GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2022

Sulayman Aninure
Anikare AFC
323 E Glenguile
Parchment, MI 49004

RE: License #: AM030412015
Investigation #: 2022A1024057
Anikare's Home

Dear Mr. Aninure:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On November 11, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030412015
Investigation #:	2022A1024057
Complaint Receipt Date:	09/26/2022
Investigation Initiation Date:	09/27/2022
Report Due Date:	11/25/2022
Licensee Name:	Anikare AFC
Licensee Address:	323 E Glenguile Parchment, MI 49004
Licensee Telephone #:	(269) 254-0241
Administrator:	Sulayman Aninure
Licensee Designee:	Sulayman Aninure
Name of Facility:	Anikare's Home
Facility Address:	328 E Morrell St Otsego, MI 49078
Facility Telephone #:	(269) 254-0241
Original Issuance Date:	06/30/2022
License Status:	TEMPORARY
Effective Date:	06/30/2022
Expiration Date:	12/30/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff found Resident A with no signs of life and did not seek medical attention until one hour and 20 minutes later.	Yes

III. METHODOLOGY

09/26/2022	Special Investigation Intake 2022A1024057
09/27/2022	Special Investigation Initiated – Telephone call with administrator and licensee designee Sulayman Aninure
09/27/2022	Contact - Telephone call made with direct care staff member Kip Pike
09/27/2022	Contact - Document Received Resident A's *Health Care Appraisal* (HCA), *Assessment Plan for AFC Residents*, *AFC Licensing Division-Incident/Accident Report*, and staff trainings
09/27/2022	Contact - Telephone call made left voicemail for Relative A1 and Relative A2
10/11/2022	Inspection Completed On-site with direct care staff member Kip Pike
11/11/2022	Contact - Telephone call received with Relative A1
11/11/2022	Exit Conference with licensee designee Sulayman Aninure
11/11/2022	Inspection Completed-BCAL Sub. Compliance
11/11/2022	Corrective Action Plan Requested and Due on 11/26/2022
11/11/2022	Corrective Action Plan Received
11/11/2022	Corrective Action Plan Approved

ALLEGATION:

Staff found Resident A with no signs of life and did not seek medical attention until one hour and 20 minutes later.

INVESTIGATION:

On 9/26/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged staff found Resident A with no signs of life but did not seek medical attention until one hour and 20 minutes later. This complaint further stated that on 9/20/2022 Resident A tested positive for COVID-19 and had congested heart failure. This complaint stated staff called the family when Resident A was found with no pulse on 9/26/2022 who instructed staff to call the funeral home and to refrain from performing any life saving techniques such as cardiopulmonary resuscitation (CPR).

On 9/27/2022, I conducted an interview with administrator Sulayman Aninure regarding this allegation. Mr. Aninure stated Resident A was ill had multiple health issues and was diagnosed with COVID-19 a few days before he passed away. Mr. Aninure stated after being diagnosed with COVID-19, Mr. Aninure observed Resident A was very tired and laid in his bed on most days. Mr. Aninure stated on the morning of 9/26/2022, Mr. Aninure assisted Mr. Pike with changing Resident A's adult brief and helped Resident A transfer to his chair where he was observed to fall asleep. Mr. Aninure stated Resident A seemed more lethargic during this time and was not able to stand independently as usual therefore Mr. Pike called Relative A1 who instructed him not to call emergency medical services and to allow Resident A to rest. Mr. Aninure stated he left the facility and a couple of hours later was notified by Mr. Pike that Resident A did not have a pulse. Mr. Aninure stated he instructed Mr. Pike to call 911 and to call the family however Mr. Aninure stated Mr. Pike failed to call 911 after speaking to the family and called the funeral home instead, who then advised Mr. Pike to call 911. Mr. Aninure stated Resident A had a Do Not Resuscitate order in place however the family never provided the actual documentation for this order to put in Resident A's record.

