GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2022

Zubair Ahmed
Prestige Health Management Inc
685 E Square Lake Road
Troy, MI 48085

RE: License #: AS630411654
Investigation #: 2022A0611041
Safe Haven Acres

Dear Mr. Ahmed:

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:

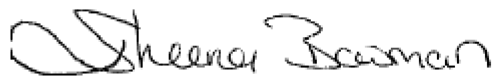
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630411654
Investigation #:	2022A0611041
Complaint Receipt Date:	09/26/2022
Investigation Initiation Date:	09/28/2022
Report Due Date:	11/25/2022
Licensee Name:	Prestige Health Management Inc
Licensee Address:	685 E Square Lake Road Troy, MI 48085
Licensee Telephone #:	(248) 710-7056
Administrator:	Zubair Ahmed
Licensee Designee:	Zubair Ahmed
Name of Facility:	Safe Haven Acres
Facility Address:	685 E Square Lake Road Troy, MI 48085
Facility Telephone #:	(248) 710-7056
Original Issuance Date:	06/21/2022
License Status:	TEMPORARY
Effective Date:	06/21/2022
Expiration Date:	12/20/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
A new caregiver started working and it is believed she has not been trained.	Yes
A resident is not getting her insulin before meals and her wound care is not being done properly. Medication was found on a resident’s chest.	Yes
A resident with dementia was wandering for 15 minutes. It is believed that no caregiver was in the home last night.	Yes

III. METHODOLOGY

09/26/2022	Special Investigation Intake 2022A0611041
09/28/2022	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed the home manager, Harris Cheema, the licensee designee, Zubair Ahmed, staff member, Kenliesha Marshall, and Resident N. I received copies of Resident N and Resident M’s MAR for the month of September 2022.
10/07/2022	Contact - Telephone call made I left a voice message for the reporting source requesting a call back.
10/11/2022	Contact - Telephone call made I returned the reporting source phone call however; there was no answer. A voice message was left.
10/12/2022	Contact - Telephone call made I made a telephone call to Nurse Terry Jordan from Home MD House Call Services. Nurse Terry stated she provides physician services to specific residents at the AFC group home. Nurse Terry did not want to provide any further details without getting consent from her supervisor.
10/12/2022	Contact - Telephone call made I made a telephone call to Divinity Home Care however; there was no answer. I left a voice message requesting a call back.

10/12/2022	Contact - Telephone call made I left a voice message for staff member Erica Ellsworth requesting a call back.
10/12/2022	Contact - Telephone call made I made a telephone call to Divinity Home Care main office. I spoke with the receptionist (Carol). I received information regarding the allegations.
10/12/2022	Contact - Telephone call received I received a return phone call from the owner of Divinity Home Care, Alex Sabich. Mr. Sabich provided information.
10/12/2022	Contact - Telephone call made I left a voice message for the physical therapist from Divinity Home Care requesting a call back.
10/12/2022	Contact - Telephone call made I made a telephone call to the occupational therapist, Cindy Hogan from Divinity Home Care. The allegations were discussed.
10/12/2022	Contact - Telephone call made I left a voice message for the new staff member, Brianna Taylor requesting a call back.
10/12/2022	Contact - Telephone call received I received a return phone call from staff member, Brianna Taylor. Ms. Taylor provided information regarding the allegations.
10/12/2022	Contact - Face to Face I completed an announced onsite. I reviewed the employee files, I observed the menu, the food in the refrigerator, and I interviewed Resident E.
10/12/2022	Contact - Telephone call received I received a return phone call from the reporting source. The allegations were discussed.
10/12/2022	Exit Conference I completed an exit conference with the licensee designee, Zubair Ahmed via telephone.

ALLEGATION:

- **A new caregiver started working and it is believed she has not been trained.**
- **A resident with dementia was wandering for 15 minutes. It is believed that no caregiver was in the home last night.**

INVESTIGATION:

On 09/27/22, I received an Adult Protective Services (APS) Investigation report regarding the abovementioned allegations. According to the Adult Protective Services Investigation report, the disposition was denied being assigned for an investigation.

