GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 6, 2023

Queen Ogunedo
Grace Mercy Faith, LLC
2726 Clark Street
Jackson, MI 49202

RE: License #: AS380391105
Investigation #: 2023A0007009
Plymouth Street Home

Dear Ms. Ogunedo:

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,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604
(517) 763-0211

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380391105
Investigation #:	2023A0007009
Complaint Receipt Date:	01/17/2023
Investigation Initiation Date:	01/19/2023
Report Due Date:	03/18/2023
Licensee Name:	Grace Mercy Faith, LLC
Licensee Address:	2726 Clark Street Jackson, MI 49202
Licensee Telephone #:	(517) 414-6615
Administrator:	Queen Ogunedo
Licensee Designee:	Queen Ogunedo
Name of Facility:	Plymouth Street Home
Facility Address:	1506 Plymouth Street Jackson, MI 49202
Facility Telephone #:	(517) 795-1296
Original Issuance Date:	07/11/2018
License Status:	REGULAR
Effective Date:	07/11/2021
Expiration Date:	07/10/2023
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B both reside in the AFC home. The medical staff worker (Agency Worker #1) went to the home to check on Resident A. Agency Worker #1 knocked on the door for 15 minutes. There was no answer. The front door was tied shut with a cord and it could not be opened. Agency Worker #1 heard Resident A yelling that someone was at the door. The police were contacted. Police tried knocking at the front door, but there was no answer; they went to back door and staff finally answered the door. The caregiver was upset and stated he was sleeping.	Yes
Resident B had a black eye yesterday and the details of the black eye are unknown.	No
Additional Findings	Yes

III. METHODOLOGY

01/17/2023	Special Investigation Intake - 2023A0007009
01/17/2023	APS Referral Received.
01/19/2023	Special Investigation Initiated - On Site
02/03/2023	Contact - Document Sent - Police Report Requested.
02/06/2023	Contact - Document Received - Copy of Police Report #497-01242-23.
03/03/2023	Contact - Telephone call made - message left for Agency Worker #1. I requested a returned phone call.
03/03/2023	Contact - Telephone call made - Case discussion with Guardian B.
03/06/2023	Exit Conference conducted with Mrs. Ogunedo, Licensee Designee.
03/06/2023	Contact – Telephone call received from Mrs. Ogunedo.

ALLEGATIONS:

Resident A and Resident B both reside in the AFC home. The medical staff worker (Agency Worker #1) went to the home to check on Resident A. Agency Worker #1 knocked on the door for 15 minutes. There was no answer. The front door was tied shut with a cord and it could not be opened. Agency Worker #1 heard Resident A yelling that someone was at the door. The police were contacted. Police tried knocking at the front door, but there was no answer; they went to back door and staff finally answered the door. The caregiver was upset and stated he was sleeping.

INVESTIGATION:

As a part of this investigation, I reviewed the complaint, and the additional information was noted: Resident A was asked if he had eaten three different times. Resident A finally said that he had Cheerios; it was after 12:00 p.m. at that point.

On January 18, 2023, I spoke with APS Worker #1. She informed me that Resident C was the only resident in the home on her caseload. Resident C is her own guardian.

On January 19, 2023, I conducted an unannounced on-site investigation and made face to face contact with Mr. Ogunedo, Resident A, Resident B and Resident C. Mrs. Ogunedo arrived a little while later, after I arrived at the home.

I inquired about the incident and Mr. Ogunedo stated Agency #1 had a flood in the office; therefore, the care team was being sent out to the home. Agency Worker #1 came to see Resident A at the home. She was knocking on the door. Mr. Ogunedo stated that he did not know exactly how long she was outside knocking; however, it was approximately twenty to twenty-five minutes. Mr. Ogunedo confirmed that the police were contacted. Mr. Ogunedo stated that then he came upstairs and let the police into the home. Agency Worker #1 met with Resident A and then left. Mr. Ogunedo later called Agency #1 and stated they would appreciate a phone call to say that they are outside. He stated that he was not happy with their actions. Mr. Ogunedo stated they had an established protocol, which included if they’re going to stop by, to call. There was a question about if Agency #1 really called the facility to begin with.

When asked why it took him so long to answer the door, Mr. Ogunedo stated that he was doing laundry in the basement. Mr. Ogunedo stated that Resident A concluded that he was sleeping but he was not.

I inquired about the door being held shut with a cord, and Mr. Ogunedo informed that he did not know anything about that. I informed him that I saw a screw in the door

frame, next to the handle on the screen door. It appeared that a cord or rope could be wrapped around the screw and the door handle, preventing the screen door from being easily opened. I did not observe a cord or rope wrapped around the screen door, preventing egress. It should be noted that there was a previous rule violation as the screen door, leading to the required means of egress, was equipped with locking against egress hardware. To be in compliance with the rule, the locking mechanism was disengaged.

While at the home, I also interviewed the residents.
I interviewed Resident B. I inquired if she had breakfast, and Resident B replied, "No, I had something, it was toast." During the interview, Resident B appeared to be very confused.

