GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 10, 2022

Chinyelu Anwunah
Gracious Hands Services, LLC
46908 Wareham Dr.
Canton, MI 48187

RE: License #: AS820353056
Investigation #: 2022A0116034
Graceville Manor

Dear Ms. Anwunah:

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820353056
Investigation #:	2022A0116034
Complaint Receipt Date:	07/11/2022
Investigation Initiation Date:	07/15/2022
Report Due Date:	09/09/2022
Licensee Name:	Gracious Hands Services, LLC
Licensee Address:	46908 Wareham Dr. Canton, MI 48187
Licensee Telephone #:	(313) 408-3227
Administrator:	Chinyelu Anwunah
Licensee Designee:	Chinyelu Anwunah
Name of Facility:	Graceville Manor
Facility Address:	7786 Canterbury Dr. Romulus, MI 48174
Facility Telephone #:	(313) 408-3227
Original Issuance Date:	09/25/2014
License **Status:**	REGULAR
Effective Date:	03/24/2021
Expiration Date:	03/23/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A alleges she is providing care to other residents in the home by showering them and cooking meals daily.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/11/2022	Special Investigation Intake 2022A0116034
07/11/2022	APS Referral Received.
07/12/2022	Referral - Recipient Rights
07/15/2022	Special Investigation Initiated - On Site Interviewed Resident A, reviewed Resident A's records, interviewed staff, Florence Nwaka and visually observed Resident B.
07/15/2022	Contact - Face to Face Interviewed Resident's C-F at their workshop program and visually observed Resident G.
07/15/2022	Contact - Telephone call received Interviewed licensee designee, Chinyelu Anwunah.
08/04/2022	Contact - Telephone call made Interviewed Resident A's Support Coordinator, Tami Schaar.
08/04/2022	Contact - Telephone call made Interviewed Paul Tornony, Public Guardian, at Faith Connections.
08/04/2022	Contact - Telephone call made Interviewed staff, Issac Onowuola.
08/04/2022	Contact - Telephone call made Left a message for Guardian (1) requesting a return call.
08/04/2022	Inspection Completed-BCAL Sub. Compliance

08/08/2022	Contact - Telephone call made Left a message for Guardian (1) requesting a return call.
08/08/2022	Exit Conference With licensee designee, Chinyelu Anwunah.
08/09/2022	Contact- Telephone call received Interviewed Guardian (1).

ALLEGATION:

Resident A alleges she is providing care to other residents in the home by showering them and cooking meals daily.

INVESTIGATION:

On 07/15/22, I conducted an unscheduled onsite inspection and interviewed Resident A, staff, Florence Nwaka, visually observed Resident B and reviewed Resident A's records.

Resident A reported that the allegations are in fact true, and she has had enough. Resident A reported that she has showered Resident C and D at least three times each. Resident A reported that on one occasion staff Florence Nwaka was on shift and the other time staff Issac Onowuola was on shift. Resident A also reported that Resident D's guardian asked her to shower Resident D as the staff in the home was busy assisting another resident. Resident A reported that Resident D's guardian wanted to take Resident D on an outing and asked her to shower her. Resident A reported that Resident D's guardian promised to pay her. Resident A reported that she showered Resident D, but never received any compensation from the guardian. I asked Resident A during the times she showered Resident C and D were staff aware, Resident A reported that they were, and they did not take issue with it as it was one less thing they had to do.

Resident A also reported that she has been cooking at least two meals per day for the home. Resident A reported that she is allowed to cook as she is working towards moving into her own apartment within the next year. Resident A reported that she enjoys cooking, but the goal in place is for her to cook for herself only. Resident A reported that she has been cooking for all of the residents and reported that the staff expect her to cook daily and reported she is sick of it. Resident A reported that sometimes she will volunteer to cook for the other residents in the home because they enjoy her meals, but reported some days she doesn't want to cook, but the staff come to her asking and expecting her to cook every day. Resident A reported that the other residents will confirm this information. Resident A reported she has notified

her guardian and supports coordinator of what has been happening in the home also.

I interviewed staff, Florence Nwaka, and she denied the allegations as reported. Ms. Nwaka denied that she has ever asked Resident A to shower any of the residents and reported if it ever occurred while she was working, she was unaware. Ms. Nwaka reported that she knows better and reported that no resident should be providing any type of care to another resident. Ms. Nwaka also denied that Resident A is forced to cook meals daily. Ms. Nwaka reported that Resident A does help with cooking; will season meats and prep side dishes but is in no way forced to cook. Ms. Nwaka reported that when Resident A cooks it is by choice.