On 09/28/22, I completed an unannounced onsite. I interviewed the home manager, Harris Cheema, the licensee designee, Zubair Ahmed, staff member, Kenliesha Marshall, and Resident N. I received copies of Resident N and Resident M's MAR for the month of September 2022.

On 09/28/22, I interviewed the home manager, Harris Cheema. Regarding the allegations, Mr. Cheema stated there are five residents in the AFC group home. Mr. Cheema stated staff member Erica Ellsworth was a live-in staff however; she has not returned to work. Ms. Ellsworth was given Saturday off and she was expected to return Saturday evening (9/24/22) at 9:00pm. Mr. Cheema stated it is unlike Ms. Ellsworth to disappear and not return phone calls. Mr. Cheema plans to file a missing person police report regarding Ms. Ellsworth.

Mr. Cheema stated staff member Kenliesha Marshall was hired on 09/22/22. Ms. Marshall started shadowing the home manager, Amir Nizami at another AFC group home (Safe Haven Hill, AS630408702) on 09/22/22. Ms. Marshall started working at Safe Haven Acres on 09/26/22. I observed Ms. Marshall workforce background check letter and confirmed the date of the letter which was 09/22/22.

Mr. Cheema stated Ms. Marshall is a live-in staff member. Ms. Marshall is typically awake and on duty between the hours of 8:00am-11:00pm. Mr. Cheema stated the residents have a call button in their bedrooms and Ms. Marshall is able to hear the call buttons in her bedroom. Mr. Cheema stated he was unaware of the licensing rule that requires a staff member to supervise all the residents at all times. Mr. Cheema thought a live-in staff member fulfills the supervision rule requirement even if the live-in staff member is asleep and there is no other staff member on duty to supervise the residents. Mr. Cheema stated the AFC group home will not be able to afford to hire multiple staff members to ensure proper supervison because most caregivers want a salary of $30 an hour.

Mr. Cheema stated Resident D and Resident J have dementia. Mr. Cheema denied Resident D or Resident J walking out of the AFC group home. Resident J will wander around the home, but staff are watching her.

On 09/28/22, I interviewed the licensee designee, Zubair Ahmed. Regarding the allegations, Mr. Ahmed stated he was planning to replace Ms. Ellsworth as she spent too much time engaging with the residents and neglecting her other duties and she was not open to constructive criticism. Mr. Ahmed stated Ms. Marshall has not completed any of the required trainings. Ms. Marshall has been provided with a brief description of how to care for the residents however; she has not been properly and/or thoroughly trained. Mr. Ahmed explained that it was urgent for Ms. Marshall to start caring for the residents due to Ms. Ellsworth not returning to work. Mr. Ahmed confirmed that he has never hired any other direct care staff members other than Ms. Ellsworth and Ms. Marshall. Therefore, the residents are not being supervised at nighttime when Ms. Ellsworth or Ms. Marshall were asleep. Mr. Ahmed stated there is no structure for Ms. Marshall to take a break nor is there a schedule for another staff member to relieve her. Mr. Ahmed stated he and Mr. Cheema spend a lot of time at the AFC group home to assist with caring for the residents. However, there is no staff schedule.

Although Mr. Ahmed is aware that he is required to provide 24/7 supervison for every resident, he also believes that a live-in staff fulfills the supervision rule requirement even if the live-in staff member is asleep and there is no other staff member on duty to supervise the residents. Mr. Ahmed and Mr. Cheema were adamant about the definition of supervision does not mean physically monitoring a resident at all times. Both Mr. Ahmed and Mr. Cheema believe the majority of the AFC group homes in the metropolitan area operate their AFC group homes in this manner regarding supervison.

