GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 30, 2021

Jawad Shah
Insight Healing Center (dba Jawad A Shah MD PC)
Ste 1875
4800 S. Saginaw St.
Flint, MI 48507

RE: License #: AM250389863
Investigation #: 2022A0572001
Insight Healing Center

Dear Mr., MD Shah:

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 (906) 226-4171.

Sincerely,

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 #:** | AM250389863 |
| **Investigation #:** | 2022A0572001 |
| | |
| **Complaint Receipt Date:** | 10/04/2021 |
| | |
| **Investigation Initiation Date:** | 10/06/2021 |
| | |
| **Report Due Date:** | 12/03/2021 |
| | |
| **Licensee Name:** | Insight Healing Center (dba Jawad A Shah MD PC) |
| | |
| **Licensee Address:** | Ste 1875<br>4800 S. Saginaw St.<br>Flint, MI 48507 |
| | |
| **Licensee Telephone #:** | (810) 893-6049 |
| | |
| **Administrator:** | Jawad Shah |
| **Licensee Designee:** | Jawad Shah |
| | |
| **Name of Facility:** | Insight Healing Center |
| | |
| **Facility Address:** | STE 1875<br>4800 S Saginaw St.<br>Flint, MI 48507 |
| | |
| **Facility Telephone #:** | (810) 732-8336 |
| | |
| **Original Issuance Date:** | 06/07/2018 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 12/07/2020 |
| **Expiration Date:** | 12/06/2022 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff requested that Resident A be admitted to the psychiatric unit. He was discharged as not meeting criteria. Staff initially refused to take him back but did. | No |
| Resident A does not get his Oxycodone medication as prescribed. | Yes |
| Resident A alleges staff feed him old and moldy food. | No |
| | |
| | |

## III. METHODOLOGY

| | |
|---|---|
| 10/04/2021 | Special Investigation Intake<br>2022A0572001 |
| 10/06/2021 | Special Investigation Initiated - On Site<br>Director of Nursing, Nancy Petzole; LPN, Archia Underwood; Cook/CNA, Eileen Rauch, LPN, Nachia Cochran and Resident A. |
| 11/29/2021 | Inspection Completed-BCAL Sub. Compliance |
| 11/30/2021 | Contact – Telephone call made<br>Dr. Belascher. |
| 11/30/2021 | Exit Conference<br>Licensee, Shah Jawad. |
| | |

**ALLEGATION:**
Staff requested that Resident A be admitted to the psychiatric unit. He was discharged as not meeting criteria. Staff initially refused to take him back but did.

**INVESTIGATION:**
On 10/04/2021, the local licensing office received a complaint for investigation. No other investigative entity was involved with this investigation.

On 10/06/2021, I made an unannounced onsite to Insight Healing Center, located in Genesee County, Michigan. Interviewed were the following: Director of Nursing, Nancy Petzole; LPN, Archia Underwood; Cook/CNA, Eileen Rauch, LPN, Nachia Cochran and Resident A.

On 10/06/2021, I interviewed the Director of Nursing, Nancy Petzole, regarding an allegation that staff refused to take Resident A back after he was not admitted for psychiatric treatment at Hurley Hospital. Ms. Petzole informed that they were not going to take Resident A back because he made physical threats to staff, wrote threaten and racists remarks on the office door with a permanent marker and has run over staff intentionally with his wheelchair. Hurley Medical Center contacted the facility and informed that they could not evict Resident A without a police report. The police came to the facility, but she does not believe that they wrote a report since he went to the hospital. She agreed with the Hurley Medical Center and agreed to take him back. He was only gone for a few hours. She is hoping that with some therapy, he will be able to meet his needs.

On 10/06/2021, I observed the graffiti on the office door. It was written in a permanent marker and very obscene.

