GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 27, 2022

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

RE: License #: AS820293701
Investigation #: 2022A0101004
Florence Manor

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820293701
Investigation #:	2022A0101004
Complaint Receipt Date:	11/23/2021
Investigation Initiation Date:	11/30/2021
Report Due Date:	01/22/2022
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:	Florence Manor
Facility Address:	30834 Florence St. Garden City, MI 48135
Facility Telephone #:	(734) 422-2233
Original Issuance Date:	01/29/2008
License **Status:**	REGULAR
Effective Date:	03/21/2021
Expiration Date:	03/20/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The licensee failed to provide the level of protection and supervision Resident A requires. Resident A has a guardian and on 11/20/2021, Resident A was sent to the hospital without staff and staff did not send identifying information. And according to hospital staff, "Resident A appeared alert and oriented, and since there was no worker or paperwork with her, they had to treat her as if she were her own person and released her by herself." After being discharged Resident A's whereabouts were unknown for three days.	No
The licensee failed to properly report Resident A's hospitalization to the guardian.	Yes

III. METHODOLOGY

11/23/2021	Special Investigation Intake 2022A0101004
11/23/2021	Referral received from Adult Protective Services and Office of Recipient Rights
11/30/2021	Special Investigation Initiated - Telephone Josephine Uwazurike, Licensee Designee
11/30/2021	Contact - Telephone call made Maude Dean, Home Manager
12/02/2021	Contact - Document Received Incident report
01/12/2022	Contact - Telephone call made Ms. Dean
01/18/2022	Contact - Document Received Assessment Plan
01/20/2022	Contact - Telephone call made Raymond Hagerman Mental Health Provider
01/20/2022	Contact - Telephone call made

	Cherise Donelson Support Coordinator
01/20/2022	Contact - Telephone call made Ms. Dean
01/20/2022	Contact - Telephone call made Josephine Okoye, Direct care staff (DCS)
01/20/2022	Contact - Telephone call made Resident A's Guardian-Left voice mail message
01/21/2022	Contact - Telephone call received Ms. Carroll
01/25/2022	Exit Conference

ALLEGATION: The licensee failed to provide the level of protection and supervision Resident A requires. Resident A has a guardian and on 11/20/2021, Resident A was sent to the hospital without staff and staff did not send identifying information. And according to hospital staff "Resident A appeared alert and oriented, and since there was no worker or paperwork with her, they had to treat her as if she were her own person and released her by herself." Resident A's whereabouts were unknown for three days.

INVESTIGATION: On 11/30/2021, I spoke with the home manager, Maude Dean. Ms. Dean stated on 11/20/2021, Resident A was not feeling well and was transported to the hospital via EMS. Ms. Dean assumed Resident A had been transported to Garden City Hospital because it is the closest hospital to the home's location. Ms. Dean stated when she returned to work on 11/22/2021, she called Garden City Hospital to check on Resident A's progress. Ms. Dean was informed Resident A was not at this hospital and Resident A had not been seen at this hospital on 11/20/2021. Ms. Dean contacted Resident A's Support Coordinator, Cherise Donelson. Ms. Donelson instructed Ms. Dean to contact nearby hospitals. When Ms. Dean contacted staff at St. Mary's Hospital, they indicated Resident A had not been seen there. Ms. Dean later learned Resident A was taken to Garden City and received treatment for Hypoglycemia on 11/20/2021. Ms. Dean also learned that Resident A was discharged from Garden City Hospital on 11/20/2021.

Ms. Dean further stated staff could not accompany Resident A to the hospital because staff are not allowed to ride in the ambulance with the resident or enter the hospital due to the pandemic. Hospital personnel will call the home when the resident is ready for discharge. Ms. Dean stated DCS Josephine Okoye gave the EMS Worker the needed paperwork, medication log and identifying information, which is required when a resident in a group home is transported to the hospital. Ms.

Dean also stated Resident A had been treated at Garden City Hospital on at least three occasions and therefore Garden City Hospital has her medical records on file.

I reviewed Resident A's assessment plan on 01/18/2022. Resident A has a guardian. Resident A is high functioning and completed two years of college at Wayne State University. Resident A also raised her children. For these reasons Resident A does not believe she has a mental health illness.