On 9/27/2022, I conducted an interview with direct care staff member Kip Pike who stated Resident A began to decline for about a week after he was diagnosed with Covid-19. Mr. Pike stated Resident A became more tired and eventually stopped walking on his own two days before passing away. Mr. Pike stated Resident A's family was made aware of Resident A's health status and advised Mr. Pike to not seek medical attention for Resident A as this was part of his Do Not Resuscitation order. Mr. Pike stated he changed Resident A's adult brief on the morning of 9/26/2022 and Resident A was observed to be extremely lethargic and noted he could no longer stand on his own without staff's assistance which was unusual for Resident A. Mr. Pike stated he checked on Resident A a couple of hours later and observed Resident A to be slumped over in his chair with no pulse. Mr. Pike stated he immediately called Mr. Aninure and Resident A's family who advised Mr. Pike to

call the funeral home. Mr. Pike stated the funeral home director instructed him to call 911, so he did but he stated this was about an hour after discovering Resident A with no pulse. Mr. Pike stated he did not initially call 911 because he wanted to respect the family's wishes of the DNR order that was in place for Resident A.

On 9/27/2022, I reviewed Resident A's *Health Care Appraisal* dated 7/29/2022. According to this appraisal, Resident A was diagnosed with Dementia, Anxiety, HTN, Diabetes Type II, Confusion and Constipation.

I reviewed Resident A's *Assessment Plan for AFC Residents* dated 7/25/2022. According to his assessment, Resident A's date of birth was 3/27/35 and he required assistance with all personal care needs and used a walker and wheelchair for mobility.

I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 9/26/2022 at 12:40pm. According to this report, when staff member Kip Pike entered in Resident A's bedroom, Resident A was observed not breathing. The report stated Resident A has a DNR in place therefore CPR was not given. The report also stated Mr. Aninure was called, Relative A1, the funeral home and then 911.

I also reviewed Mr. Pike's direct care staff trainings which included CPR/AED training certificate issued on 6/22/2022.

On 10/11/2022, I conducted an onsite investigation at the facility with direct care staff member Kip Pike who stated that although Resident A had a DNR in place, there was no documentation in Resident A's records to verify this. I found no concerns with the home conditions.

On 11/11/2022, I conducted an interview with Relative A1 who stated care staff members communicated with him and his brother regularly. Relative A1 confirmed that he instructed direct care staff to refrain from calling emergency medical services when he was informed that Resident A was demonstrating extreme fatigue while diagnosed with Covid-19. Relative A1 stated he was notified by Mr. Pike when Resident A became even more lethargic on 9/26/2022 and believed Mr. Pike handled the situation as Resident A wished. Relative A1 stated Resident A had a DNR in place and he has no concerns for how the staff members handled Resident A death and believe staff communicated effectively with him and other family members regarding the health status of Resident A up until his passing away.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on my investigation which included interviews with administrator Mr. Aninure, direct care staff member Kip Pike, review of Mr. Pike's staff trainings, Resident A's assessment plan, health care appraisal and incident report there is evidence direct care staff found Resident A with no signs of life yet did not seek medical attention by calling 911 or Resident A's physician until one hour and 20 minutes later. According to both Mr. Aninure and Mr. Pike on the morning of 9/26/2022 hours before Resident A passed away, Resident A showed signs of being extremely lethargic and was immobile which was unusual for Resident A however neither Mr. Aninure nor Mr. Pike sought needed attention by contacting Resident A's physician for guidance. Mr. Pike and Mr. Aninure further stated when Resident A was found with no signs of life by Mr. Pike, Mr. Pike did not call 911 until over an hour later after being instructed by the funeral home to call. Despite Relative A1 wishes for Resident A to not have contact with a hospital due a Do Not Resuscitation order in place, that was not verified by any documentation by Mr. Pike and/or administrator Mr. Aninure. Consequently, direct care staff should have obtained needed care immediately when Resident A was observed to have an adverse change in his condition when he appeared lethargic and was no longer able to stand on his own. In addition, Mr. Pike should have called 911 immediately when Resident A was found with no signs of life.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/11/2022, I conducted an exit conference with licensee designee Sulayman Aninure. I informed Mr. Aninure of my findings and allowed him an opportunity to ask questions or make comments.

On 11/11/2022, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore I recommend the current license status remain unchanged.

11/11/2022

Ondrea Johnson
Licensing Consultant

Date

Approved By:

11/16/2022

Dawn N. Timm
Area Manager

Date