Mr. Ahmed stated Ms. Ellsworth completed CPR and first aid training. During the onsite, I observed Ms. Ellsworth training for CPR and first aid dated 04/26/22. I also observed a behavioral health management (BHM) receipt of training for Ms. Ellsworth dated 05/10/22 from community mental health. Mr. Ahmed stated BHM includes medication training.

On 09/28/22, I interviewed staff member, Kenliesha Marshall. Regarding the allegations, Ms. Marshall stated she is still being trained. Ms. Marshall completed first aid training today, but she has not completed CPR training. Ms. Marshall was trained to administer medications on Monday which was her first day. Ms. Marshall has not completed any written test for trainings to demonstrate competence. Ms. Marshall sleeps in a room that was initially an empty room that was reserved for staff only. Ms. Marshall stated she has also slept on the couch so that she can be aware of what is going on in the home.

On 10/12/22, I made a telephone call to Divinity Home Care. I spoke with the receptionist. I was informed that the licensee designee, Zubair Ahmed discontinued services for all of his AFC group homes effective 09/28/22. Mr. Ahmed discontinued services because he assumed that Divinity Home Care called Adult Protective Services against his AFC group home. Prior to discontinuing services, the AFC group home was receiving services from a physical therapist and occupational therapist. Mr. Ahmed’s other AFC group home (Safe Haven Hill AS630411654) was receiving services from a nurse and a physical therapist from Divinity Home Care.

On 10/12/22, I received a return phone call from the owner of Divinity Home Care, Alex Sabich. Mr. Sabich stated he has never been to the AFC group home. Mr. Sabich confirmed that no concerns regarding the AFC group home has ever been reported to him from a nurse or therapist.

On 10/12/22, I made a telephone call to the occupational therapist from Divinity Home Care, Cindy Hogan. Regarding the allegations, Ms. Hogan stated she provided services for Resident N and Resident E. Resident E does not have dementia. Resident E is a retired registered nurse, and she is cognitively cognizant. Ms. Hogan provided services for Resident E for about two months. Ms. Hogan provided services for Resident N for a couple of weeks as Resident N was a new resident. Ms. Hogan visited the AFC group home twice a week. Ms. Hogan stated she started to have concerns towards the last few weeks before her services were discontinued.

Ms. Hogan stated when Resident J moved into the AFC group home, she became Resident E's roommate. Resident J has Alzheimers, and she wanders around consistently. Resident J would also wander in and out of other resident's bedrooms. Ms. Hogan stated Ms. Ellsworth could not give residents showers when she was expected to because she had to watch Resident J. Ms. Hogan stated there was an instance when Ms. Ellsworth put Resident J in the bathroom with her while she gave Resident E a shower. Ms. Ellsworth was not getting much sleep as she had to watch Resident J 24/7. Ms. Hogan stated Ms. Ellsworth would have Resident J sleep with her in her bed or they would both sleep on the couch until Resident J became acclimated with going to sleep. Ms. Ellsworth only had Saturday afternoon's off for eight hours as she was expected to return to work Saturday evenings. Ms. Hogan stated Ms. Ellsworth was the only staff member seven days a week.

Ms. Hogan stated when Ms. Marshall started working at the AFC group home, she did not have enough experience. Ms. Hogan was told by Resident N and Resident E that Ms. Marshall would serve them soup to eat with a fork and nothing else to eat. Therefore, Resident N and Resident E did not feel like they were getting enough nutrition. Ms. Hogan was informed by Resident E that she did not feel safe with Ms. Marshall transferring her in and out of her wheelchair because she did not feel that she was properly trained.

On 10/12/22, I received a return phone call from the new staff member, Brianna Taylor. Ms. Taylor started working for the AFC group home on Thursday (10/6/22). Ms. Taylor shift is 8:00am - 8:00pm. Ms. Taylor was off on 10/8/22 and today (10/12/22). Ms. Taylor is not a live in staff member. Ms. Taylor stated when she is working, Mr. Cheema is present. Ms. Taylor stated she was trained on all the required trainings via in-service on her first day of work. Ms. Taylor is a certified nursing assistant (CNA).