On 01/20/2021, I spoke with Resident A's Support Coordinator, Cherise Donelson. Ms. Donelson stated on 11/22/2021, after learning Resident A was missing, she contacted the Garden City Fire Department EMS Division. Garden City Fire Department EMS Division confirmed Resident A was taken to Garden City Hospital. Ms. Donelson further stated according to Resident A's medical records at Garden City Hospital, Resident A was admitted to and discharged from their hospital on 11/20/2021. Ms. Donelson stated she believes Resident A walked away from the hospital.

On 01/20/2022, I spoke with DCS Josephine Okoye. Ms. Okoye stated she copied and gave the EMS worker the required documentation to transport Resident A to the hospital.

On 01/21/2022, I spoke with Resident A's Guardian. Resident A's Guardian stated she called Florence Manor on 11/22/2021 to check on her mother. The guardian was informed that her mother was sent to the hospital on 11/20/2021, and since then her mother's whereabouts were unknown. Resident A's guardian filed a missing person report with the Garden City Police Department.

Resident A's guardian further stated she went to visit her grandmother on 11/22/2021, at a nursing home in Harper Woods. The guardian's grandmother told her Resident A was there earlier with her (Resident A's) sister. Resident A's sister was not allowed to visit Resident A at the group home due to inappropriate behaviors. Multiple calls were made, by Resident A's guardian and Garden City Police, to Resident A's sister but all calls went unanswered. On 11/23/2021, Resident A was found sitting in the lobby at Detroit Receiving Hospital. Resident A was admitted into the psychiatric unit and is still there. Resident A's guardian stated Resident A did have her own cell phone and could have called her sister.

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 insufficient evidence to determine the licensee failed to provide the protection and supervision Resident A required. Since Resident A is an incapacitated adult and has a guardian, Resident A should have been escorted to the emergency room. However, due to the pandemic, the protocol for sending a resident to the hospital has changed. On 11/30/2021, I spoke with Ms. Dean,home manager. Ms. Dean stated staff did not accompany Resident A to the hospital. Ms. Dean stated staff are not allowed to ride in the ambulance or enter the hospital due to the pandemic. Ms. Dean further stated when the resident is ready for discharge, hospital personnel will contact the group home. According to Ms. Dean and DCS Ms. Okoye, the EMS Workers were given the required documentation to transport Resident A to the hospital. According to Ms. Donelson, Resident A's Support Coordinator, Garden City Fire Department EMS Division verified Resident A was transported to Garden City Hospital on 11/20/2021. Resident A's medical records verified that on 11/20/2021, she was admitted and discharged from Garden City Hospital under her real name. Since Resident A's medical records verified, she received treatment at Garden City Hospital on 11/20/2021. It is concluded Resident A medical records were on file from previous admittance at the hospital and Resident A's medical records would have contained all pertinent information, name, address, insurance, mental health status and guardianship information.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The licensee failed to properly report Resident A's hospitalization.

INVESTIGATION: On 01/20/2022, I spoke with Ms. Dean. Ms. Dean stated the on 11/22/2021 Resident A's guardian was verbally notified of Resident A's hospitalization on 11/20/2021 and being missing thereafter.

On 01/21/2022, I spoke with Resident A's guardian. Resident A's guardian stated

on 11/22/2021, she called the group home to check on her mom. She was informed that Resident A was hospitalized on 11/20/2021, and since then her whereabouts are unknown.

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: Any accident or illness that requires hospitalization.
ANALYSIS:	The licensee failed to make a reasonable attempt to contact the resident's designated representative and did not follow the attempt with a written report to the resident's designated representative within 48 hours of any of the following: Any accident or illness that requires hospitalization. On 01/20/2022, I spoke with Ms. Dean. Ms. Dean stated the on 11/22/2021, Resident A's guardian was verbally notified of Resident A's hospitalization on 11/20/2021 and being missing thereafter. Ms. Dean stated Resident A's guardian was not given written notification regarding these matters. On 01/21/2022, I spoke with Resident A's guardian. Resident A's guardian stated on 11/22/2021, she called the group home to check on her mom. She was informed that Resident A was hospitalized on 11/20/2021 and since then her whereabouts are unknown.
CONCLUSION:	**VIOLATION ESTABLISHED**

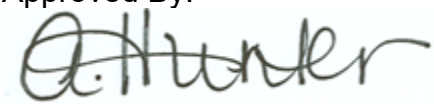
IV. RECOMMENDATION

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

Edith Richardson
Licensing Consultant

01/25/2022
Date

Approved By:



01/27/2022

Ardra Hunter
Area Manager

Date