RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 26, 2018

Charles Udanoh
Angel Care Homes Inc
16565 Sunderland Road
Detroit, MI 48219

RE: License #: AS820299055
Investigation #: **2019A0992003**
Cherry AFC Home

Dear Mr. Udanoh:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820299055
Investigation #:	2019A0992003
Complaint Receipt Date:	10/10/2018
Investigation Initiation Date:	10/11/2018
Report Due Date:	12/09/2018
Licensee Name:	Angel Care Homes Inc
Licensee Address:	16565 Sunderland Road Detroit, MI 48219
Licensee Telephone #:	(313) 387-6042
Administrator:	Charles Udanoh
Licensee Designee:	Charles Udanoh
Name of Facility:	Cherry AFC Home
Facility Address:	30214 Cherry Avenue Romulus, MI 48174
Facility Telephone #:	(734) 941-4033
Original Issuance Date:	10/15/2009
License Status:	REGULAR
Effective Date:	03/23/2017
Expiration Date:	03/22/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
It was reported Resident A was choked by Charles Udanoh, licensee designee, because she refused to take her medications.	No
Additional Findings	Yes

III. METHODOLOGY

10/10/2018	Special Investigation Intake 2019A0992003
10/11/2018	Special Investigation Initiated - On Site I interviewed Emeka Obi, direct care staff, Residents A-C.
10/12/2018	Contact - Telephone call made Attempted telephone contact with Mr. Udanoh; he was not available, message left.
10/15/2018	Contact - Telephone call received Voicemail received from Mr. Udanoh
10/16/2018	Contact - Telephone call made Mr. Udanoh
10/17/2018	Contact - Document Received Resident A's guardian name and contact information / incident report received from Mr. Udanoh.
11/01/2018	Contact - Telephone call made Relative A, Resident A's guardian. Relative A was not available, message left,
11/01/2018	Contact - Telephone call made Relative B, Resident A's guardian.
11/14/2018	Contact - Telephone call made Mr. Udanoh
11/14/2018	Contact - Telephone call made Relative A
11/16/2018	Contact - Document Received

	Appointment logs and travel logs for Cherry AFC received from Mr. Udanoh.
12/11/2018	Contact - Telephone call made Mr. Udanoh. He was not available, message left.
12/12/2018	Contact - Telephone call made Mr. Udanoh
12/12/2018	Contact - Telephone call made Blandine Banedne, direct care staff. She was not available, message left.
12/12/2018	Contact - Document Received Incident reports pertaining to Resident A's from Mr. Udanoh.
12/12/2018	Exit Conference Mr. Udanoh

ALLEGATION:

It was reported resident A was choked by Charles Udanoh, licensee designee, because she refused to take her medications

INVESTIGATION:

An Adult Protective Services complaint was generated at intake.

On 10/11/2018, I completed an unannounced onsite inspection. I interviewed Residents A-C and Emeka Obi, direct care staff regarding the allegations. Resident A stated Mr. Udanoh placed his hands around her neck and twisted his hands, choking her. She further stated that Mr. Udanoh proceeded to scream in her ear. I asked if anybody witnessed the reported incident and Resident A said yes, two staff and two other Residents. Resident A was unable to provide the name and/or description of the staff that witnessed the incident. She said she experienced memory loss as a result of being physically abused by her ex-husband in the past. Resident A changed her previous statement and said that there was one staff and two Residents that witnessed the incident; Resident A was unable to provide name and/or description of the witnesses. I asked Resident A if the police were called when the incident occurred, and she said no. She said she does not trust the police and don't want them involved. Resident A became very defensive during the interview and did not want to proceed. She said she want the group home shut down because Mr. Udanoh is aggressive and unreasonable.