On 10/12/22, I completed an announced onsite. I reviewed the employee files, I observed the menu, the food in the refrigerator, and I interviewed Resident E.

The employee file for Harris Cheema consisted of all of the required trainings, a copy of his bachelor's degree, driver's license, medical clearance, TB results, and workforce background clearance.

The employee file for Erica Ellsworth consisted of her driver's license, social security card, CPR and first aid training, Behavioral health management (BHM) training regarding medication, employee application, and workforce background clearance. Ms. Ellsworth file did not have a medical clearance, TB results, reference checks, or verification of completion of the other required trainings.

The employee file for Brianna Taylor consisted of her diploma, TB results, CPR and first aid training, workforce background clearance, driver's license, nurse aide registry document, employee application, job description, a list of her references, and a training checklist. The training checklist included all of the required trainings. Ms. Taylor signed the training checklist, but she did not date it. Ms. Taylor start date was 10/06/22. Mr. Ahmed stated Ms. Taylor will receive her medical clearance within 30 days of her hire date.

The employee file for Kenliesha Marshall consisted of her driver's license, employee application, job description, workforce background clearance. Ms. Marshall's file was missing reference checks, social security card, medical clearance, and TB results. A training checklist was observed in Ms. Marshall file which included all of the required trainings. Ms. Marshall signed the checklist however; it was not dated. Mr. Ahmed stated Ms. Marshall was provided with the in-service trainings after my onsite on 09/28/22. Ms. Marshall was terminated shortly after my onsite on 09/28/22 however; an end date was not observed in her file.

The employee file for Dorjon Spicer consisted of her driver's license, nurse assistant certificate, CPR and first aid training, workforce background clearance, application, and job description. Ms. Spicer file was missing reference checks, medical clearance, TB results, social security card, and an employee end date. Mr. Ahmed stated Ms. Spicer was hired on 10/05/22 however; he does not intend to keep her as an employee.

I observed a potential hire file for Latoya Stokes. The employee file consisted of a workforce background clearance, driver's license, employee application, and job description.

On 10/12/22, I observed Resident N's health care appraisal dated 08/29/22. According to the health care appraisal, Resident N is ordered to have a regular diet with regular texture and with thin consistency fluids. I observed the menu which was posted on the refrigerator. I observed sufficient food in the refrigerator. Mr. Ahmed stated there are now three residents in the home as Resident D passed away on 10/8/22 and Resident M moved back home on 09/30/22. I observed Resident J siting in the living room watching T.V.

On 10/12/22, I interviewed Resident E in her bedroom. Regarding the allegations, Resident E has lived at the AFC group home for six weeks. Resident E likes living at the AFC group home. Resident E stated when she first moved in, Ms. Ellsworth, Mr. Cheema, and Mr. Ahmed worked in the home. Ms. Ellsworth lived in the home. Resident E stated there were two staff in the home every day. Resident E stated at nighttime she does not know if another staff member was present when Ms. Ellsworth went to sleep. Resident E stated staff does check on her throughout the night.

Resident E stated she does not think Ms. Marshall lived in the home. Resident E stated Ms. Taylor is a new staff member and she takes care of her appropriately. Resident E stated by choice she does not take a shower every day. Resident E receives a shower two or three times a week. Resident E stated she receives assistance from a staff member when she takes a shower. Resident E denied another resident being present in the bathroom when she is receiving a shower. Resident E stated Resident J is her roommate. Resident E stated the staff monitor Resident J closely to prevent her from wandering.