According to Resident C, she has been placed in the home since August. I inquired how things were going and she stated she had nothing to complain about. Resident C informed me that she shares a room with Resident B. She also informed that they are the only occupants of the home who sleep on the second floor of the facility. I inquired about what she had for breakfast, she reported to have cereal, coffee, and her medications. Resident C reported to be full after breakfast, and that she gets plenty of food to eat in the home. I inquired if she has ever observed the front door held shut with a cord, and she informed that she has not.

I interviewed Resident A. I inquired about the incident in which it took Mr. Ogunedo a while to answer the door. Resident A stated, "I guess he was sleeping." Resident A informed me that their (the licensee's) bedroom is in the basement. I inquired what he does if he needs help and night, and Resident A replied, "I can help myself." He informed that staff helps Resident B a lot because she cannot take care of herself.

While at the home, I reviewed the resident files. I reviewed the weight records for Resident A. Mr. Ogunedo reported that one of Resident A's goals was weight loss. Resident A's weight fluctuated within ten pounds over the past year.

I also observed the home, including the basement and followed-up regarding the previous written corrective action plan that was submitted to determine continued compliance. It should be noted that there was a previous investigation regarding allegations that the Mrs. Ogunedo's family was sleeping in the basement of the facility. Mrs. Ogunedo submitted a written statement documenting that they would not utilize the basement for the purpose of sleeping pending a meeting with the city authorities regarding the city ordinances. Please see **SIR #2022A0007030** for additional information. Mr. Ogunedo reported that his family utilized one bedroom upstairs and one on the first level of the home. I observed mattresses on the floor (upstairs), a hospital bed (downstairs), and what appeared to be their belongings in the respective bedrooms.

During the on-site investigation, I observed that the facility did not have the food listed on the menu for two of the meals that day. Mrs. Ogunedo stated they were

taking the residents out for lunch that day. When I asked what the residents would be having for dinner, Mrs. Ogunedo stated it depends. Resident C was extremely excited to go out to lunch. Resident A did not want to go out for lunch, so it was determined that Mrs. Ogunedo would take Resident C with her and bring the food back to the home. Technical assistance was provided regarding the menus. The licensee was informed that the menus must be posted one week in advance, be dated, and any substitutions must be documented.

As a part of this investigation, I requested Police Report #497-01242-23 from The Jackson City Police Department. I received a brief report which documented that on January 16, 2023, law enforcement was dispatched to the home (12:04 p.m.) for a welfare check on Resident A. Agency Worker #1 had been knocking on the door for the past 30 minutes and there was no answer. Agency Worker #1 could hear Resident A yelling that there was someone at the door. There should always be a home care (giver) at the home. At approximately 12:15 p.m., law enforcement made face to face contact with the care worker and Resident A. It was noted that they were sleeping. The status of the complaint is in progress.

A review of the Original Licensing Study Report reflects that the applicant intends to provide 24-hour supervision, protection, and personal care to 5 male or female residents who are 18 to 75 years of age, are aged or have mental illness, physical handicaps, or developmental disabilities.

The staffing pattern includes a minimum of 1 staff for 5 residents per shift. The applicant acknowledged that the staff to resident ratio may need to be increased to provide the level of supervision or personal care required by the residents due to changes in their behavioral, physical, or medical needs. The applicant has indicated that direct care staff will be awake during sleeping hours.

On March 6, 2023, I conducted the exit conference with Mrs. Ogunedo. I explained the findings and my recommendations. She stated that she carries a phone with her in the home and visitors are expected to call. I explained to her the concern regarding the amount of time it took for staff (Mr. Ogunedo) to answer the door when a resident could be heard inside the home. I stated that if Mr. Ogunedo could not hear the door or the resident yelling for an extended period of time, how would he know to respond if a resident was in need of immediate care. I informed Mrs. Ogunedo that I would be requesting a written corrective action plan.

On this same day, a few minutes later, Mrs. Ogunedo called me back and inquired as to why there were established violations for the outdated paperwork. She stated that I came to the home to investigate one matter and then looked into other information. I explained to her that conducting a complete investigation often includes the review of resident documents and files; to assess if the care the residents required is being provided.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	According to Mr. Ogunedo, Agency Worker #1 came to see Resident A at the home. She was knocking on the door. Mr. Ogunedo stated that he did not know exactly how long she was outside knocking; however, it was approximately twenty to twenty-five minutes. Mr. Ogunedo stated they had an established protocol, which included if they're going to stop by, to call. There was a question about if Agency #1 really called the facility to begin with. Mr. Ogunedo confirmed that law enforcement was contacted. According to the police report reviewed, on January 16, 2023, law enforcement was dispatched to the home (12:04 p.m.) for a welfare check on Resident A. Agency Worker #1 had been knocking on the door for the past 30 minutes and there was no answer. Agency Worker #1 could hear Resident A yelling that there was someone at the door. There should always be a home care (giver) at the home. At approximately 12:15 p.m., law enforcement made face to face contact with the care worker and Resident A. It was noted that they were sleeping. During the interview with Resident A, I inquired about the incident in which it took Mr. Ogunedo a while to answer the door. Resident A stated, "I guess he was sleeping." While Mr. Ogunedo reported that he was not asleep, as he was doing laundry in the basement, it took a while for him to respond and answer the door. Resident A could be heard yelling from inside the home that someone was at the door. A significant amount of time passed, as there was enough time for law enforcement to be contacted, arrive on the scene, and to assist with getting staff to answer the door of this 24-hour supervised home. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that the amount of supervision and protection that was required by the residents was not provided in the home on January 16, 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(2) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.
ANALYSIS:	I inquired about the door being held shut with a cord, and Mr. Ogunedo informed that he did not know anything about that. I informed him that I saw a screw in the door frame, next to the handle on the screen door. It appeared that a cord or rope could be wrapped around the screw and the door handle, preventing the screen door from being easily opened. During my interview with Resident C, I inquired if she had ever observed the front door held shut with a cord, and she informed that she had not. While at the facility, I did not observe a cord or rope wrapped around the screen door, preventing egress. Based on the information gathered during this investigation, it's determined that there is not a preponderance of the evidence to support the allegations that the means of egress was obstructed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Resident B had a black eye yesterday and the details of the black eye are unknown.

