GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2022

Josephine Uwazurike
Kevdaco Human Services LLC
PO Box 4199
Southfield, MI 48037

RE: License #: AS820295931
Investigation #: 2022A0992003
Kevdaco Redford II

Dear Ms Uwazurike:

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 #:	AS820295931
Investigation #:	2022A0992003
Complaint Receipt Date:	11/15/2021
Investigation Initiation Date:	11/15/2021
Report Due Date:	01/14/2022
Licensee Name:	Kevdaco Human Services LLC
Licensee Address:	Suite 200 23999 Northwestern Hwy Southfield, MI 48075
Licensee Telephone #:	(248) 722-5004
Administrator:	Josephine Uwazurike
Licensee Designee:	Josephine Uwazurike
Name of Facility:	Kevdaco Redford II
Facility Address:	26520 West Chicago Road Redford, MI 48239
Facility Telephone #:	(313) 766-4696
Original Issuance Date:	07/17/2008
License Status:	REGULAR
Effective Date:	05/15/2020
Expiration Date:	05/14/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Per incident report, Resident A lost her balance and fell on 11/4/2021; no injuries observed. On 11/5/2021, Resident A started experiencing shortness of breath, staff called 911. There are concerns Resident A was not monitored resulting in her falling and injuring herself.	Yes
Resident A's designated representatives/adult foster care licensing were not notified of the fall.	Yes

III. METHODOLOGY

11/15/2021	Special Investigation Intake 2022A0992003
11/15/2021	Special Investigation Initiated - Telephone Relative A, Resident A's co-guardian
11/15/2021	Inspection Completed On-site Florence Ejefiavwo, direct care staff
11/18/2021	Contact - Telephone call made Josephine Uwzariuke, licensee designee
11/18/2021	Contact - Document Received Resident A's AFC assessment, treatment plan and DCS schedule
11/22/2021	Contact - Telephone call made Jawana Kelly, Adult Protective Services (APS)
11/24/2021	Contact - Telephone call made Rose Cummings, home manager
11/29/2021	Contact - Telephone call made Rasheed Olannewaju, direct care staff
11/29/2021	Contact - Telephone call made Andrea Green, Licensing Consultant
11/29/2021	Contact - Telephone call made Wayne County Medical Examiner

12/08/2021	Contact - Telephone call made Relative A
12/08/2021	Contact - Telephone call made Laura Ferentine, Resident A's Support Coordinator with MORC
12/08/2021	Contact - Document Received MORC requesting a copy of Resident A's IPOS
12/08/2021	Contact - Telephone call made Ms. Cummings
12/08/2021	Contact - Telephone call made Oakland County Medical Examiner
12/14/2021	Contact - Telephone call made Ms. Ferentine
12/14/2021	Contact - Telephone call made Ms. Cummings
12/16/2021	Exit Conference Ms. Uwzariuke, she was not available, and a message was left.
12/16/2021	Contact - Telephone call received Stella Ojo, program manager
1/14/2022	ORR Referral

ALLEGATION:

● Per incident report, Resident A lost her balance and fell on 11/4/2021; no injuries observed. On 11/5/2021, Resident A started experiencing shortness of breath, staff called 911. There are concerns Resident A was not monitored resulting in her falling and injuring herself.

● Resident A’s designated representatives/adult foster care licensing were not notified of the fall.

INVESTIGATION:

On 11/15/2021, I made telephone contact with Relative A, Resident A's co-guardian. Relative A explained that Relative B is Resident A's primary guardian. Relative A said Relative B is currently with her and she placed the call on speaker phone. I attempted to discuss the allegations, however, Relative A refused to discuss the allegations and deferred me to their attorney.

