RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

February 11, 2019

Milton Kennedy
K & K Assisted Living LLC
P.O.BOX 27560
Detroit, MI 48227

RE: License #: AS820343350
Investigation #: **2019A0989003**
K & K Assisted Living 3

Dear Mr. Kennedy:

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) 975-5053.

Sincerely,

Theresa Cipponeri, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-8590

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820343350
Investigation #:	2019A0989003
Complaint Receipt Date:	10/01/2018
Investigation Initiation Date:	10/02/2018
Report Due Date:	11/30/2018
Licensee Name:	K & K Assisted Living LLC
Licensee Address:	16530 Warwick Detroit, MI 48219
Licensee Telephone #:	(313) 231-3605
Administrator:	Milton Kennedy
Licensee Designee:	Milton Kennedy
Name of Facility:	K & K Assisted Living 3
Facility Address:	16100 Sunderland Detroit, MI 48219
Facility Telephone #:	(313) 231-3605
Original Issuance Date:	10/29/2013
License Status:	REGULAR
Effective Date:	05/01/2018
Expiration Date:	04/30/2020
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	Violation Established?
Resident A needs new glasses but staff will not get them for him.	No
Resident A's hip hurts and it is unknown if he has been taken to a doctor.	No
Resident A is not receiving his medications.	Yes

II. METHODOLOGY

10/01/2018	Special Investigation Intake 2019A0989003
10/01/2018	Contact - Document Received Received denied referral from Adult Protective Services (APS).
10/02/2018	Special Investigation Initiated - Telephone Contacted Resident A via telephone. Was unable to have a lucid conversation.
10/08/2018	Contact - Telephone call made Spoke to staff, Philip Obi. Scheduled onsite inspection for 10/12/2018 at 10:00 a.m.
10/10/2018	Contact - Telephone call received Spoke to Mr. Obi.
10/12/2018	Contact - Telephone call made Left a voicemail message for Resident A's brother, Gary Seleck, requesting a return call.
10/12/2018	Inspection Completed On-site Conducted announced onsite inspection. Interviewed Resident A, staff, Philip Obi, and the Home Manager, Ezeanya Oby.
10/12/2018	Contact - Telephone call made Spoke to Mr. Seleck.

O2/07/2019	Exit Conference I attempted to call the Licensee Designee, Milton Kennedy, however his voicemail was full.

ALLEGATION:

Resident A needs new glasses but staff will not get them for him.

INVESTIGATION:

On 10/2/2018, I contacted Resident A via telephone to discuss the allegations. I was unable to have a lucid, understandable conversation with Resident A, as his words were incoherent and rambling.

On 10/10/2018, I spoke to staff, Philip Obi, via telephone, and he provided me with Gary Seleck's phone number; Resident A's brother. An onsite inspection was scheduled for 10/12/2018.

On 10/10/2018, I called Resident A's brother, Gary Seleck, who stated that Resident A is "hopeless." Mr. Seleck stated that either he or Resident A's guardian will bring him glasses, however, as soon as Resident A gets them he breaks them in various ways such as throwing them against the wall or snapping them in half. Mr. Seleck stated that Resident A has been in at least 20 group homes and no one can handle his behaviors. Mr. Seleck stated that there are times where Resident A won't sleep for 3 days because he is so agitated.

On 10/12/2018, I conducted a scheduled onsite inspection to the facility and interviewed Resident A, staff, Philip Obi, and the Home Manager, Ezeanya Oby.

I interviewed Resident A, who stated that he needs glasses. Resident A was difficult to understand, slurred his words, and spoke of his life living on Mars when he used to be an alien.

I interviewed Mr. Obi, who stated that Resident A complains about everything, calls 911 constantly, and calls the Office of Recipient Rights (ORR) all the time as well but nothing ever comes of it. Mr. Obi stated that Resident A does not sleep, throws water on the floor, pulls the fire alarm, and breaks other resident's things. Mr. Obi stated that Resident A's guardian and/or his brother bring him glasses all the time, however, Resident A will just throw them or snap them in half. Mr. Obi stated that the insurance company will open pay for one pair of glasses every 1-2 years or somewhere around that timeframe.

