GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 5, 2022

Anthony Ezeanya
Acon Services, Inc.
6481 Royal Pointe
West Bloomfield, MI 48322

RE: License #: AS820379150
Investigation #: 2022A0992002
Sunderland AFC Home

Dear Mr. Ezeanya:

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 (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

I. IDENTIFYING INFORMATION

License #:	AS820379150
Investigation #:	2022A0992002
Complaint Receipt Date:	11/01/2021
Investigation Initiation Date:	11/02/2021
Report Due Date:	12/31/2021
Licensee Name:	Acon Services, Inc.
Licensee Address:	17126 Prevost St. Detroit, MI 48235
Licensee Telephone #:	(313) 729-3970
Administrator:	Obiageli Ezeanya
Licensee Designee:	Anthony Ezeanya
Name of Facility:	Sunderland AFC Home
Facility Address:	17127 Sunderland Road Detroit, MI 48219
Facility Telephone #:	(313) 694-3829
Original Issuance Date:	08/05/2016
License Status:	REGULAR
Effective Date:	03/24/2020
Expiration Date:	03/23/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is not being provided her medications on time. Staff are not checking Resident A's blood sugar in the evening.	Yes

III. METHODOLOGY

11/01/2021	Special Investigation Intake 2022A0992002
11/01/2021	APS Referral Denied at intake
11/02/2021	Special Investigation Initiated - Telephone Complainant
11/03/2021	Inspection Completed On-site Anthony Ezeanya, licensee designee; Obiageli Ezeanya, administrator and Becilia Uzoigwe, direct care staff.
11/05/2021	Contact - Telephone call received Ms. Obi
11/08/2021	Contact - Telephone call received Ms. Obi
11/18/2021	Contact - Telephone call made Ms. Obi was not available, message left.
11/18/2021	Contact - Telephone call made Resident A was not available, message left.
11/18/2021	Contact - Telephone call received Ms. Obi
11/23/2021	Contact - Telephone call made Resident A was not available; number appears to be disconnected.
11/29/2021	Contact - Telephone call made Resident A was not available; number appears to be disconnected.

11/29/2021	Contact - Telephone call made Ms. Obi
11/30/2021	Contact - Telephone call made Resident A
12/01/2021	Exit Conference Mr. Ezeanya
1/05/2022	ORR Referral Submitted

ALLEGATION: Resident A is not being provided her medications on time. Staff are not checking Resident A's blood sugar in the evening.

INVESTIGATION: On 11/2/2021, I contacted the Complainant and discussed the allegations. The Complainant stated she received a voicemail message from Resident A expressing concerns regarding her medication. The Complainant said Resident A was very detailed regarding her medication and that she is not getting her medication as prescribed. The Complainant said she is very familiar with Resident A and that Resident A is very knowledgeable about her medications. The Complainant said Resident A said she feel as though the staff is incompetent and not giving her enough insulin according to her blood sugar levels. The Complainant further stated that she feels threatened when she tries to tell the staff about her medications.

On 11/03/2021, I completed an unannounced onsite inspection. Upon arrival, I interviewed Anthony Ezeanya, licensee designee and Becilia Uzoigwe, direct care staff regarding the allegations. Mr. Ezeanya denied the allegations and said to his knowledge Resident A receives her medication accordingly. I requested to review Resident A’s medication administration records (MARs); I was provided with her current MARs. I reviewed Resident A’s MARs in comparison to her actual medications. Based on the medications observed, Resident A is prescribed NovoLog Mix 70/30 FlexPen Prefilled Syringe; per the label inject 50 Units subcutaneously twice daily. According to the MARs Resident A’s NovoLog Mix 70/30 FlexPen Prefilled Syringe instructions are as follows: take 20 Units subcutaneously twice daily. I explained to Mr. Ezeanya that there’s a conflict because according to the label on the medication, Resident A is supposed to 50 Units subcutaneously twice daily, not 20 Units; Mr. Ezeanya was unable to provide an explanation. I asked him if her medication was changed by the doctor, and he was uncertain. He said Mrs. Obiageli Ezeanya, administrator (Mrs. Obi) handles the medication records. I asked to review Resident A’s past medication records, which Mr. Ezeanya was unable to provide and said he needs to call Mrs. Obi.

I proceeded to interview Becilia Uzoigwe, direct care staff regarding the allegations. Ms. Uzoigwe said when administering Resident A's medication, specifically her NovoLog Mix 70/30 FlexPen Prefilled Syringe she calls Mrs. Obi and reports Resident A's blood sugar levels and Mrs. Obi determines how much insulin is required based on Resident A's reading. I asked Ms. Uzoigwe if Resident A is on a sliding scale as it pertains to her insulin, and she was uncertain.