On 11/15/2021, I completed an unannounced onsite inspection and interviewed Florence Ejefiavwo, direct care staff (DCS) regarding the allegations. According to Ms. Ejefiavwo on 11/3/2021 she worked the midnight shift along with Elise Talufor; she said the incident occurred on the morning of 11/4/2021 before her shift ended. She said Resident A was on her way to the bathroom and she assisted her. She said while Resident A was using the bathroom, she went to check change the incontinence briefs of another Resident. Ms. Ejefiavwo said when she went to back to check on Resident A, she observed her getting up off the floor. She said Resident A said she fell while trying to pull up her underwear. Ms. Ejefiavwo said she proceeded to help Resident A up and asked her if she was injured, and she said no. Ms. Ejefiavwo said she conducted a body check and didn't observe any marks or bruises on Resident A. Ms. Ejefiavwo said she proceeded to shower Resident A and assisted her with grooming. Ms. Ejefiavwo said once Resident A got dressed, she had breakfast and sat on the couch. Ms. Ejefiavwo said she monitored Resident A following the fall and she didn't demonstrate any abnormal behaviors. Ms. Ejefiavwo said on 11/05/2021 she worked the morning shift along with Rasheed Olannewaju and Rose Cummings, home manager. She said Mr. Olannewaju noticed Resident A was having difficulty breathing so he checked her oxygen levels, which was 35%; Ms. Ejefiavwo said Mr. Olannewaju called 911. Ms. Ejefiavwo said Resident A was admitted to the hospital and has remained hospitalized. I asked Ms. Ejefiavwo if she sent the incident report and she said yes. I asked for a copy of the incident report, which she said was not in the house at the time. For documentation purposes, I observed the area in the bathroom where Resident A fell. Walking in the bathroom the toilet is in the far left-hand corner, there's a handrail on the left side and a partition in front of the toilet.

On 11/18/2021, I contacted Josephine Uwazurike, licensee designee, and discussed the allegations. Ms. Uwazurike said she spoke with Ms. Ejefiavwo regarding the incident. She said Ms. Ejefiavwo said she assisted Resident A to the bathroom and went to assist another resident. She said when she returned to the bathroom, Resident A was getting up off the floor and Ms. Ejefiavwo helped her up. She said no marks or bruises were observed and Resident A said she wasn't injured. She said the following day Ms. Ejefiavwo said Resident A was having trouble breathing and she was observed to have a black eye. I requested the following documents Resident A's treatment plan/individual plan of service (IPOS), adult foster care assessment, all incident reports regarding the incident and staffing schedule; in which Ms. Uwazurike agreed to provide.

On 11/18/2021, I received a copy of Resident A's AFC assessment and Wayne Center IPOS to determine her needs and services provided by the AFC facility. According to the AFC assessment plan that was completed on 7/06/2021 by Ms. Cummings and signed by Relative B on 7/29/2021, Resident A does not require assistance with toileting. The Wayne Center IPOS effective date was 11/01/2020 through 10/31/2021; does not specify a certain amount of assistance required when with toileting or mobility issues. The IPOS objective states, “I will increase/maintain my ADLs such as bathing/showering, dressing grooming, toileting, medication administration, meal prep, laundry socialization and relationship building, transportation, leisure choice and participation in community activities, attendance at medical appointments, monitoring for protection of health and safety. Interventions: Group home staff will train/teach me and provide verbal prompts and hand over hand assistance with ADLs as needed. I will attempt to bathe, groom and dress myself.”

On 11/22/2021, I made telephone contact with Jawana Kelly, Adult Protective Services (APS) regarding the allegations. Ms. Kelly made me aware that she had an opportunity to speak with Relative A and Resident A expired on 11/11/2021. Ms. Kelly said Relative A/B are willing to speak with licensing. She said she is actively investigating the complaint. She said based on the allegations she questions the DCS competency as it pertains to seeking medical treatment following Resident A falling. She said she will keep me updated as she gathers information.

On 11/24/2021, I contacted Rose Cummings, home manager regarding the allegations. Ms. Cummings explained that she was not on shift when Resident A fell. However, she said she is knowledgeable of the situation because she had an opportunity to speak with Ms. Ejefiavwo and read the incident report. Ms. Cummings said based on her understanding, Resident A fell in the bathroom on the morning of 11/04/2021 but didn’t sustain any obvious injuries. Ms. Cumming said she worked the morning of 11/04/2021 and observed Resident A throughout her shift, there were no obvious changes in her physical state. She said the following day (11/05/2021) as she was in route to work, she received a call from Mr. Olannewaju stating Resident A was having trouble breathing. Ms. Cummings said since the pandemic, staff has been trained to monitor the resident’s breathing patterns and they don’t take any chances. So, when Mr. Olannewaju noticed Resident A having trouble breathing, he checked her oxygen level which was 35% and immediately called 911. She said Resident A was transported to Garden City Hospital and she met them there. I asked Ms. Cummings about the facilities protocol if a Resident falls. She said the DCS are to assess the resident, the situation and make sure the resident is not injured. She said the person that observes the situation completes the incident report and notifies guardian if applicable. Ms. Cummings said in this instance Ms. Ejefiavwo completed the incident report and attempted to notify the guardian by telephone but didn’t get an answer. Ms. Cummings said she personally notified the family that Resident A was hospitalized. Ms. Cummings said as it pertains to the guardians, sometimes the DCS have trouble because there’s a primary (Relative B) and secondary guardian (Relative A). Ms. Cummings said the Relative A is more involved and hands-on. However, Relative B is the primary and she requested the incident reports are mailed

opposed to faxed, although Relative A wants the incident reports emailed to her; it's quite conflicting. She said the staff make efforts to notify either guardian regarding Resident A.