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: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	On 09/28/22, according to the licensee designee Zubair Ahmed, Ms. Marshall had been provided with a brief description of how to care for the residents. However, she had not been properly and/or thoroughly trained nor had she completed any of the required trainings. Ms. Marshall was a live-in staff and was performing assigned tasks by herself before she was fully trained and determined to be competent to do so. According to Ms. Marshall employee file, she received in-service trainings regarding all of the required trainings. However, the date of the in-service trainings is unknown. Mr. Ahmed

	confirmed that Ms. Marshall received her in-service trainings after 09/28/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	According to the home manager Harris Cheema, Ms. Marshall is a live-in staff member. Ms. Marshall is typically awake and on duty between the hours of 8:00am-11:00pm. The residents have a call button in their bedrooms and Ms. Marshall is able to hear the call buttons in her bedroom. On 09/28/22, the licensee designee, Zubair Ahmed confirmed he has never hired any other direct care staff members other than Ms. Ellsworth and Ms. Marshall. Therefore, the residents were not being supervised at all times during the evening when Ms. Ellsworth or Ms. Marshall were asleep. Mr. Cheema and Mr. Ahmed believe that a live-in staff fulfills the supervision rule requirement even if the live-in staff member is asleep and there is no other staff member on duty to supervise, protect, or care for the residents. Mr. Ahmed and Mr. Cheema were adamant about the definition of supervision that it does not mean physically monitoring a resident at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.**

	(e) Verification of experience, education, and training. **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.**
ANALYSIS:	According to Ms. Ellsworth employee file, the following documents were missing: medical clearance, TB results, reference checks, or verification of completion of the majority required trainings. According to Ms. Marshall employee file, the following documents were missing: reference checks, social security card, medical clearance, TB results, and an employment end date. According to Ms. Spicer employee file, the following documents were missing: reference checks, medical clearance, TB results, social security card, and an employee end date.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 09/28/22, the licensee designee Zubair Ahmed admitted that there is no structure for Ms. Marshall to take a break nor is there a schedule for another staff member to relieve her. Mr. Ahmed confirmed there is no daily schedule of advance work assignments that includes job titles, hours, date of schedule, or any scheduling changes for the AFC group home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

A resident is not getting her insulin before meals and her wound care is not being done properly. Medication was found on a resident's chest.

INVESTIGATION:

On 09/28/22, Mr. Cheema stated on 09/26/22, Resident N did not receive her 7:00 am dose of insulin on time. Mr. Cheema, Mr. Ahmed, and Ms. Marshall were present in the home, and they were busy preparing breakfast. Resident N had to inform Mr. Cheema that she did not receive her insulin. Mr. Cheema allowed Ms. Marshall to administer Resident N's insulin on her first official day working at the AFC group home. Mr. Cheema denied medication being found on a resident's chest and no one monitoring a resident taking their medications.

Mr. Cheema stated the home manager, Amir Nizami from Safe Haven Hill visits Safe Haven Acres to help out and oversee the group home. Mr. Cheema stated Mr. Nizami trained Ms. Ellsworth on how to complete the wound care for Resident N. Mr. Nizami was present at Safe Haven Acres on 09/25/22 to complete the wound care for Resident N because the nurse was not there to do it. Resident N's wound care needs to be completed every day. Mr. Cheema stated he was present in the home when Mr. Nizami completed the wound care for Resident N. Mr. Cheema did not see Mr. Nizami complete the wound care but he said he did it correctly. Mr. Cheema stated there are no written instructions in the home pertaining to how to complete Resident N's wound care.

On 09/28/22, Mr. Ahmed stated Resident N and Resident M are prescribed insulin. Mr. Ahmed denied either resident not getting their insulin. Mr. Ahmed denied any knowledge of medication being found on a resident's chest and no one watching the resident swallow the medication. Mr. Ahmed accurately provided a verbal medication simulation. Resident N requires wound care as her foot was recently amputated prior to her admission into the AFC group home. Resident N receives services from Divinity Home Care and from Home MD House Call Services. A nurse practitioner or a RN from Home MD House Call Services visits Resident N about every two weeks or as needed.