Mrs. Obi arrived, I proceeded to interview her regarding the allegations, in which she denied. Mrs. Obi said Resident A receives her medication as prescribed. She said sometimes Resident A does her own blood sugar reading and if she refuses to show staff the reading, it's not recorded. She said they can't write down what they didn't see. I explained to Mrs. Obi that according to the MARs, Resident A's blood sugar level should be checked twice daily. Mrs. Obi said Resident A is not the most cooperative; I explained that if Resident A refuses medications, it should be documented on the MARs. She said Resident A requested staff administer her medications prior to work, which was at 6:30 a.m. in which Mrs. Obi refused. She further explained that the facility operates on a schedule. She said breakfast is made at a certain time, medications are administered at a certain time, etc. She said as for Resident A, some of her medications require breakfast, so staff must prepare breakfast for all the residents and then pass medications. Mrs. Obi said sometimes Resident A refuses to eat and in that instance her sugar is low and insulin is not administered. Mrs. Obi said Resident A has clearly expressed that she doesn't want to live here and she's very uncooperative. I explained to Mrs. Obi that after reviewing Resident A's MARs, there appears to be a discrepancy with her NovoLog Mix 70/30 FlexPen Prefilled Syringe. I further stated according to the MARs Resident A's NovoLog Mix 70/30 FlexPen Prefilled Syringe instructions are as follows: take 20 Units subcutaneously twice daily. However, the label on the medication, states 50 Units subcutaneously twice daily. Mrs. Obi reviewed the medications and said Resident A's medication was changed during her last doctor's appointment. She said the doctor told her to administer 20 Units opposed to 50 Units. I asked Mrs. Obi if she has that in writing and she said no. Mrs. Obi said the medication was sent to the pharmacy, so they should have a record. Mrs. Obi proceeded to call the pharmacy, but they didn't have any records of the medication modification. She further explained that Resident A was hypoglycemic, and the doctor changed her insulin from 50 Units to 20 Units. Mrs. Obi said in addition, she's a nurse and Resident A's medication is administered based on her blood sugar reading. I explained to Mrs. Obi that although she may be a nurse by profession, when working at the facility she's working in the capacity of an administrator and/or direct care staff and she cannot adjust and/or modify residents' medication. I further explained that if the doctor changed the medication, it must be recorded in writing. I asked Mrs. Obi, if Resident A is on a sliding scale as it pertains to her insulin, and she said no. Mrs. Obi said she can contact the doctor and get it writing, she attempted to contact the doctor's office, but the doctor was not available. Mrs. Obi said she will go to the doctor's office to get a copy of Resident A's records outlining her medication change.

It should be noted that the NovoLog Mix 70/30 FlexPen Prefilled Syringe instructions were noticeably modified in the MARs from 50 Units subcutaneously twice daily to 20 Units subcutaneously twice daily, at 8 a.m. and 8 p.m. both of which were not consistently initialed. The 8 a.m. dosage was not initialed on the following days: 10/3/2021, 10/4/2021, 10/5/2021, 10/8/2021, 10/9/2021, 10/11/2021 and 10/18/2021. The 8 p.m. dosage was not initialed on the following days: 10/1/2021, 10/2/2021, 10/3/2021, 10/4/2021, 10/5/2021, 10/7/2021,10/8/2021, 10/10/2021, 10/12/2021, 10/14/2021, 10/17/2021 and 10/19/2021. Some of the initials included the blood sugar levels and others included “20U”, which is believed to be the amount of insulin administered on that particular day.

On 11/05/2021, I received a telephone call from Ms. Obi. She said she spoke with the doctor, and he said he forgot to send over the script and that he would send it over today. I suggested that she request the doctor put it in writing and provide her with a copy. I explained that if the doctor sent over the prescription to the pharmacy, the medication is going to be effective as of todays date and not back dated to the date and time that he allegedly changed the medications, which will not correspond with the MARs and the 20 Units that were administered. Mrs. Obi said she will go into the office and request a copy of Resident A’s medical records. I explained that there’s no guarantee that the medical records will reflect the medication modification and I wouldn’t want her to waste her time, if the doctor can just confirm he authorized the medication modification and put it in writing. Mrs. Obi agreed to contact the doctor and follow-up with me.