On 11/29/2021, I contacted Mr. Olannewaju and interview him regarding the allegations. Mr. Olannewaju said he was not on shift the day Resident A fell. In fact, he said he wasn't aware Resident A fell prior to his shift. However, he said he worked the evening shift on 11/04/2021 and he said Resident A didn't demonstrate any abnormal behaviors, she seemed fine. He said on 11/05/2021, he worked the morning shift and he noticed Resident A was winded, so he checked her oxygen levels which were 35%; Mr. Olannewaju said he immediately called 911. He said he didn't notice Resident A had a black eye until the emergency medical services (EMS) arrived. Mr. Olannewaju said he accompanied Resident A to the hospital and Ms. Cumming later arrived at the hospital. Mr. Olannewaju said after Resident A was examined the doctor made him aware that Resident A was being transferred to Providence Hospital.

On 11/29/2021, I contacted Andrea Green, Licensing Consultant regarding the reported allegations. I asked Ms. Green if she received an incident report regarding the reported allegations and she said no.

On 11/29/2021, I contacted the Wayne County Medical Examiner in attempt to obtain a copy of the post-mortem report. I was informed that Resident A's case was not received and/or pending with Wayne County Medical Examiner.

On 12/08/2021, I contacted Relative A regarding the allegations. Relative A apologized for the previous encounter. She said Resident A was previously at a different Adult Foster Care (AFC) facility and this process has been overwhelming. In regard to Resident A, she said she tries to stay in contact with the providers and be involved. However, Relative A said she lives out of state and although Relative B is her primary guardian, she's older in age and not really technology savvy or knowledgeable about the process, so she tries to assist by staying on top of everything. Relative A said to her knowledge Resident A requires 24hr supervision and assistance with her daily activities. She said per her IPOS, Resident A was legally blind (which she wasn't aware) and had mobility issues. Relative A said Resident A needs assistance with toileting, which is outlined in her IPOS, and she has an unsteady gait due to severe arthritis. I explained to Relative A that based on the AFC assessment plan and IPOS I received, it doesn't indicate Resident A needs any assistance with toileting and/or mobility. Relative A explained that Macomb Oakland Regional Center (MORC) completed an IPOS around July 2021 and it outlines all of Resident A's needs specifically. Relative A identified Resident A's Supports Coordinator as Laura Ferentine and provided me with her contact number saying Ms. Ferentine can provide me with a copy of the most recent IPOS. Relative A said she feel as though the fall could have been avoided if Resident A was receiving the services outlined in her current IPOS. She said when she observed Resident A at

the hospital, she had a black eye and a minor cut under her eye, so she obviously injured herself when she fell, if that's how she sustained the injuries.

On 12/08/2021, I contacted Ms. Ferentine, inquiring about Resident A's IPOS and her needs. Ms. Ferentine confirmed a IPOS was completed in 2021. She was driving and said she didn't know the specifics off hand but requested I submit a request to MORC to receive a copy of Resident A's IPOS, which I agreed.

On 12/08/2021, I contacted Ms. Cummings and explained that I am aware there was an IPOS completed by MORC. I asked if she has the updated IPOS because the one she previously provided me was completed by Wayne Center. Ms. Cumming explained that Ms. Ferentine or someone from MORC emailed a copy of the current IPOS on 11/06/2021 and by that time Resident A was already hospitalized. She said the IPOS completed by Wayne Center didn't expire until 10/31/2021, so it was still valid up until that point.

On 12/08/2021, I made telephone contact with Oakland County Medical Examiner in attempt to obtain a copy of the post-mortem report. I was informed that Resident A's case was not received and/or pending with Oakland County Medical Examiner. At the time Resident A expired she was at Providence Hospital which is in Oakland County. However, the medical examiner explained that an autopsy is not completed in all cases. She stated that an autopsy is performed if the death is suspicious or if the family requests it.

