GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 13, 2022

Josephine Uwazurike
Allied Continuing Care Inc
Suite 200
23999 Northwestern Hwy
Southfield, MI 48075

RE: License #: AS820269544
Investigation #: 2022A0992039
Rose 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,

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 #:	AS820269544
Investigation #:	2022A0992039
Complaint Receipt Date:	08/29/2022
Investigation Initiation Date:	08/29/2022
Report Due Date:	10/28/2022
Licensee Name:	Allied Continuing Care Inc
Licensee Address:	Suite 200 23999 Northwestern Hwy Southfield, MI 48075
Licensee Telephone #:	(248) 569-1040
Administrator:	Josephine Uwazurike
Licensee Designee:	Josephine Uwazurike
Name of Facility:	Rose Manor
Facility Address:	16216 Middlebelt Romulus, MI 48184
Facility Telephone #:	(248) 569-1040
Original Issuance Date:	10/28/2004
License Status:	REGULAR
Effective Date:	09/06/2021
Expiration Date:	09/05/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 08/26/2022, Resident A left the home without staff knowledge. Staff was notified by a neighbor that Resident A was walking down the street. There is lack of supervision.	Yes

III. METHODOLOGY

08/29/2022	Special Investigation Intake 2022A0992039
08/29/2022	Special Investigation Initiated - Telephone Sunny Nwogwgw, home manager
09/09/2022	Inspection Completed On-site Mr. Nwogwgw, home manager; Darlington Agwua, direct care staff; Resident A
09/09/2022	Referral - Recipient Rights
09/09/2022	APS Referral
09/09/2022	Contact - Document Received Resident A's individual Plan of Service (IPOS)
09/12/2022	Contact - Telephone call made Paul Torony, Resident A's guardian with Faith Connections
09/12/2022	Contact - Telephone call made Rebecca Bringman, Faith Connections
09/12/2022	Contact - Telephone call made Josephine Uwazurike, licensee designee
09/12/2022	Contact - Telephone call made Jerri Sterrett, Office of Recipient Rights (ORR) Investigator
09/12/2022	Contact - Telephone call made Lawrence Caldwell, ORR Investigator
10/12/2022	Contact - Telephone call made

	Michael Dean, Resident A's Supports Coordinator with Wayne Center was not available. Message left.
10/12/2022	Exit Conference Ms. Uwazurike

ALLEGATION: On 08/26/2022, Resident A left the home without staff knowledge. Staff was notified by a neighbor that Resident A was walking down the street. There is lack of supervision.

INVESTIGATION: On 08/29/2022, I contacted Sunny Nwogwgw, home manager, regarding the reported allegations. Mr. Nwogwgw confirmed Resident A was found wandering down the street by a neighbor. He further explained that he had transported Resident A to a doctor's appointment and when they returned to the facility, he went into the office area to return the resident file when he heard a knock at the door, it was the neighbor stating Resident A was down the street. Mr. Nwogwgw said he went and picked Resident A up and he seemed a bit confused. He said Resident A returned to the home without incident and he has not eloped since. I asked Mr. Nwogwgw how many staff were on shift at the time, and he said two.

On 09/09/2022, I completed an unannounced onsite inspection and interviewed Mr. Nwogwgw and Darlington Agwua, direct care staff; and observed Resident A. Mr. Nwogwgw said as he previously stated he had transported Resident A to the doctor that day and typically when the residents have an appointment, they take their file and/or medication records. He said when they returned from the appointment, he immediately went to put the file documents away and enter progress notes. He said there were two staff on shift at the time including himself and another staff who was in the sitting area. He said at some point Resident A went out the front door. Mr. Nwogwgw said minutes later the neighbor knocked on the door and notified him that Resident A was down the street. He said he went to pick him up and he was approximately 2-3 houses down the street. Mr. Nwogwgw said Resident A appeared to be somewhat disoriented because he did not know where he was and when asked where he was going, he said to his room. Mr. Nwogwgw said Resident A had recently received a new medication injection "Invega", so his confused state could have been because of him receiving the new medication. However, Mr. Nwogwgw said he spoke with Resident A's doctor and explained the situation and asked him to review his medications, in which he did. Mr. Nwogwgw said although Resident A is relatively new to the home, he does not have a history of elopement. Mr. Nwogwgw identified Paul Torony, Faith Connections as Resident A's guardian. Mr. Nwogwgw said Resident A does require 24hr supervision, but he does not require 1:1 staffing. He said Resident A wears a helmet because he has seizures and cannot be in the community independently.