I interviewed Resident B regarding the allegations, in which he denied. He stated he's resided at the reported address for the past 5 years and he has never witnessed Mr. Udanoh choke anybody, specifically any of the Residents. He said sometimes Mr. Udanoh raises his voice but he has never been physical with the staff or Residents. Resident B said Resident A has been hallucinating and very delusional. He said on yesterday (10/10/2018) she said it was snowing outside and it wasn't. He further stated that she took the patio chair in her room because someone was coming to get it. Resident B reiterated that he did not witness Mr. Udanoh choke Resident A.

I interviewed Resident C regarding the allegations, in which he denied. Resident C said Mr. Udanoh did not choke Resident A and that she is lying like "hell." He said nobody put their hands on Resident A. Resident C said Mr. Udanoh is not a violent person to his knowledge and he has never witnessed him be aggressive with the staff or other Residents.

I interviewed Mr. Obi, regarding the allegations, in which he denied. He stated that he does not have any knowledge of Charles Udanoh, licensee designee, choking Resident A. He stated that Resident A has been refusing her medications and she is not mentally stable. Mr. Obi presented the medication book and I observed Resident A's medication administration record (MARs) for the past two months. Based on Resident A's MARs, she has been refusing her medication off and on, which is documented by entering a "R" on the specific date and time. Mr. Obi suggested I contact Mr. Udanoh and speak with him regarding the allegations. He said Mr. Udanoh was currently transporting another Resident to a follow-up doctor's appointment.

Per the MARs Resident A refused the following medications:

MEDICATIONS
VENTOLIN HFA (PROVENTIL HFA) 90MC/1ACT IH SPRAY Inhale 2 puffs into lungs every 6 hours as needed for shortness of breath. • There was an "R" 9/1/2018 through 9/30/2018 at 8:00 a.m., 2:00 p.m. and 8:00 p.m. • There was an "R" 10/1/2018 through 10/11/2018 at 8:00 a.m. and 10/1/2018 through 10/10/2018 at 2:00 p.m. and 8:00 p.m.
HM NICOTINE TRANSDERMAL (NICOTINE THRANSDERMAL SYSTEM) 14MG/24HR TR PATCH Apply one patch onto skin once daily.

• There was an “R” 9/1/2018 through 9/30/2018 at 8:00 a.m.
METOPROLOL TARTRATE (METOPROLOL TARTRATE) 25MG PO TAB Take ½ tablet (12.5MG) by mouth twice daily. • There was an “R” 9/23/2018 through 9/30/2018 at 8:00 a.m. and 9/22/2018 through 9/30/2018 at 5:00 p.m. • There was an “R” 10/1/2018 through 10/11/2018 at 8:00 a.m. and 10/1/2018 through 10/10/2018 at 5:00 p.m.
DONEPEZIL HCL (DONEPEZIL HCL) 5MG PO TAB Take 1 tablet by mouth at bedtime. • There was an “R” 9/22/2018 through 9/30/2018 at 8:00 p.m. • There was an “R” 10/1/2018 through 10/11/2018 at 8:00 p.m.
LORATADINE (LORATADINE) 10MG PO TAB Take 1 tablet by mouth once daily. •There was an “R” 9/23/2018 through 9/30/2018 at 8:00 a.m. • There was an “R” 10/1/2018 through 10/11/2018 at 8:00 a.m.
HALOPERIDOL (HALDOL) 5MG PO TAB Take 1 tablet by mouth three times daily for 14 days. • There was an “R” 9/14/2018 at 8:00 a.m.
BENZTROPINE MESYLATE (COGENTIN) 1MG PO TAB Take 1 tablet by mouth twice daily for 14 days. • There was an “R” 9/23/2018 through 9/30/2018 at 8:00 a.m. and 9/22/2018 through 9/30/2018 5:00 p.m.

On 10/16/2018, I contacted Mr. Udanoh regarding the allegations, in which he denied. Mr. Udanoh said he has never touched Resident A. He further stated that he does not administer medications and that the allegations are farfetched. Mr. Udanoh

said there has been ongoing issues with Resident A and that she's been refusing her medications. He made efforts to address the issues by encouraging Resident A to take her medications, discussing the issue with her guardians and transporting her to the hospital to be examined. Mr. Udanoh agreed to provide me with contact information for Resident A's guardians and incident reports pertaining to Resident A's behaviors.

