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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 9, 2022

Israel Agodu
Chi-Chi Home, Inc.
6474 Rosemont Ave.
Detroit, MI 48228

RE: License #: AS820283598
Investigation #: 2022A0121026
Chi-Chi Home

Dear Mr. Agodu:

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,

Kara Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820283598
Investigation #:	2022A0121026
Complaint Receipt Date:	05/06/2022
Investigation Initiation Date:	05/11/2022
Report Due Date:	07/05/2022
Licensee Name:	Chi-Chi Home, Inc.
Licensee Address:	6474 Rosemont Ave. Detroit, MI 48228
Licensee Telephone #:	(313) 231-2924
Administrator:	Israel Agodu, Designee
Name of Facility:	Chi-Chi Home
Facility Address:	6474 Rosemont Ave. Detroit, MI 48228
Facility Telephone #:	(313) 441-5212
Original Issuance Date:	10/26/2006
License **Status:**	REGULAR
Effective Date:	12/09/2021
Expiration Date:	12/08/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care workers, Stella and Salimont are not fully trained. They lack verification of training in Recipient Rights.	No
The home does not have adequate staffing on duty.	No
Direct care workers Shauntel, Stella and Salimont have not been trained in medication administration.	No
Note: Some allegations listed in the complaint are not rule related and will not be investigated.	
Additional Findings	Yes

III. METHODOLOGY

05/06/2022	Special Investigation Intake 2022A0121026
05/11/2022	Special Investigation Initiated - Telephone Call to DWIHN
05/11/2022	Contact - Telephone call made Left message for licensee designee, Israel Agodu
05/12/2022	Contact - Telephone call received Return call from Mr. Agodu
06/24/2022	Contact - Telephone call made Left message for Mr. Agodu
06/24/2022	Contact - Telephone call made Call to Ms. Jackson with DWIHN
06/27/2022	Contact - Telephone call received Return call from Mr. Agodu
06/28/2022	Contact - Telephone call made Phone interview with former Home Manager, Shauntel Dye
07/26/2022	Contact - Telephone call made Call to Guardian 1B

07/28/2022	Contact - Telephone call made Follow up call to Mrs. Dye
07/28/2022	Exit Conference Israel Agodu, licensee designee

ALLEGATION: Direct care workers, Stella and Salimont are not fully trained. They lack verification of training in Recipient Rights.

INVESTIGATION: Due to the Covid-19 pandemic, an onsite inspection was not completed to mitigate risks. Additionally, there are no residents in care. On 5/11/22, I initiated the complaint with a phone call to Sharee Jackson with the Detroit Wayne Integrated Health Network (DWIHN). Ms. Jackson indicated she is investigating the home for multiple contract violations, including the allegations listed above. According to Ms. Jackson, direct care workers Stella Ihuonu and Salimont Taiwo had not been trained in Recipient Rights.

I requested a copy of their training transcripts from licensee designee, Israel Agodu. On 5/14/22, Mr. Agodu sent copies of the requested documents. Mr. Agodu indicated he was not able to provide contact phone numbers for Ms. Ihuonu or Ms. Taiwo because his phone contacts were no longer accessible through his mobile device. Upon review of the employee records, I determined Ms. Ihuonu completed Recipient Rights for New Hires training on 9/18/20, as well as Recipient Rights Annual training on 9/18/20. Ms. Ihuonu was hired to work at the facility on 8/26/16, she left the company and was rehired on 4/8/21. Ms. Taiwo was hired to work at the facility on 4/1/16. Ms. Taiwo completed Recipient Rights training on 4/29/16.

APPLICABLE RULE	
R 400.14204	**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: **(e) Resident rights.**

ANALYSIS:	I reviewed Ms. Ihuonu's and Ms. Taiwo's training transcripts and determined both workers completed Recipient Rights training before assuming the job duties or shortly thereafter.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The home does not have adequate staffing on duty.

INVESTIGATION: Mr. Agodu reported when the home was occupied, he cared for 4 male residents. According to Mr. Agodu none of the residents had a 1:1 staffing assignment. On 7/28/22, I interviewed former home manager, Shauntel Dye. Mrs. Dye verified none of the residents had a 1:1 Staffing requirement. Mrs. Dye reported the home maintained a staff to resident of 1:4.

However, Ms. Jackson said she determined the home required at minimum, 2 Staff on duty at all times because Resident A was a "fall risk", Resident B was verbally and physically aggressive, and Resident C had poor hygiene and was easily agitated.

I reviewed the AFC Assessment Plans for all 4 residents. According to the plans, all residents can be in the community independently. Therefore, the residents do not require close supervision. On 7/26/22, I interviewed Resident B's guardian by phone. According to Guardian 1B, she has no complaints about the placement other than she did not like the area where it is located. Guardian 1B did not think the area was good for Resident B to explore. Guardian 1B confirmed Resident B was allowed to go in the community without Staff.

I also reviewed Staff schedules as provided upon request from Mr. Agodu. There is one worker scheduled to work one of three shifts each day.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	• Although Ms. Jackson determined the staff to resident ratio should be 2:4, I found no evidence to support her assessment. • Mr. Agodu was not contracted to provide 1:1 staffing for any resident. • In addition, I determined having poor hygiene or aggressive tendencies does not rise to the level of requiring constant supervision. • Therefore, this allegation is unsubstantiated due to a lack of evidence.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care workers Shauntel, Stella and Salimont have not been trained in medication administration.

INVESTIGATION: I reviewed the training transcripts of Mrs. Dye, Ms. Ihuonu, and Ms. Taiwo. Mrs. Dye completed Medication Administration on 10/7/19; she confirmed this finding verbally. Ms. Ihuonu completed Basic Medication training on 2/19/16. Ms. Taiwo has not completed medication training. Per Mr. Agodu, Ms. Taiwo did not administer resident medication while she was employed there because she did not possess training in this area.

I reviewed Resident A and D's medication logs for the month of October 2021. According to the log, Ms. Taiwo did not administer resident medication as her signature is not included on these records.

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:	• Mrs. Dye reported she has been trained in medication administrations. Both Mrs. Dye and Ms. Ihuonu have proof of medication training in their respective employee record. • There is no indication Ms. Taiwo administered resident medication while on duty according to the 10/22 Medication Administration Record (MAR). • Mr. Agodu reported all Staff who administered resident medication were properly trained.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: Upon review of the October MAR, I observed an additional signature of an employee who was not listed on the Staff schedule. I completed an exit conference with Mr. Agodu on 7/28/22. I asked Mr. Agodu who's initial are on the MAR as "AA". Per Mr. Agodu, the initials AA belong to a male worker (name not provided) who works as an on-call worker whenever the home faces a staffing shortage. Mr. Agoud acknowledged he did not update the schedule or adjust it to document schedule changes in cases where the assigned worker called in sick to work. I explained to Mr. Agodu that the schedules are not accurate since "AA" is never documented as having worked at the home.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	• Worker AA worked at the home on multiple occasions as evidenced by his signature on the MAR, however, his name is not written on the schedule as someone who worked there. Worker AA is never mentioned on the schedule. • Therefore, Mr. Agodu failed to include any schedule changes.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

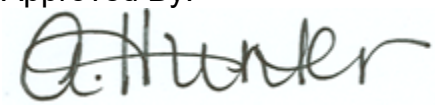
IV. RECOMMENDATION

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

08/03/22

Kara Robinson — Date
Licensing Consultant

Approved By:



08/09/22

Ardra Hunter — Date
Area Manager