GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 15, 2021

Esther Mwankenja
Zanzibar Adult Foster Care, LLC
5806 Outer Drive
Bath, MI 48808

RE: License #: AS330406614
Investigation #: 2021A0466044
Zanzibar Adult Foster Care, LLC

Dear Ms. Mwankenja:

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330406614
Investigation #:	2021A0466044
Complaint Receipt Date:	08/13/2021
Investigation Initiation Date:	08/16/2021
Report Due Date:	10/12/2021
Licensee Name:	Zanzibar Adult Foster Care, LLC
Licensee Address:	5806 Outer Drive Bath, MI 48808
Licensee Telephone #:	517-885-0716
Administrator:	Esther Mwankenja
Licensee Designee:	Esther Mwankenja
Name of Facility:	Zanzibar Adult Foster Care, LLC
Facility Address:	520 S. Holmes Street Lansing, MI 48912
Facility Telephone #:	(517) 885-0716
Original Issuance Date:	02/17/2021
License Status:	REGULAR
Effective Date:	08/17/2021
Expiration Date:	08/16/2023
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATION;

	Violation Established?
Licensee designee Esther Mwankenja left the country for 23 days and did not leave the designated caregiver with ample supplies.	No
Resident A did not receive any medications from 8/13/2021 through 8/23/2021.	No
Additional Findings	Yes

III. METHODOLOGY

08/13/2021	Special Investigation Intake-2021A0466044.
08/16/2021	Contact - Document Sent- Email to Complainant.
08/16/2021	Special Investigation Initiated – Letter- Email recevied from Complainant.
08/18/2021	Inspection Completed On-site.
08/26/2021	Contact - Document Received from Brooke Hall from Community Mental Health, interviewed.
09/01/2021	Contact - Document Recevied additional allegations made.
09/01/2021	Contact - Document Recevied from adult protective services worker Steve Marchlewicz, additional allegations.
10/06/2021	Contact- Telephone Call to licensee designee Esther Mwankenja, message left.
10/06/2021	Contact - Document Sent to adult protective services worker Steve Marchlewicz.
10/06/2021	Contact - Document Sent to Brooke Hall.
10/06/2021	Contact - Document Recevied from adult protective services worker Steve Marchlewicz.
10/06/2021	Contact- Telephone Call from licensee designee Esther Mwankenja.
10/08/2021	Inspection Completed On-site.

10/08/2021	Exit Conference with licensee designee Esther Mwankenja.

ALLEGATION: Licensee designee Esther Mwankenja left the country for 23 days and did not leave the designated caregiver with ample supplies.

INVESTIGATION:
On 08/13/2021, Complainant reported licensee designee and live-in staff Esther Mwankenja left on a planned trip between 8/3/2021-8/26/2021. Complainant reported licensee designee Mwankenja left direct care worker (DCW) Tracy Siemon to care for the residents however DCW Siemon was not left with an ample food supply and stated she was not sure that she plans to stay and care for the residents for the duration of time that licensee designee Mwankenja will be gone.

On 08/16/2021, I spoke with Community Mental Health (CMH) case manager Christina Johnson who reported that licensee designee Mwankenja left DCW Siemon to care for the residents while she was out of town. Case manager Johnson stated DCW Siemon reported that she was not left with ample food and DCW Siemon stated she was not sure she plans to stay and care for the residents for the duration of time that licensee designee Mwankenja will be gone. Case manager Johnson reported she has been in the facility weekly and reported that there is still ample food in the facility. Case manager Johnson reported that she and or her co-worker plan to go to the facility weekly while licensee designee Mwankenja is out of town.

On 08/16/2021, I conducted an unannounced investigation on-site, and I observed that the facility had food in both the refrigerator and freezer. Additionally, the facility has a second freezer with food and other non-perishable items in the pantry. When I conducted a visual inspection of the facility, I saw two plates of food on the kitchen table.

On 08/16/2021, I interviewed DCW Siemon who reported the plated food I was observing was lunch for Resident A and Resident B. DCW Siemon reported the facility has ample food for the duration of time that licensee designee Mwankenja will be gone. DCW Siemon reported she has not been paid by licensee designee Mwankenja but that she intends to care for the residents 24 hours a day, seven days a week. DCW Siemon reported that she will care for the residents for the duration of time that licensee designee Mwankenja is going to be gone. DCW Siemon reported she has moved into the facility to care for the residents while licensee designee Mwankenja is gone.

On 08/16/2021, I interviewed Resident A and Resident B who both reported that they had breakfast and that DCW Siemon is feeding them three meals and snacks daily. Resident A and Resident B were the only residents currently residing at the facility.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	On 08/16/2021, I conducted an unannounced investigation. I observed DCW Siemon caring for the residents in the absence of licensee designee Mwankenja. DCW Siemon reported that she will stay and care for Resident A and Resident B until licensee designee Mwankenja returns from her scheduled trip therefore there is not enough evidence to establish a violation. The facility has DCW Siemon caring for Resident A and Resident B 24 hours a day, seven days a week.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	On 08/16/2021, I conducted an unannounced investigation and DCW Siemon, Resident A and Resident B all reported that DCW Siemon was providing the residents with three meals and snacks daily. I observed the facility to have a refrigerator and two freezers with food plus a pantry with non-perishable food items therefore the facility has ample food therefore is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A did not receive any medications from 8/13/2021 through 8/23/2021.