I reviewed Resident A's current individualized plan of service (IPOS) and the plan does not document or reference anything regarding Resident A cooking meals or assisting staff with cooking.

On 07/15/22, I interviewed Residents C-F and visually observed Resident G at their workshop program.

Resident C reported that Resident A has showered her a couple of times, with the last time being a couple months ago. Resident C reported that she had defecated on herself and really needed to be showered. Resident C reported that a male staff was on shift and Resident A had explained what happened to him. Resident C reported that she cannot recall the name of the staff person but reported that Resident A showered her and helped her get dressed in clean clothes. Resident C reported that male staff do not shower the female residents unless it is an emergency. Resident C reported she is not comfortable having a male staff shower her and was glad that Resident A took care of her.

Resident C reported that Resident A does cook a lot but denied that she cooks everyday or every meal. Resident C reported that Resident A is a good cook and reported that she enjoys eating the meals she prepares.

Resident D reported that Resident A has showered her three times and reported that each time the staff in the home were aware. Resident D reported that the staff is lazy and all they do is sit and play on their cell phones all day. Resident D reported that Resident A cares about the residents and always does what she can to help them out.

Resident D reported that Resident A does cook lunch and dinner sometimes and reported she is a really good cook. Resident D reported that Resident A's food is way better then what the staff prepare. Resident D reported all of the residents are happy when Resident A cooks.

Resident E reported that she is aware that Resident A has showered Resident C and D a few times and reported she is sure that the staff were aware. Resident E reported that the staff overall do a good job but reported they can be lazy at times.

Resident E also reported that Resident A does not do all of the cooking but reported she does prepare some meals and at other times she assists staff with preparation of meals.

Resident F denied being showered by Resident A and reported not being aware of her showering other residents.

Resident F reported that Resident A is a good cook and reported she prepares some meals for them. Resident F reported that the staff also cook and prepare meals.

Resident G was not interviewed as she was in the middle of eating lunch and interacting with program staff.

On 07/15/22, I interviewed licensee designee, Chinyelu Anwunah and she reported being unaware of Resident A being allowed to shower any of the residents and reported this should not have happened. Ms. Anwunah reported she will address this

with all of the staff to prevent another occurrence. Ms. Anwunah reported being shocked and in disbelief that staff allowed this to happen.

Ms. Anwunah reported that Resident A does cook a lot and reported she thoroughly enjoys doing so, Ms. Anwunah reported that Resident A goes to the grocery store with staff to purchase the foods that she likes and wants to prepare. Ms. Anwunah reported that Resident A is not forced to cook, and staff are fully aware of their responsibilities. Ms. Anwunah reported she will address this with the staff and will make sure Resident A's supports coordinator includes her ability to prepare meals for herself in her plan so that it does not create any further issues.

On 08/04/22, I interviewed Tami Schaar, supports coordinator, at Community Living Services (CLS). Ms. Schaar reported that Resident A informed her of the allegations and reported that she has addressed the concerns with Ms. Anwunah. Ms. Schaar reported that she also spoke at great length with Resident A and advised her that under no circumstance should she ever shower or provide any sort of care to another resident as she is not a paid staff. Ms. Schaar reported that the actions of the staff is unacceptable and reported that because Resident A is high functioning, she is being taken advantage of.

Ms. Schaar reported, as it relates to Resident A cooking, she is allowed and fully capable of preparing meals for herself only. Ms. Schaar reported she should not be preparing meals for the home. Ms. Schaar reported that Resident A can assist staff in meal preparation for the home, if she desires, but is not to cook for the entire home multiple times per week as she is currently reporting is happening. Ms. Schaar added that the plan is to move Resident A into an apartment with supportive services as she is doing well with meeting her goals toward semi-independence. I requested that Resident A's IPOS be amended to include her ability to prepare meals for herself and to assist staff with preparation of meals if she desires. Ms. Schaar reported that she would amend the plan.