On 10/17/2018, I received incident report dated 8/13/2018. The incident report stated Resident A refused to go to the hospital and spent all day talking to herself and the television. It stated the guardian arrived and called 911 and Resident A was taken to the hospital and admitted.

On 11/1/2018, I contacted Relative B, Resident A's secondary guardian regarding the reported allegations. Relative B said she does not believe Mr. Udanoh choked Resident A and she has been hallucinating lately; she said she just petitioned Resident A this week due to her behaviors. She further stated Resident A has signs of dementia/early onset, schizophrenia, bipolar and severe hallucinations. Relative B said it was brought to her attention that Resident A has been refusing her medications which is a direct result of her behaviors. She said she is very instrumental in Resident A's life and would've liked for her to have been taken to the hospital before it got to this point. Relative B said she has spoken with Mr. Udanoh on multiple occasions regarding Resident A's behavior and he refused to have her petitioned and/or contact medical professionals to address Resident A's behaviors. Relative B said although she does not believe Mr. Udanoh choked Resident A, she will not be returning to the home because of the poor service and inability to address Resident A's needs.

On 11/14/2018, I contacted Mr. Udanoh and explained that after interviewing Resident A, reviewing her MARs and speaking with her guardian, it is believed that Resident A has been hallucinating as a result of not taking her medications as prescribed. Mr. Udanoh confirmed Resident A has been refusing her medications. He said he has taken her to see the psychiatrist and contacted the doctor because she continues to refuse her medications. I asked Mr. Udanoh if he contacted the emergency medical services or attempted to get Resident A medical treatment after she refused her medications consecutively and he said yes. He said Resident A refused medical treatment several times, refused to see the doctor and doesn't want him to accompany her to medical appointments which prevents him from knowing what's going on with her medically. He said he has also contacted the guardians and made them aware of the situation as well; he said because Resident A's continuously refuses her medication, the guardian instructed him to contact her every time she refuses her medications. Mr. Udanoh agreed to provide me with additional incident reports documenting Resident A's refusals, appointment log documenting Resident A's medical appointments and transportation log that detail transportation provided to Resident A for medical appointments.

On 11/14/2018, I contacted Relative A and interviewed her regarding the allegations. Relative A said she was previously made aware of the allegations by Adult Protective Services. She said she was recently informed that Resident A has been refusing her medications which can trigger behaviors including hallucinations and possibly becoming a threat to herself and/or others. Relative A said this has happened in the past and Resident A refused her medications for approximately two weeks and no one contacted her. She said during recent conversation with Mr. Udanoh and the staff, she instructed them to contact her if Resident A refuse her medications. Relative A said she would like to be notified and speak with Resident A before the situation gets out of hand. Relative A said she is aware that efforts have been made to schedule doctor appointments by the doctor for Resident A and she would refuse. She said she is also aware that transportation would be arranged for Resident A to go to the hospital and she would refuse; Relative A said you can't make her do anything she doesn't want too. However, she said she feel as though the staff are not trained to deal with manic episodes and that there is no protocol in place to deal with the Residents with such behaviors. She said Mr. Udanoh refuse to have Resident A petitioned and leaves the responsibility on the guardian. Relative A said although there's no evidence that Mr. Udanoh choked Resident A, she will not be returning to the home because of the lack of professionalism and inability to address Resident A's needs.

On 11/16/2018, I received appointment logs and travel logs for Cherry AFC received from Mr. Udanoh. Based on the appointment logs Resident A was seen by the psychiatrist on 9/6/2018 and 9/17/2018; she was also seen by the doctor on 10/18/2018.