The Home Manager, Ezeanya Oby, arrived at the facility. Ms. Oby stated that Resident A throws his glasses or breaks them in half and the insurance company will not keep paying for new glasses. Resident A's insurance will only pay for a new pair of glasses every 1-2 years.

I was unable to interview Residents B and C, as they are non-verbal.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	I interviewed Resident A, Resident A's brother, Gary Seleck, staff, Philip Obi, and Ezeanya Oby, Home Manager. Resident A stated that he needs glasses, however, he could not provide any more meaningful information. Mr. Seleck, Mr. Obi, and Ms. Oby all stated that Resident A often throws or breaks his glasses and his insurance will only pay for a new pair of glasses every 1-2 years or so.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A's hip hurts and it is unknown if he has been taken to a doctor.

On 10/10/2018, I called Resident A's brother, Gary Seleck, who stated that Resident A's hip has been sore for a very long time and he doesn't even know if his hip truly hurts. A doctor frequently comes to the facility to check on him, however, Resident A will either refuse to see him or say that his hip doesn't hurt.

On 10/12/2018, I conducted a scheduled onsite inspection to the facility and interviewed Resident A, staff, Philip Obi, and the Home Manager, Ezeanya Oby.

I interviewed Resident A, who stated that his hip hurts but was unable to provide me with any additional information. Resident A was difficult to understand, slurred his words, and spoke of his life living on Mars when he used to be an alien.

I interviewed Mr. Obi, who stated that Resident A refuses to see the doctor when the doctor comes to the facility. The Home Manager, Ezeanya Oby, arrived at the facility, and also stated that a doctor comes out to the facility every month, however,

Resident A usually refuses to see him. Ms. Oby called Dr. Mark Demuccio while I was still onsite so I could interview him via telephone. Mr. Demuccio stated that he comes out to the facility every month, or more if needed, and he will attempt to see Resident A every time he is there. Resident A often leaves when he gets there so he does not have to see him, or if he stays there he will adamantly refuse to allow Dr. Demuccio to touch him. Dr. Demuccio stated that he tries very hard to perform a physical exam on Resident A, however, Resident A won't allow him. Dr. Demuccio stated that he does not know if Resident A's hip is hurting him or why, and will not elaborate or tell anyone. Dr. Demuccio stated that Resident A has never said one word to him about his hip hurting.

I was unable to interview Residents B and C, as they are non-verbal.

R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	I interviewed Resident A, Resident A's brother, Gary Seleck, staff, Philip Obi, Ezeanya Oby, Home Manager, and Dr. Demuccio. Mr. Seleck stated that he does not really know if Resident A's hip hurts, but he has been saying that it has been sore for a while. Mr. Obi, Ms. Oby, and Dr. Demuccio stated that Resident A refuses to see Dr. Demuccio for a physical exam or medical treatment when Dr. Demuccio comes to the facility. Dr. Demuccio stated that Resident A has never told him at all that his hip hurts, and Resident A will not allow him to conduct a physical exam.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not receiving his medications.

INVESTIGATION:

On 10/10/2018, I called Resident A's brother, Gary Seleck, who stated that Mr. Seleck stated that Resident A is prescribed medication, however, he does not know how much, when, or why.

On 10/12/2018, I interviewed Resident A at the facility, who stated that he doesn't think he gets his medications every day and staff won't tell him why he needs it.

On 10/12/2018, I interviewed Ms. Oby and Mr. Obi at the facility, and they both stated that staff gives Resident A his medications every day, however, he still acts out of control and is unmanageable.

While onsite, I checked Resident A's medication logs. Mr. Obi stated that he could only find the medication logs for September 2018 and one blank medication log for October 2018 which only listed three of Resident A's medications, none if which were initialed. Ms. Oby stated that she does not have Resident A's other medication logs for October. I asked Mr. Obi at least 5 times if Resident A has been getting his October medications, and each time he replied, "Yes". I asked him where the medications were and why they weren't signed for. Mr. Obi didn't answer. I asked him again and he said he didn't know. I asked Mr. Obi and Ms. Oby where Resident A's October medications were and they stated that they did not know. Mr. Oby then stated, "I guess he hasn't been getting them."