On 12/14/2021, I made follow-up contact with Ms. Ferentine regarding the IPOS. I referenced the dates on the IPOS, which were as follows: meeting date 7/01/2021; effective date 8/01/2021 and the expiration date 7/31/2022; which she confirmed. I asked Ms. Ferentine if the facility received a copy of the IPOS prior to 11/06/2021, which Ms. Ferentine said she couldn't confirm because she's not the person that send out the IPOS. She said it's not sent until it's officially signed by all parties (the copy I have is not signed by the guardian). However, she said once it's signed it is available in Detroit Wayne Integrated Health Network (DWIHN) services system. She said the provider can always access a copy through the portal because as a special certification home, they need to be well versed on the resident's needs. It should also be noted that Ms. Cummings was present at the IPOS meeting.

On 12/14/2021, I contacted Ms. Cummings and confirmed she was present at Resident A's IPOS meeting with MORC, in which she confirmed. I explained that based on the IPOS that was developed during that meeting outlines Resident A's needs including the fact that she required assistance with toileting. Ms. Cummings said she wasn't aware she said during the meeting Resident A's needs were not specifically discussed. I explained to Ms. Cumming that in the future it should be a best practice to access DWIHN portal and review the residents IPOS to better service the residents; in which she agreed.

On 12/16/2021, I received a telephone call from Stella Ojo, program manager in response to the message I left for Ms. Uwazurike. She said Ms. Uwazurike asked that she contact me to conduct the exit conference in her absence, she said Ms. Uwazurike is currently out of town. I proceeded to conduct an exit conference with Ms. Ojo. I explained that Resident A's IPOS that was completed by Wayne Center expired on 10/31/2021 and although MORC completed an updated IPOS, according to Ms. Cummings the facility did not receive a copy of the updates IPOS until 11/06/2021. I explained that the updated IPOS contained information that was vital to Resident A's needs including assistance with toileting/ unsteady gait which would have possibly prevented her fall if the staff were aware of Resident A's needs outlined in her current IPOS. However, the services outlined in the current IPOS were not being provided and as a result the allegation is substantiated. I also referenced rule R 400.14311 (1) investigation and reporting incidents and explained that the guardian/designated representative and licensing consultant should have received a copy of the incident report when Resident A fell. Although I'm unable to determine if the guardian received a copy via email or fax; after consulting with Ms. Green, she did not receive a copy of the incident report, as a result the allegation is substantiated. Ms. Ojo said she understands, and she will make sure Ms. Uwazurike is brought up to speed regarding the investigation.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	During this investigation, I interviewed Josephine Uwazurike, licensee designee; Rose Cummings, home manager; Florence Ejefiavwo, direct care staff; Rasheed Olannewaju, direct care staff; Laura Ferentine, Resident A's Support Coordinator with MORC; Jawana Kelly, APS; Relative A, Resident A's co-guardian regarding the allegations. An IPOS meeting was held with MORC on 7/01/2021, which resulted in a new IPOS; Ms. Cummings was in attendance. Ms. Cummings said the IPOS from that meeting was not received until 11/06/2021 and the facility continued following Resident A's previous IPOS which expired on 10/31/2021. Not only did Ms. Cummings attend the IPOS meeting but the facility also had access to Resident A's most recent IPOS through the DWHIN online portal. The staff should have been aware of Resident A's needs but failed to provide appropriate care. Based on the investigative findings, Ms. Uwazurike and direct care staff failed to provide supervision, protection, and personal care as defined in the act and as specified in Resident A's written assessment plan. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**

	(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	During this investigation, I interviewed Josephine Uwazurike, licensee designee; Rose Cummings, home manager; Florence Ejefiavwo, direct care staff; Andrea Green, licensing consultant; Resident A's co-guardian regarding the allegations. Although Ms. Ejefiavwo said she sent the incident report to adult foster care licensing as required, the incident report was not received, and Ms. Ejefiavwo was unable to provide verification that the incident report was sent. Based on the investigative findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/14/2022

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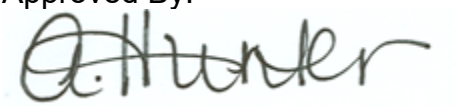
Denasha Walker Date
Licensing Consultant

Approved By:



01/19/2022

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Ardra Hunter Date
Area Manager