On 08/04/22, I interviewed Paul Torony, guardian case manager at Faith Connections. Mr. Torony reported he recently learned of the allegations and reported that he spoke at length with Resident A. Mr. Torony reported his displeasure with the staff at the home allowing Resident A to complete tasks that they are paid to perform. Mr. Torony reported that he educated Resident A on the importance of respecting the other residents' rights to privacy as well as her own and advised against her ever being in the restroom with another resident, let alone showering them. Mr. Torony reported that Resident A understood and reported she would not shower another resident again.

Mr. Torony reported that Resident A is allowed to prepare meals for herself but should not be encouraged or forced to prepare meals for all of the residents. Mr. Torony reported he has been in contact with Ms. Schaar regarding this matter and is hopeful that there will not be a reoccurrence.

On 08/04/22, I interviewed staff, Issac Onowuolo, and he denied the allegations. Mr. Onowuolo reported that he has never asked Resident A to shower a resident and reported not being aware of it ever happening during his shifts. Mr. Onowuolo

reported that although male staff normally do not shower the female residents, he reported that if an emergency arose, where the resident needed to have a shower, he would shower them. Mr. Onowuolo reported that he would not allow a resident to lie in their own feces. He also reported that if the resident was not comfortable with him showering her, he would immediately contact Ms. Anwunah and have her send a female staff to the home to complete the shower. Mr. Onowuolo reported he would never ask a resident to shower another resident.

Mr. Onowuolo reported he works two shifts a week at the home and reported he cannot speak to what happens when he is not at the home. Mr. Onowuolo reported that Resident A has not cooked any meals during his shifts in the home. He reported that one day each week he works a midnight shift and a day shift. Mr. Onowuolo reported there is no cooking done on the midnight shift and reported during the day shift he prepares the meals.

On 08/08/22, I conducted the exit conference with licensee designee, Chinyelu Anwunah, and informed her of the findings of the investigation and the specific rule violations. Ms. Anwunah reported an understanding.

On 08/09/22, I interviewed Guardian (1) and she reported that Resident A has showered Resident D on a few occasions. Guardian (1) denied that she ever asked Resident A to shower Resident D and denied offering her compensation to do so. Guardian (1) reported that Resident A has offered to shower Resident D and she allowed her to do so. Guardian (1) reported that the staff on shift during those times were aware that Resident A was showering Resident D and did not have a problem with it. I informed Guardian (1) of the inappropriateness of allowing a resident to preform a task that staff are responsible and paid to do. I informed Guardian (1) of the privacy, dignity, respect and possible liability issues that this presents and cautioned her about allowing Resident A to shower Resident D in the future. Guardian (1) reported understanding and reported she will not allow this to happen again.

APPLICABLE RULE	
R 400.14102	**Definitions.**
	(1) As used in these rules: **(h) "Direct care staff" means the adult who is designated by the licensee to provide personal care, protection, and supervision to residents.**

ANALYSIS:	Resident A has been performing tasks in the home that are supposed to be completed by direct care staff. Resident A has showered Resident C and D on multiple occasions and has been preparing meals for the entire home on a regular basis. Residents C-E all confirmed that Resident A has showered Resident's C-D and reported staff were aware. Residents C-F all confirmed that Resident A cooks meals for the entire home and does so on a regular basis. This violation is established as Resident A is not the adult designated by the licensee designee to provide personal care, protection, and supervision to residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.

ANALYSIS:	Residents A admitted that she has showered Residents C-D at least three times each. Resident A reported that each time she showered Residents C-D the staff on shift were aware and allowed her to complete the task. Residents C-D both confirmed that Resident A has showered them on multiple occasions and reported that the staff were aware and did not take issue with it. Guardian (1) reported that Resident A has showered Resident D multiple times and reported staff were aware. Guardian (1) confirmed that the staff did not have a problem with it, nor did they intervene. Residents A and C-F all reported that Resident A prepares meals for the entire home on a regular basis. Residents C-F reported that Resident A is a really good cook, and they enjoy her meals. Resident A reported that she enjoys cooking; however, reported that the staff at the home expect her to prepare lunch and dinner at the home everyday and that she is tired of it. Resident A reported her desire to cook she be a choice and not a mandate. This violation is established as the employees, through their actions and inactions were not suitable to assure the welfare of the residents. Their knowledge of what was occurring and their failure to intervene brings into question their suitability.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Resident's C and D were not treated with dignity or respect as the staff responsible for their care, allowed another resident to provide personal care to them by allowing Resident A to shower them on multiple occasions. Resident A was not treated with dignity as she was allowed to preform direct care staff responsibilities by showering two of her housemates. Additionally, her personal needs, including protection and safety were not attended to at all times, as the staff took advantage of her by allowing her to continually shower Residents C-D and prepare meals daily, while being fully aware that this is not appropriate and is their responsibility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/15/22, I conducted an unscheduled onsite inspection and interviewed Resident A. Resident A reported that there are seven residents living in the home. Resident A named each of the residents but was unsure of how long there had been seven residents in the home. I reviewed the resident register to compare it with the information provided to me by Resident A. The resident register documented 6 residents currently residing in the home, and next to Resident C's name had a discharge date of 01/28/22, however, Resident A confirmed she was still living in the home.