On 10/06/2021, I interviewed LPN, Archia Underwood, regarding an allegation that staff refused to take Resident A back after he was not admitted for psychiatric treatment at Hurley Hospital. Ms. Underwood informed that she is not aware of the facility refusing Resident A to come back because they did not give him a 30-Day Notice, which is required. Resident A had written a lot of slander on Director of Nursing, Nancy Petzole's office door. There is no reasoning with Resident A as he thinks that everyone is working against him. All of the slander and verbal abuse sometimes scares the other workers because they do not know how to approach him.

On 10/06/2021, I interviewed Cook, Eileen Rauch, regarding an allegation that staff refused to take Resident A back after he was not admitted for psychiatric treatment at Hurley Hospital. Ms. Rauch is not aware of the facility refusing Resident A to return to the facility because he left during her shift, and he returned during her shift.

On 10/06/2021, I interviewed LPN, Nachia Cochran, regarding an allegation that staff refused to take Resident A back after he was not admitted for psychiatric treatment at Hurley Hospital. Ms. Cochran remember Resident A being sent out for

Psychiatric treatment but is not aware of the staff refusing for him to return. She informed that they are not able to do that without a 30-Day discharge notice.

On 10/06/2021, I interviewed Resident A, regarding an allegation that staff refused to take Resident A back after he was not admitted for psychiatric treatment at Hurley Hospital. Resident A informed that staff refused for him to come back to the facility. Then he indicated that staff told the police that he could come back, but he did not believe them and indicated that him going to the hospital was a complete waste of time.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14302** | **Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.** |
| | **(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.** |
| **ANALYSIS:** | Resident A went to the hospital for psychiatric treatment, but he was not admitted as he did not meet the criteria. the Director of Nursing, Nancy Petzole did not want to take him back, but agreed with the hospital to take him back because they did not have a police report indicating that he couldn't come back. Staff informed that they knew that Resident A was sent out to the hospital but do not know anything about him not being able to return because they did not issue him a 30-Day Discharge Notice and he returned within the same shift. Resident A informed that staff refused for him to come back but indicated that staff informed the police that he was able to come back. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**
Resident A does not get his Oxycodone medication as prescribed.

**INVESTIGATION:**
On 10/06/2021, I interviewed the Director of Nursing, Nancy Petzole, regarding an allegation that Resident A does not get his Oxycodone medication as prescribed. Ms. Petzole informed that upon Resident A's admission to their facility, the

pharmacy did not have all of his medications. Resident A was prescribed 10mg of Oxycodone, but since they did not have it yet, they gave him two 5mg of the same medication from the backup meds. They have backup meds for in case changes are made or during the holidays when they are unable to get medications filled. Resident A also believes that if his 2pm meds are not given to him at exactly 2pm, then they are not giving him his meds on time. Resident A was informed that they have a window of time to give him his meds and that he will not always get his meds exactly on time as sometimes he will receive them 30 minutes after the scheduled time, depending on what the nurses are doing.

On 10/06/2021, I interviewed LPN, Archia Underwood; regarding an allegation that Resident A does not get his Oxycodone medication as prescribed. She informed that they have narcotics that are kept locked away in the backup medication box when they run out of medications. They did not have the 10mg of Oxycodone, so they gave him two 5mg of Oxycodone. Resident A believed that this was wrong and accused the nurse of stealing his medications. She informed that the medications do not belong to anyone as it comes from the pharmacy. These medications are not discontinued meds or meds from a previous or current resident.

On 10/06/2021, I interviewed Cook, Eileen Rauch; regarding an allegation that Resident A does not get his Oxycodone medication as prescribed. She informed that she does not know anything about meds as she does not pass medications.

On 10/06/2021, I interviewed LPN, Nachia Cochran; regarding an allegation that Resident A does not get his Oxycodone medication as prescribed. She informed that Resident A refused the medication from the backup box. He will take meds from some staff but refuse from others. She informed that they have the backup medication box for when the pharmacy has not filled a resident's medication. These meds are not for any specific resident. When they use this, they have to initial and say who the medication is for. There has to be a witness for when the meds from the backup medication box is used.