I interviewed Darlington Agwua, direct care staff regarding the allegations. Mr. Agwua confirmed he was on shift the day the reported incident occurred. He said he was doing laundry and was in the laundry room when the neighbor knocked on the door. Mr. Agwua said he did not hear Resident A leave the home. He said Resident A has never left the home in the past and this is unusual behavior for him.

On 09/09/2022, I received a copy of Resident A's individual Plan of Service (IPOS), in which I reviewed. The IPOS does not indicate Resident A required 1:1 staffing; nor does it indicate if he can be in the community independently.

On 09/12/2022, I contacted Paul Torony, Resident A's guardian with Faith Connections and interviewed him regarding the allegations. Mr. Torony said he was not aware of the incident and did not receive an incident report (IR). He said it is possible that the incident report was sent to the office, and not sent to him directly. Mr. Torony suggested I contact Rebecca Bringman, Faith Connections to determine if the IR was received. Regarding the allegations, Mr. Torony agreed to follow-up with the staff and Resident A.

On 09/12/2022, I contacted Ms. Bringman and asked if she received an IR regarding the reported allegations. Ms. Bringman said it is a possibility the IR was received. However, she is short-staffed and unable to say with certainty if it was received or not. She said if her memory serves her correctly, there were some concerns in the past with residents leaving that home. She said Resident A is a wanderer and she is considering moving him to another home that is in a more residential setting.

On 09/12/2022, I contacted Josephine Uwazurike, licensee designee and discussed the allegations. Ms. Uwazurike confirmed she was aware of the allegations. She said she has discussed the allegations with her staff, and it seems as though everything transpired within five minutes of them returning from the doctor’s appointment. I expressed concern as it pertains to supervision as the home is located on a Middlebelt which is a major main street that has both industrial and residential traffic. There are no sidewalks, which forces pedestrians to walk on the shoulder of the road. I further mentioned that there were two staff on shift and neither heard Resident A leave the home. I suggested Ms. Uwazurike considering installing a chime or a form of alarm on the door to notify the staff when someone enters or exits the home. Ms. Uwazurike said she discussed the possibility of installing a chime or some type of alarm on the door with Jerri Sterrett, Office of Recipient Rights (ORR) Investigator and she was told she would have to obtain approval to have an alarm system installed. I made Ms. Uwazurike aware that I will follow-up with her upon completion of the investigation to conduct an exit conference.

On 09/12/2022, I contacted Ms. Sterrett, regarding the investigation. Ms. Sterrett explained that she briefly spoke with Ms. Uwazurike about the allegations, but the investigation has been assigned to Lawrence Caldwell, ORR Investigator. Ms. Sterrett said she did not tell Ms. Uwazurike that she cannot install chimes or a form of alarm on the door but suggested she contact Resident A’s support coordinator

and psychologist so that everyone can be on the same accord as it pertains to Resident A's behaviors and needs. She said that his assessments will be updated to reflect accurate behaviors.

On 09/12/2022, I called Lawrence Caldwell, ORR Investigator regarding the allegations. Mr. Caldwell explained that this investigation was newly assigned to him and that he would follow-up with me regarding his findings.

On 10/12/2022, I completed an exit conference with Ms. Uwazurike. I made her aware that based on the investigative findings, I determined there is sufficient evidence to support the allegations. I expressed concern regarding the lack of supervision and that the staff were notified by a neighbor that Resident A had left the home. In addition, the home is located on a Middlebelt which is a major main street that has industrial and residential traffic. There are no sidewalks, which forces pedestrians to walk on the shoulder of the road. Ms. Uwazurike said she understands and will complete the corrective action plan as required; she is also going to follow-up with Michael Dean, Supports Coordinator with Wayne Center to update the IPOS.

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:	During this investigation I interviewed all involved parties, reviewed the incident report and Resident A's IPOS. Although the IPOS does not indicate if Resident A can be in the community independently. Resident A was able to leave out the home without staff knowledge and travel 2-3 houses down the street. Staff was later notified by a neighbor. Based on the investigative findings, I have determined the direct care staff failed to provide sufficient supervision and protection of Resident A at all times. This allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/12/2022

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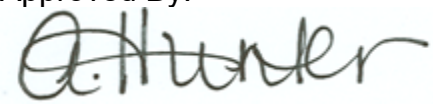
Denasha Walker Date
Licensing Consultant

Approved By:



10/13/2022

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Ardra Hunter Date
Area Manager