I interviewed staff, Florence Nwaka, and she confirmed that there are currently seven residents living in the home. Ms. Nwaka reported that Ms. Anwunah could explain why the home was over capacity.

On 07/15/22, I interviewed licensee designee, Chinyelu Anwunah, and she reported that the home does have seven residents at the present. Ms. Anwunah reported that due to residents having to be moved from one of her other homes, she made the decision to temporarily place Resident F at Graceville. Ms. Anwunah reported that Resident F does not adapt to change well but knew that the Graceville home would be a better fit then the Detroit home. I informed Ms. Anwunah that while I understand her rationale and concern for Resident F, the rules do not allow for a home to operate over its licensed capacity. Ms. Anwunah reported understanding and stated she is working on making some decisions to get the home back to six residents.

I conducted the exit conference with licensee designee Chinyelu Anwunah on 08/08/22 and informed her of the findings of the investigation. Ms. Anwunah reported

an understanding and stated that Resident C's guardian has submitted a request to Detroit Wayne Integrated Health Network (DWIHN) to have Resident C moved to another one of her licensed homes in Garden City. Ms. Anwunah reported that once DWIHN approves the request Resident C will be moved and she will be back at her licensed capacity.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.
ANALYSIS:	On 07/15/22, during the unscheduled onsite inspection, I was informed that there were seven residents living in the home. Resident A and staff, Ms. Nwaka confirmed to me that there were indeed seven residents in the home. On 07/15/22, I interviewed licensee designee, Ms. Anwunah, and she confirmed that the home had seven residents and she was working on moving one of the residents out. This violation is established as the number of residents cared for in the home and the number of resident beds is more than the capacity that is authorized by the license.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/15/22, I conducted an unscheduled onsite inspection and reviewed Resident A's records. Resident A's records did not contain a health care appraisal completed within the 90-day period before Resident A's admission into the home on 06/15/20. Resident A's record also did not contain annual health care appraisals for 2021 or 2022.

On 07/15/22, I interviewed licensee designee, Chinyelu Anwunah, and she reported that the health care appraisals should have been in the home and reported that she believes they were done.

On 08/08/22, I conducted the exit conference with Ms. Anwunah and informed her of the findings of the investigation. Ms. Anwunah reported an understanding and stated she would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

ANALYSIS:	On 07/15/22, I reviewed Resident A's records and observed that they did not contain a completed health care appraisal completed with the 90-day period before Resident A's admission to the home. The record also did not contain annual health care appraisals for 2021 and 2022. They were due to be completed in June of each year.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/15/22, I conducted an unscheduled onsite inspection and requested to review Resident A's records. Resident A's records did not contain a completed resident care agreement for 2021 or 2022. The care agreements should have been completed in June of both years.

On 07/15/22, I interviewed licensee designee, Chinyelu Anwunah, and she reported that she believed that she had completed the resident care agreements are required by these rules. Ms. Anwunah reported that she would have to review the files to see what is going on.

On 08/08/22, I conducted the exit conference with Ms. Anwunah and informed her of the findings of the investigation. Ms. Anwunah reported an understanding and stated she would submit an acceptable corrective action plan addressing each of the violations.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.

ANALYSIS:	On 07/15/22, I reviewed Resident A's records and observed that the records did not contain a completed written resident care agreement for 2021 or 2022. Both care agreements were due to be completed in June of each year.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/09/22

Pandrea Robinson — Date
Licensing Consultant

Approved By:

08/10/22

Ardra Hunter — Date
Area Manager