On 10/06/2021, I interviewed Resident A; regarding an allegation that he does not get his Oxycodone medication as prescribed. There are several times where he has refused to take his medications. There's a certain nurse that he refuses to take medications from. He stated, "They tried to give me some old medication and I don't know why they did not have my medications." He informed that staff said that the medications is the same as what is prescribed to him. He believes that they are old medications that they are getting out of a box.

On 10/06/2021, I interviewed Dr. Belascher; regarding an allegation that Resident A does not get his Oxycodone medication as prescribed. Dr. Belascher informed that the facility has a backup medication box that they utilize for after-hours and emergency situations. He orders additional medications for situations where a resident may need something for pain, an anti-biotic or an antihistamine, that's not life-threatening, so they won't have to transport them to an emergency room. The

medications are not prescribed to anyone. They are there for the sole purposed of after-hours or weekends and holidays and is a one-time only thing that they do.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.** |
| **ANALYSIS:** | All staff that were interviewed, including Resident A, indicated that the facility is utilizing a backup box that has medications for when the run out or when the pharmacy has not filled a resident's meds. Dr. Belascher informed that when the nurses contacts him to inform that a resident does not have a medication, he gives them consent for one-time only to give a resident a medication from the backup medication box. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**
Resident A alleges staff feed him old and moldy food.

**INVESTIGATION:**
On 10/06/2021, I interviewed the Director of Nursing, Nancy Petzole, regarding an allegation that the staff feed Resident A old and moldy food. Ms. Petzole informed that this is not true as they are spending $1,000 per week in groceries, so she finds it very hard to believe that there is any moldy food in their facility. She indicated that Resident A does refuse meals a lot. Resident A will say that he does not want any cold food, so when they warm it up, he'll say that he does not want any warmed-up food. If the food is moldy, she does not understand why he would not mention this to the cook.

On 10/06/2021, I interviewed LPN, Archia Underwood, regarding an allegation that the staff feed Resident A old and moldy food. She denied ever given Resident A or any other residents any moldy food. She informed that they have a cook and that they go grocery shopping every week. The cook makes whatever is on the menu and if they do not want what's on the menu, then they offer other meals.

On 10/06/2021, I interviewed the Cook, Eileen Rauch, regarding an allegation that staff feed Resident A old and moldy food. She informed that this is not true. Resident A did not want a grilled cheese sandwich because it makes him constipated, so she made him a ham sandwich and he took it outside to eat. The very next day, he told her, "By the way, that bread was moldy yesterday. You made me sick, so now I can't eat." She said that she explained to him that she fed all the other residents, and no one complained or informed her that the bread was moldy. She said that it was

Hillbilly Bread, not white bread, so maybe he thought it was supposed to be white in color. Resident A always complains about the food. She informed that the facility has food delivered on a weekly basis.

On 10/06/2021, I interviewed Resident A, regarding an allegation that the staff feed him old and moldy food. Resident A informed that the facility is serving him spoiled food but are not doing better since the complaint.

On 10/06/2021, I observed the residents eating their food and none of the food appeared to be spoiled. I also observed the food in the refrigerator, freezers, cabinets, and pantry. All food were dated and did not appear to be spoiled. There was more than enough food at the facility. Ms. Petzole showed me a few grocery bills for the week and they were all approximately $1,000 each.

| **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:** | All staff denied that any of the food is spoiled in their facility and that they receive groceries on a weekly basis. Resident A informed that the food was spoiled, but they have gotten better since the complaint. I observed the kitchen and pantry areas, and the food did not appear to be spoiled. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

On 11/30/2021, an Exit Conference was held with Licensee, Shah Jawad, MD; regarding the results of the investigation.

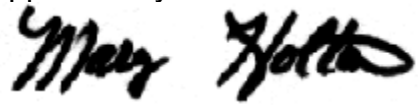
## IV. RECOMMENDATION

I recommend no change to the licensing status of this medium sized group home pending the receipt of an appropriate corrective action plan (Capacity 1-12).

11/30/2021

Anthony Humphrey Date
Licensing Consultant

Approved By:



11/30/2021

Mary E Holton Date
Area Manager