



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 18, 2021

Nakia Woods
lyana's A.F.C. INC.
1117 Adams
Saginaw, MI 48602

RE: License #: AS730398654
Investigation #: 2021A0572034
lyana's A.F.C. INC.

Dear Ms. Woods:

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 (810) 787-7031.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The signature is written in a cursive style with a large, looping flourish at the end of the name.

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730398654
Investigation #:	2021A0572034
Complaint Receipt Date:	05/24/2021
Investigation Initiation Date:	05/24/2021
Report Due Date:	07/23/2021
Licensee Name:	Iyana's A.F.C. INC.
Licensee Address:	1117 Adams Saginaw, MI 48602
Licensee Telephone #:	(989) 332-4130
Administrator:	Alfonzie Pipkins
Licensee Designee:	Nakia Woods
Name of Facility:	Iyana's A.F.C. INC.
Facility Address:	1117 Adams Saginaw, MI 48602
Facility Telephone #:	(989) 980-7899
Original Issuance Date:	08/13/2020
License Status:	REGULAR
Effective Date:	02/13/2021
Expiration Date:	02/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The Facility is using a video recording device in the facility.	Yes
There have been times where there has been no staff in the facility.	No
Resident A repeatedly is not being administered his medications.	No

III. METHODOLOGY

05/24/2021	Special Investigation Intake 2021A0572034
05/24/2021	Special Investigation Initiated - Letter
06/10/2021	Contact - Face to Face Staff, Leia Brewer; Resident A and Resident B.
06/11/2021	APS Referral Referral made to APS.
06/11/2021	Inspection Completed On-site
06/11/2021	Contact - Telephone call made Licensee, Nakia Woods.
06/11/2021	Inspection Completed-BCAL Sub. Compliance
06/14/2021	Contact - Face to Face Licensee, Nakia Woods.
06/14/2021	Exit Conference Licensee, Nakia Woods.

ALLEGATION:

The facility is using a video recording device in the facility.

INVESTIGATION:

On 05/24/2021, the local licensing office received a complaint for investigation. APS was referred for further investigation.

On 06/10/2021, an unannounced onsite was made at Iyana's A.F.C., located in Saginaw County. Interviewed were Staff, Leia Brewer, Resident A and Resident B.

On 06/10/2021, I conducted an interview with Staff, Leia Brewer regarding an allegation that the facility is using a video record device in the facility. Ms. Brewer pointed to the cameras in the common areas of the facility and informed that they have cameras on the outside of the facility as well. There are no cameras in the bedrooms or bathrooms.

On 06/14/2021, I conducted an interview with Licensee, Nakia Woods regarding an allegation that the facility is using a video record device in the facility. She informed that they have cameras in the common areas of the home and on the perimeter of the home. All residents and guardians are aware of the use of cameras. She was not aware that cameras were not allowed in the facility but had created a form in case one was needed but admits that she had not had any residents or guardians sign at this point. She indicated that she would take them down if need be until she has the camera policy signed by the residents and/or guardians. The cameras were for the safety of the residents and also to protect staff. She gave an example of when law enforcement was called to the home and a resident indicated that she had bumped them, but the camera showed that the resident had bumped into her.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.
ANALYSIS:	The facility is actively utilizing video recording without the written consent of the residents and/or guardian. I observed the cameras in the common areas of the home.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

There have been times where there has been no staff in the facility.

INVESTIGATION:

On 06/10/2021, I conducted an interview with Staff, Leia Brewer regarding an allegation that there are times when there are no staff at the facility. Ms. Brewer denied this allegation. Her and the Licensee are the only two workers at this time because previous staff were not reliable as they were always calling in. Her and Ms. Nakia relieves each other so that the residents are never left alone.

On 6/10/2021, I reviewed the staff schedule. There were more than two staff initially, but now there are only Ms. Brewer and Ms. Woods.

On 06/10/2021, I conducted an interview with Resident B regarding an allegation that there are times when there are no staff at the facility. She denied this allegation and stated, "There is always someone here with us, even at night." She informed that both Ms. Brewer and Ms. Woods takes turns being at the home with them. When one leaves, the other comes in. She feels safe in the home and she really love Ms. Woods because she is respectful and patient with them.

On 06/10/2021, I conducted an interview with Resident A regarding an allegation that there are times when there are no staff at the facility. Resident A informed that it had seemed like it once before during shift change, but he is not certain because he has memory loss. He thinks it was one time where he thought there was no staff because he did not see a car, but then saw a staff in another room. Resident A really likes the facility because the staff are really good to him, they go out to eat and they plan stuff together. He is really glad he is at this home and he feels safe.

On 06/14/2021, I conducted an interview with Licensee, Nakia Woods regarding an allegation that there are times when there are no staff at the facility. She informed that residents are never left alone. Ms. Brewer is always at the home and she relieves her. There were other staff working before, but it was always an issue with them calling in or coming to work late.

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:	There is no evidence that the residents are left alone in the home. Resident B informed that there are staff there at all times, which mimics what the staff and Licensee had indicated. Resident A admits to memory loss and informed that he thought that they were alone at one time because he did not see a vehicle on the property, but there was a staff there with them.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A repeatedly is not being administered his medications.

INVESTIGATION:

On 06/10/2021, I conducted an interview with Staff, Leia Brewer regarding an allegation that Resident A repeatedly is not being administered his medications. Ms. Brewer informed that this was not true and that all the residents receive their medications according to their med sheet.

On 06/10/2021, I conducted an interview with Resident A regarding an allegation that he is repeatedly not being administered his medications. He informed that the staff always gives him his medications. He has not missed one day. He is trying to get his medications in order because he does not believe that they are working.

On 06/14/2021, I conducted an interview with Licensee, Nakia Woods regarding an allegation that Resident A repeatedly is not being administered his medications. She informed that Resident A always received his medications and has not missed a day. The only thing she can think of is when the program van picked him up for program right before 8am, he left without taking his meds because the med passer start administering the meds at 8am. They called the program and informed him that he had not taken his medications yet, so they brought him back home to take his meds and then took him back to program.

Resident A's medication records were reviewed. Medication records shows that he is receiving his medications.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Resident A informed that he is receiving his medications and is only trying to get a med change. The Staff and the Licensee also informed that Resident A always receives his medications. Records show that his meds have been administered timely.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 06/14/2021, Ms. Woods was informed of the citation for the use of video recordings. She informed that she would take them down until she has written consent from the residents and their guardians.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the licensing status of this small adult foster care facility (capacity 1-6).

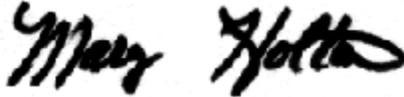


06/16/2021

Anthony Humphrey
Licensing Consultant

Date

Approved By:



06/18/2021

Mary E Holton
Area Manager

Date