream, which were being stored on a table in Resident B's bedroom.

During my interviews with Resident B's guardian and hospice nurse, they expressed concern that staff, Michelle Neal, had not been passing Resident B's Remeron 7.5mg correctly. They stated that the pharmacy originally gave Resident B 15mg tablets with instructions to administer ½ tablet, which would equal 7.5mg. When hospice later filled the prescription, they filled it with 7.5mg pills. Michelle Neal believed that Resident B was supposed to receive ½ of the 7.5mg pills, and she would not stop arguing that she was correct. Resident B's guardian and hospice nurse stated that Ms. Neal wrote instructions on the pill bottle to give ½ tablet of the 7.5mg pill, which was incorrect. Resident B's guardian expressed concerns that Ms. Neal did not understand how to interpret the MAR and did not know how to properly pass medication. Resident B's hospice nurse stated that Resident B was also prescribed ½ tablet of 2.5mg Oxycodone. She stated that staff cut all of the pills in the bottle in half, rather than

cutting the pill in half at the time it was being administered. She stated that this could cause confusion if other staff did not know the pills had already been halved, as the label instructions stated to give one half of the tablet.

During the onsite inspection on 03/04/26, I reviewed Resident C's medications and March 2026 medication administration record (MAR). I noted the following:

- Resident C's March 2026 MAR was not initialed for 8:00am or 12:00pm medications on 03/04/26.
- Resident C's 12:00pm dose of Diltiazem Hydrochloride 30mg Tab (take one tablet every six hours by oral route) was not administered from 03/01/26-03/04/26 and the 4:00pm dose was not administered from 03/01/26-03/03/26. Resident C's 4:00pm dose of Sevelemar Carbonate 800mg Tab (take one tablet three times a day by oral route with meals) was not administered from 03/01/26-03/03/26.
- Direct care worker, Katrina McGhee, stated that Resident C goes to dialysis and goes out with family during the day. His afternoon medications are not given to anyone to administer when Resident C is out of the facility. Resident C was not out of the facility at the time of my onsite inspection on 03/04/26. Ms. McGhee stated that Resident C did not receive his 12:00pm dose on 03/04/26, because the temp staff and I arrived at the home at noon. It should be noted that I arrived at the facility after 12:30pm, and Ms. McGhee was in the garage smoking upon my arrival. She was not in the midst of passing medications, and she did not indicate that she needed to do so during my time in the home. During my onsite inspection, Ms. McGhee told the temp staff, Nkiruka (Stacey) Crook, that none of the residents receive medications in the afternoon, and medications would not need to be passed until the next staff arrived at 7:00pm.

During the onsite inspection, I observed a tube of Resident D's prescription Septine ointment on the table by his bed.

On 04/16/26, I conducted an exit conference via telephone with licensee designee, Huma Shahid. Ms. Shahid stated that they terminated Katrina McGhee and have brought in new staff to help address some of the issues identified during the investigation.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based on the information gathered through my investigation and observations during my onsite inspection, there is sufficient information to conclude that medications were not given as prescribed. Resident B's 8:00am medications were sitting in a medication cup on her dresser during the onsite inspection at 2:00pm on 03/04/26. Resident C's 12:00pm dose of Diltiazem Hydrochloride 30mg Tab was not administered from 03/01/26-03/04/26 and the 4:00pm dose was not administered from 03/01/26-03/03/26. Resident C's 4:00pm dose of Sevelemar Carbonate 800mg Tab was not administered from 03/01/26-03/03/26. Resident B's guardian and hospice nurse also stated that direct care worker, Michelle Neal, was not giving Resident B the correct dose of her Remeron 7.5mg medication. Resident B was initially prescribed 15mg tablets that were to be cut in half to equal 7.5mg. Ms. Neal insisted that Resident B should still receive half a tablet after the prescription was filled with 7.5mg pills. She wrote incorrect instructions on Resident B's Remeron pill bottle.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.

ANALYSIS:	Based on the information gathered through my investigation and observations during my onsite inspection, there is sufficient information to conclude that prescription and over the counter medications were not kept in a locked cabinet or drawer. During the onsite inspection, there were loose pills in a medication cup on Resident B's dresser. Wound supplies, including cleansers and ointments, were being stored in Resident B's bedroom. Resident A's Diclofenac gel and Resident D's Septine ointment were not locked up and were being stored in their bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Based on the information gathered through my onsite inspection, there is sufficient information to conclude that staff were not properly trained and competent in medication passing. Direct care worker, Katrina McGhee, stated that she does not use the residents' medication administration records (MARs) when passing medication and does not initial the MAR at the time medications are passed. Ms. McGhee was not following the six rights of medication passing when administering medications, as she was not verifying that it was the right resident, right medication, right time, right route, right dosage, or right documentation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (b) Complete an individual medication log that contains all of the following: (i) Medication name.

	(ii) Dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) Initials of the individual who administered the medication at the time given. (vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.
ANALYSIS:	During my onsite inspection in the afternoon on 03/04/26, I observed that the residents' MARs were not initialed at the time medications were given. The March 2026 MARs had not been initialed for 8:00am medications on 03/04/26. Resident A's March 2026 MAR was not updated to reflect the new instructions for Resident A's Aspirin Low Dose 81mg EC Tab. The MAR stated take one tablet by oral route once daily. An order from Resident A's physician dated 02/17/26 noted the medication was changed to every other day; however, the instructions on the MAR were not updated to reflect this change.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (c) Record the reason for each administration of medication that is prescribed on an as needed basis.
ANALYSIS:	There was no reason documented for the administration of Resident A's PRN medication Diclofenac Sodium 1% gel on 03/01/26, 03/02/26, or 03/03/26, or his PRN medication Tramadol Hydrochloride 50mg on 03/03/26.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(5) A licensee, administrator, or direct care staff shall ensure that the resident or the individual who assumes responsibility for the resident has the appropriate information, medication, and

	instructions when the resident is out of the facility but still requires medication during that period.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident C's medications were not given to the person who assumed responsibility for him when he was out of the facility. Direct care worker, Katrina McGhee, stated that Resident C goes to dialysis and goes out with family during the day. His afternoon medications are not given to anyone to administer when Resident C is out of the facility. Resident C's March 2026 MAR and medication bubble packs showed that his 12:00pm dose of Diltiazem Hydrochloride 30mg Tab was not administered from 03/01/26-03/04/26 and the 4:00pm dose was not administered from 03/01/26-03/03/26. Resident C's 4:00pm dose of Sevelemar Carbonate 800mg Tab was not administered from 03/01/26-03/03/26.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license.

04/16/26

Kristen Donnay Date
Licensing Consultant

Approved By:

For 04/16/2026

Denise Y. Nunn Date
Area Manager