On 12/12/2018, I received additional incident reports (IR) dated 9/3/2018, 9/4/2018, 9/5/2018, 9/25/2018 and 10/31/2018 pertaining to Resident A's refusing her medications. Although it was documented, the IR was not completely filled out. The section "Action Taken by Staff/Treatment Given" was not completed and as far as the "Corrective Measures Taken to Remedy and/or Prevent Reoccurrence" it stated Resident A will talk to the doctor during next medication review; the date of the medication review was not documented.

On 12/12/2018, I conducted an exit conference with Mr. Udanoh. I made him aware that based on the information obtained there is insufficient evidence to support the allegations that he choked Resident A for refusing her medications. However, pertaining to Resident A refusing her medications, it appears as though he failed to contact the appropriate health care professional(s) and/or obtain the necessary treatment for Resident A as she went without medications for several days at a time. I suggested Mr. Udanoh train his staff on completing the IR thoroughly and documenting their actions including contacting him, the guardian, psychiatrist/doctor and/or EMS because based on the documents obtained during the investigation it appears Resident A went without medication and no actions were taken. Mr. Udanoh said he completely understands and has since spoken with his staff and provided training regarding medication administration and documentation. I expressed the

need for a corrective action plan (CAP) to outline how compliance will be achieved, monitored and maintained; Mr. Udanoh agreed to complete the CAP.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	During this investigation, I interviewed Charles Udanoh, licensee designee; Emeka Obi, direct care staff, Relative A, Resident A's primary guardian; Relative B, Resident A's secondary guardian and Resident A-C. Based on the investigative findings, there is insufficient evidence to support the allegations that Mr. Udanoh used any form of physical force with Resident A. This allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/11/2018, I completed an unannounced onsite inspection and reviewed Resident A's medication administration records (MARs). Per the MARs, Resident A refused several prescribed medications for days at a time Mr. Udanoh failed to contact the appropriate health care professional(s) and/or obtain the necessary treatment for Resident A as she went without medications for several days at a time. I reviewed several incident reports (IR) dated 9/3/2018, 9/4/2018, 9/5/2018, 9/25/2018 and 10/31/2018 pertaining to Resident A's refusing medications. Although it was documented, the IR was not completely filled out. The section "Action Taken by Staff/Treatment Given" was not completed and as far as the "Corrective Measures Taken to Remedy and/or Prevent Reoccurrence" it stated Resident A will talk to the doctor during next medication review; the date of the medication review was not documented.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	During this investigation, I interviewed Charles Udanoh, licensee designee; Emeka Obi, direct care staff, Relative A, Resident A's primary guardian; Relative B, Resident A's secondary guardian and Residents A-C. Relatives A and B stated Resident A has refused her medication repeatedly and Mr. Udanoh and staff failed to contact the appropriate health care professional and/or obtain the necessary treatment for Resident A. I reviewed Resident A's medication administration record and observed several medications initialed "R" consecutively for refusal. Based on the investigative findings, there is sufficient evidence to support the allegations that Mr. Udanoh and direct care staff failed to contact the appropriate health care professional when Resident A refused her medications on a regular basis; no action was taken to rectify the reoccurrence.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.**

	(b) The date, hour, place, and cause of the accident or incident. **(c) The effect of the accident or incident on the person who was involved and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**
ANALYSIS:	During this investigation, I reviewed several incident reports that were not completely filled out. The section "Action Taken by Staff/Treatment Given" was not completed and as far as the "Corrective Measures Taken to Remedy and/or Prevent Reoccurrence," it stated Resident A will talk to the doctor during next medication review; the date of the medication review was not documented. Based on the investigative findings, there is sufficient evidence the direct care staff failed to properly complete the incident reports.
CONCLUSION:	**VIOLATION ESTABLISHED**

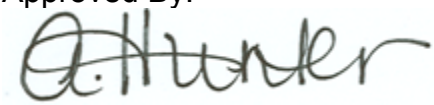
IV. RECOMMENDATION

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

12/12/2018

Denasha Walker Date
Licensing Consultant

Approved By:



12/26/2018

Ardra Hunter Date
Area Manager