On 09/28/22, I interviewed Resident N. Resident N was observed sitting in bed in her bedroom. Resident N has lived at the AFC group home for a couple weeks. Resident N likes the AFC group home. Regarding the allegations, Resident N is prescribed insulin four times a day at mealtimes and a night. A staff member always administers Resident N's insulin. Resident N stated Ms. Marshall started working at the AFC group home this week and; this week Ms. Marshall started administering her insulin. Resident N stated Mr. Cheema will sometimes administer her insulin. Resident N stated there was one instance when she did not receive her insulin at nighttime. Resident N stated she forgot to ask for her insulin (Lantus). Resident N was informed that she is not responsible for making sure the staff administer her medications. Resident N stated the rest of her medications are administered to her on time. Resident N denied observing medication on another resident's chest or laying around.

I observed Resident N's amputee left foot area. Resident N's wound care must be completed every day. Ms. Ellsworth previously completed Resident N's wound care and now Ms. Marshall does it. A nurse will also come to the home to assist with Resident N's wound care. Resident N stated this past Sunday (9/25/22), Mr. Nizami did not complete her wound care correctly. Resident N stated cream is supposed to be applied to her wound and then a dressing soaked in Dakins is wrapped around her foot. Resident N stated Mr. Nizami did not know what to do therefore; he just re-wrapped her foot without applying any cream or the Dakins.

On 09/28/22, Ms. Marshall denied seeing any medication on a resident's chest. Ms. Marshall does not know the five rights to administering medications. Ms. Marshall confirmed that she administers Resident N's insulin. Ms. Marshall stated today she administered all the resident's medications on her own.

On 09/28/22, I received a copy of Resident N and Resident M's MAR for the month of September 2022. According to Resident N's MAR, she was prescribed Lantus Solostar 100 units twice a day (8:00am and 8:00pm). This prescription was discontinued on 09/16/22. According to the MAR, there are missing staff initials for the 8:00am dose on 9/6/22, 9/8/22, 9/13/22. There are also missing staff initials for the 8:00pm dose on 9/2/22, 9/6/22, 9/9/22, and 9/11/22. Resident N was prescribed Lantus Solostar 100 units at night starting on 9/16/22. Resident N was also prescribed Novolog 100 units three times a day per sliding scale before meals. This prescription was discontinued on 9/16/22. According to the MAR, there are several staff initials missing throughout the different doses for this medication. Resident N was prescribed Novolog 100 unites three times a day with meals starting on 9/17/22. There are missing staff initials for the 11:00pm dose on 9/17/22, 3:00pm dose on 9/19/22, 3:00pm dose on 9/23/22, and 11:00pm dose on 9/24/22.

According to Resident M's MAR, Resident M is prescribed Tresiba 100 units once daily. There were no staff initials missing for this medication.

On 10/12/22, Ms. Hogan stated Resident N and Resident E are fully aware of what type of medications they are prescribed. However, Ms. Marshall was not familiar with Resident N or Resident E's medications as she did not know what they were for or the side effects. Resident E told Ms. Hogan that if the medications were not already sorted out, Ms. Marshall would not know how to administer the medications. Ms. Hogan denied witnessing any medications left on a resident's chest or left out. Ms. Hogan was never informed by Resident N that she did not receive her insulin. Ms. Hogan stated Jeanne Mikulski is a nurse who trained Ms. Ellsworth on how to complete Resident N's wound care. Resident N was confident with Ms. Ellsworth completing her wound care. Ms. Hogan does not know if Ms. Marshall was trained to complete Resident N's wound care. Ms. Hogan stated Nurse Mikulski is off work as her father recently passed away.

Ms. Hogan was informed by Resident N that Mr. Nazami said to Resident N that he did not know how to do her wound care but, he did it anyway. Ms. Hogan stated Resident N told her that Mr. Nazami did not complete her wound care correctly.