INVESTIGATION:
On 09/01/2021, Complainant reported Resident A left with her friends to go to Mackinaw City and was gone from 8/3/2021 through 8/13/2021. Complainant reported that Resident A did not receive any medications from 8/13/2021 through

8/23/2021. Complainant reported that Resident A is on a lot of medications. Complainant reported that DCW Siemon said she was confused on the medications and did not know what to give Resident A.

On 09/01/2021, I interviewed Brook Hall, Housing and Residential Supervisor at CMH who reported that as of 08/26/2021, Resident A and Resident B no longer reside at Zanzibar Adult Foster Care.

It should be noted that on 08/16/2021, I interviewed Resident A privately at the facility and Resident A did not make any allegations about not receiving medications from 08/13/2021 through 08/23/2021. Resident A reported that she was being well cared for by DCW Siemon and that all of her needs were being met.

On 10/08/2021, I conducted an on-site investigation and I reviewed Resident A's record which contained a Medication Administration Record (MAR) for Resident A for August 2021. Resident A's MAR documented that all medication was administered as prescribed based on the signatures documented on the MAR. Due to the fact that Resident A moved out of the facility on 08/23/2021, Resident A's medications were not at the facility at the time of the investigation and therefore could not be compared to the MAR.

On 10/08/2021, I interviewed licensee designee Mwankenja who reported that DCW Siemon was administering Resident A's medication as prescribed from 08/13/2021 through 08/23/2021. Licensee designee Mwankenja reported that she had trained DCW Siemon in the administration of medication for both Resident A and Resident B prior to her planned trip.

On 10/08/2021 and again on 10/13/2021, I attempted to contact DCW Siemon by phone however the number I had been provided had a message stating that the phone number has been disconnected.

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

ANALYSIS:	Although Complainant reported that Resident A did not receive any medications from 8/13/2021 through 8/23/2021, Resident A's medication administration record (MAR) documented that all medications were initialed by DCW Siemon at the time the medications were administered. Additionally, Resident A was interviewed on 08/16/2021 and did not report that medication was not being administered, rather Resident A reported that she was being provided good care by DCW Siemon therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 08/16/2021, I conducted an unannounced investigation and learned that Resident B was diagnosed with a developmental disability. The licensee designee is approved to provide care for individuals diagnosed with mental illness and/or those who are aged.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.
ANALYSIS:	The licensee is approved to provide care for individuals diagnosed with mental illness and/or aged. The licensee's program statement does not include any services provided individuals with a developmental disability. Resident B did not meet the criteria for admission based on the programs that the facility is licensed for and therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/15/2021 and 10/08/2021, I reviewed DCW Siemon's employee record and there was no documentation that DCW Siemon was competent in the required training prior to performing assigned tasks.

On 10/08/2021, licensee designee Mwankenja reported that DCW Siemon was trained at another facility but the training documentation was not transferred to DCW Siemon's employee record for this AFC facility.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) 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 competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	On 08/15/2021 and 10/08/2021, DCW Siemon's employee record did not contain any documentation that she provided in-service training nor that she was competent in the required areas prior to her performing assigned tasks. Additionally, licensee designee Mwankenja reported that DCW Siemon was trained at another facility but the training documentation was not transferred to DCW Siemon's employee record for this AFC facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/15/2021 and 10/08/2021, I reviewed DCW Siemon's employee record and there was no documentation that DCW Siemon was trained in the proper handing and administration of medications.

On 10/08/2021, licensee designee Mwankenja reported that DCW Siemon was trained at another facility but the training documentation was not transferred to DCW Siemon's employee record for this AFC facility.

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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	On 08/15/2021 and 10/08/2021, DCW Siemon's employee record did not contain any documentation that she was provided in-service training in the proper handing and administration of medications. Additionally, licensee designee Mwankenja reported that DCW Siemon was trained at another facility but the training documentation was not transferred to DCW Siemon's employee record for this AFC facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/15/2021 and 10/08/2021, the front door of the facility contained a dead bolt and therefore was not equipped with positive-latching, non-locking-against-egress hardware.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	On 08/15/2021 and 10/08/2021, the front door of the facility contained a dead bolt and therefore was not equipped with positive-latching, non-locking-against-egress hardware.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/08/2021, I conducted an exit conference with licensee designee Mwankenja who understood the findings of the investigation.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

10/13/2021

Julie Elkins Date
Licensing Consultant

Approved By:

10/15/2021

Dawn N. Timm Date
Area Manager