Resident A's September medication logs and medications were reviewed as follows:

Gabapentin Neurontin—prescribed 3/day
Resident A was only given this medication on 9/1/2018 at 8:00 a.m.; the 12:00 p.m. noon dosages on 9/24/2018 and 9/25/2018 were not given, and the 8:00 p.m. dosages on 9/10/2018-9/14/2018 and 9/19/2018-9/20/2018 were the only dosages given for the entire month. The staff did not ensure that this medication was refilled for October 2018, therefore Resident A's last dosage for this medication was 9/20/2018 according to the medication logs.

Abilify—prescribed 1 tablet/day
All 8:00 a.m. dosages were signed from 9/1/2018-9/30/2018. The staff did not ensure that this medication was filled for October 2018, therefore Resident A's last dosage for this medication was 9/30/2018.

Zoloft—prescribed 1 tablet/day
All 8:00 a.m. dosages were signed for from 9/1/2018-9/30/2018. The staff did not ensure that this medication was refilled for October 2018, therefore Resident A's last dosage for this medication was 9/30/2018.

Flomax—prescribed 1 capsule/day
This medication came in a bubble pack and Ms. Oby stated that it had already been thrown away. The medication log was signed from 9/1/2018-9/30/2018, however, the staff did not ensure that this medication was refilled for October 2018. Therefore, Resident A's last dosage for this medication was 9/30/2018.

Vitamin D—prescribed as 50000 Units 1/week

Resident A was given this medication on 9/15/2018-9/16/2018, 9/23/2018-9/26/2018, and 9/28/2018. Resident A's last dosage for this medication was 9/28/2018.

Klonopin—prescribed tablet 2/day
All dosages were signed from 9/1/2018-9/30/2018. The staff did not ensure that this medication was refilled for October 2018, therefore Resident A's last dosage for this medication was 9/30/2018.

Aspirin—1 tablet/day
Resident A was only given this medication at 8:00 a.m. from 9/1/2018-9/13/2018 only. The staff did not ensure that this medication was refilled for October 2018, therefore Resident A's last dosage for this medication was 9/13/2018.

Lipitor—1 tablet/day
Resident A was not given this medication on 9/9/2018-9/11/2018 and then from 9/15/2018-9/30/2018. The staff did not ensure that this medication was refilled for October 2018, therefore, Resident A's last dosage for this medication was 9/14/2018.

Neither Mr. Obi nor Ms. Oby could not provide an explanation to me as to why Resident A did not get his full medication dosages in September 2018, nor could they say why his medications had not been refilled for October. I stated that Resident A had been off his medications for 2 weeks and no one noticed. Ms. Oby then got on the phone with the pharmacy and blamed them for not filling the prescriptions. After getting off the phone, she informed me that it was the pharmacy's fault and that it is their job to keep track of the medications for the residents. I explained to her that the facility staff are the persons responsible for keeping track of the refill; not the pharmacy's responsibility. I further stated that Resident A needs to be put back on his medications immediately. Ms. Oby continued to blame the pharmacy and Mr. Obi kept saying that he didn't know what happened. Both Ms. Oby and Mr. Obi claimed that they had no idea that Resident A was not receiving his October medications, even though Mr. Oby stated that he passes medications to the residents every day.

On 2/7/2019, I attempted to conduct an exit conference with the Licensee Designee, Milton, Kennedy, however, his voicemail was full.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:

	(a) Medications.
ANALYSIS:	Resident A was not given his full medication dosages for the month of September 2018, and staff had not refilled his medications for October 2018, leaving him unmedicated against his physician's orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff did not follow the medication prescription directions as written on the medications, as Resident A was not given his full medication dosages for the month of September 2018. In addition, staff had not refilled his medications for October 2018, leaving Resident A unmedicated against his physician's orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	Staff only had one sheet of medications for October 2018 for Resident A, which only listed 3 of his medications (Vitamin D, Aspirin, and Klonopin). The sheet was completely blank and not initialed.
CONCLUSION:	**VIOLATION ESTABLISHED**

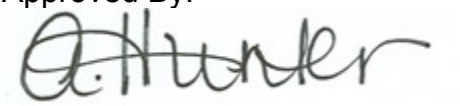
III. RECOMMENDATION

Contingent upon the receipt of a corrective action plan, I recommend no change to this license.

2/7/2019

Theresa Cipponeri — Date
Licensing Consultant

Approved By:



2/11/2019

Ardra Hunter — Date
Area Manager