On 11/08/2021, I received a telephone call from Ms. Obi. She said she received a copy of Resident A’s medical records, and the requested information was not included in her records. She said she intends to schedule Resident A a doctor’s appointment and hopefully she can get the medication modification in writing.

On 11/18/2021, I received a telephone call from Ms. Obi. She said Resident A had a doctor’s appointment on 11/11/2021 and she was seen by a different doctor. She said when she explained the situation to the doctor and the office reviewed Resident A’s record; apparently the doctor that authorized the medication modification is in his residency and he was not available. Mrs. Obi said she spoke with the office administrator, and she has agreed to investigate further and follow-up with her. Mrs. Obi said once she receives additional information, she will call me.

On 11/29/2021, I made telephone contact with Ms. Obi to see if she received any updated information from the doctor’s office and she said no. She also made me aware that Resident A was currently at Stonecrest Hospital due to behaviors. I explained to Mrs. Obi that based on the findings, there’s evidence that Resident A’s medication was adjusted and/or modify and it was not recorded in writing.

On 11/30/2021, I interviewed Resident A regarding the allegations. Resident A said she is supposed to receive 50 Units of insulin in the morning and at bedtime; she said she was not getting her medication regularly. Resident A said the staff would

call Mrs. Obi to report her blood sugar reading and depending upon the levels, Mrs. Obi would tell the staff how much inulin to administer. Resident A said if her reading was under 200, she didn't receive insulin and if it was over 200 staff would administer anywhere from 20-30 Units, but it was never a consistent amount. Resident A said anytime she tried to correct Mrs. Obi and/or staff, she would feel threatened by Mrs. Obi. Resident A confirmed Mrs. Obi did accompany her to her doctor's appointment. However, she said the doctor never changed her medications. She said Mrs. Obi took her to a follow-up doctor's appointment trying to get something in writing to justify her changing her medication, but the doctor refused. Resident A said she heard the doctor say, "I would never adjust the medication because the current medication is working fine." Resident mentioned that Mrs. Obi called the police and had her petitioned; she said she doesn't plan on returning to that facility.

On 12/01/2021, I conducted an exit conference with Mr. Ezeanya regarding the overall investigation and findings. I explained that based on the investigation there is sufficient evidence that Resident A's medication was not given, taken, or applied pursuant to label instructions. I stated that the label instructions on Resident A's NovoLog Mix 70/30 FlexPen Prefilled Syringe was as follows: 50 Units subcutaneously twice daily. However, according to the MARs Resident A was receiving 20 Units subcutaneously twice daily. Mr. Ezeanya stated Resident A's doctor told Mrs. Obi to administer 20 Units. I asked Mr. Ezeanya if the medication modification was put in writing, and he was not sure. I explained that Mrs. Obi also said the doctor verbally changed the medication and failed to put it in writing and she attempted to contact the doctor to obtain a copy of medication modification but was unsuccessful. I made him aware that she also contacted the pharmacy and the script had not been changed and she requested a copy of Resident A's medical record and there was no record of the medication modification. Mr. Ezeanya explained that Mrs. Obi is a nurse and she's familiar with blood sugar levels and what is required. I explained to Mr. Ezeanya that although she may be a nurse by profession, when working at the facility she's working in the capacity of an administrator and/or direct care staff and she cannot adjust and/or modify residents' medication. I further explained that if the doctor changed the medication, it must be recorded in writing. I made Mr. Ezeanya aware as a result of the findings, the allegation is substantiated, and a written corrective action plan is required. I further explained that this is not the first time this facility has been cited for not administering medications pursuant to label instructions and as a result this is a repeat violation. Mr. Ezeanya agreed to review the report and respond accordingly.

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

ANALYSIS:	During this investigation, I interviewed Anthony Ezeanya, licensee designee; Obiageli Ezeanya, administrator; Becilia Uzoigwe, direct care staff; Complainant and Resident A regarding the allegations. Mrs. Obi, Ms. Uzoigwe and Resident A confirmed the medication was not given pursuant to label instructions**.** Mrs. Obi stated Resident A's doctor modified the dosage, but she was unable to provide written verification that the doctor modified the medication. Based on the investigative findings, Resident A was not given her full medication dosages for the month of October 2021. The allegation is substantiated. ***REPEAT VIOLATION ESTABLISHED* LSR DATED 7/05/2019; CAP DATED 8/05/2019.**
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/05/2022

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Denasha Walker Date
Licensing Consultant

Approved By:

01/05/2022

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Ardra Hunter Date
Area Manager