On 10/12/22, I observed Resident N's Lantus and Novolog insulin in the refrigerator without it being secured in a lock box. Mr. Cheema provided a lock box for Resident N's insulin and proceeded with securing it in the refrigerator.

On 10/12/22, Resident E stated she receives her medications daily as prescribed. Resident E is not aware of any resident having medication on their chest or not being administered properly. Resident E stated Ms. Marshall properly took care of her but she did not administer her medications as Mr. Cheema did.

On 10/12/22, I received a return phone call from the reporting source. Regarding the allegations, the reporting source confirmed that Resident D was the resident who was observed to have three pills laying on top of his chest. The reporting source stated Ms. Ellsworth showed her a picture from her cell phone of the medication on Resident D's chest. The reporting source stated during Ms. Ellsworth day off, another staff member from an AFC group home in Mount Clemens was working at the AFC group home. When Ms. Ellsworth returned to the AFC group home, she observed the pills on Resident D's chest and took a picture of it. Ms. Ellsworth did not tell the reporting source what she did after she took the picture. The reporting source does not know any other details regarding the medication that was found on Resident D's chest. Resident D was known for sleeping most of the day. The reporting source stated shortly after, Ms. Ellsworth stopped showing up for work.

On 10/12/22, I completed an exit conference with the licensee designee, Zubair Ahmed. Mr. Ahmed was informed that the allegations will be substantiated, and a provisional license will be recommended. Mr. Ahmed was also informed that a corrective action plan will be required.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based on my findings above, there is sufficient information to confirm the allegations regarding Resident N’s wound care not being properly done. Resident N confirmed that Mr. Nizami did not complete her wound care correctly. Resident N stated cream is supposed to be applied to her wound and then a dressing soaked in Dakins is wrapped around her foot. Mr. Nizami did not know what to do and therefore he just re-wrapped her foot without applying any cream or the Dakins. Mr. Cheema confirmed that there are no written instructions in the home pertaining to how to complete Resident N’s wound care.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 10/12/22, I observed Resident N’s Lantus and Novolog insulin in the refrigerator without it being secured in a lock box.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on my findings above, there is sufficient information to confirm the allegation pertaining to Resident N not receiving her insulin as prescribed. Resident N confirmed that there was one instance when she did not receive her insulin at nighttime. Mr. Cheema confirmed that on 09/26/22, Resident N did not receive her 7:00 am dose of insulin on time.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	On 09/28/22, I received a copy of Resident N's MAR for the month of September 2022. According to Resident N's MAR, she was prescribed Lantus Solostar 100 units twice a day (8:00am and 8:00pm). This prescription was discontinued on 09/16/22. According to the MAR, there are missing staff initials for the 8:00am dose on 9/6/22, 9/8/22, 9/13/22. There are also missing staff initials for the 8:00pm dose on 9/2/22, 9/6/22, 9/9/22, and 9/11/22. Resident N was prescribed Lantus Solostar 100 units at night starting on 9/16/22. Resident N was also prescribed Novolog 100 units three times a day per sliding scale before meals. This prescription was discontinued on 9/16/22. According to the MAR, there are several staff initials missing throughout the different doses for this medication. Resident N was prescribed Novolog 100 unites three times a day with meals starting on 9/17/22. There are missing staff initials for the 11:00pm dose on 9/17/22, 3:00pm dose on 9/19/22, 3:00pm dose on 9/23/22, and 11:00pm dose on 9/24/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 09/28/22, Ms. Marshall confirmed that she does not know the five rights to administering medications. However, Ms. Marshall also confirmed that she administers Resident N's insulin as well as administer the other residents their medications. The licensee designee, Zubair Ahmed confirmed that Ms. Marshall did not receive an in-service training pertaining to administering medications until after 09/28/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend the issuance of a 1st provisional license.

10/13/22

Sheena Bowman
Licensing Consultant

Date

Approved By:

10/21/2022

Denise Y. Nunn
Area Manager

Date