INVESTIGATION:

I inquired about Resident B having a black eye. Mr. Ogunedo stated that Resident B hits and swipes at the other residents. Resident B got into it with Resident C. They were hitting each other, and it happened in the car. One resident was sitting too close to the other resident. Mr. Ogunedo stated that he did not see the beginning of the incident.

I inquired if he submitted an incident report as I did not recall seeing one. Mr. Ogunedo stated that he believed he had completed an incident report. At the end of my visit, Mr. Ogunedo provided me with a copy of the incident report.

I interviewed Resident B. I observed Resident B's left eye to be bruised. I asked what happened and Resident B stated, "I got hit by somebody." When asked who hit her, she stated "I don't know." Resident B then stated that she could not remember what happened. She also stated, "I don't think anybody knocked me out." During the interview, Resident B appeared to be very confused. A picture of the injury was taken for the file.

During the interview with Resident C, she stated that she did not know how Resident B got the black eye. Resident C recalled that Resident A and Resident B were in the back seat of the vehicle fighting. She saw Resident B hitting Resident A. I inquired what staff did when the residents were fighting, and Resident C stated that they separated them. Resident C stated that she did not care for Resident B.

I interviewed Resident A and inquired about how Resident B got the black eye. Resident A stated, "I bumped her." He stated that his elbow bumped her. He denied that they were fighting.

As a part of this investigation, I reviewed the incident report authored by Mrs. Ogunedo. Mrs. Ogunedo documented that on January 1, 2023, while on their way back from the community, Resident B began to attack, hitting the other resident (Resident C). It was noted that on Saturday, December 31, 2022, Resident B had these same behaviors. When Resident B attacked the other residents on January 1, 2023, they got mad and attacked her back. Resident B was hit in the eye.

The actions taken included staff would report to the family that Resident B is beginning to attack others; then encourage Resident C not to attack her back. Staff put a band aid on the open skin around the left eye, applied ice and gave Resident B Tylenol.

The corrective measures included staff would find out what triggers Resident B to attack people and report the information to her physician.

On March 3, 2023, I spoke with Resident B's daughter, Guardian B. Guardian B informed me that when she visited her mother, she did notice greenish bruising around her eye, as she had hit or bumped her head. I informed her of the information as reported in the incident report. Guardian B stated that her mother can be very opinionated, but she usually did not physically attack others. Guardian B stated that her mother does have dementia and it was possible that her behaviors may be changing. Guardian B then recalled that the facility staff did inform her that there was a confrontation between her mother and another resident; however, she was not aware that her mother attacked the other residents. Guardian B stated that she would be visiting her mother soon. Guardian B reported positive information regarding the licensee and the home. She appreciated the home-like setting and reported that her mother appears to be doing better in this home. Guardian B thanked me for following up with her.

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:	Mr. Ogunedo stated that Resident B hits and swipes at the other residents. Resident B got into it with Resident C. While in the car, the residents were hitting each other. I observed Resident B's left eye to be bruised. I asked what happened and Resident B stated, "I got hit by somebody." When asked who hit her, she stated "I don't know." Resident B then stated that she could not remember what happened. Resident C stated that she did not know how Resident B got the black eye. Resident C recalled that Resident A and Resident B were in the back seat of the vehicle fighting. She saw Resident B hitting Resident A. Resident A stated, "I bumped her." He stated that his elbow bumped her (Resident B). He denied that they were fighting. The residents and staff reported there was an altercation between the residents in the vehicle. Resident C reported that staff intervened once they observed the situation. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that Resident B was not treated with dignity and respect and her personal needs, including protection were not attended to at all times, in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The *AFC Assessment Plan* for Resident A was not signed and dated.

While Mr. Ogunedo reported the *AFC Assessment Plan* for Resident B was completed; there was no documentation available for review.

The *AFC Assessment Plan* for Resident C was completed and signed as required.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The *AFC Assessment Plan* for Resident A was not signed and dated, as required. The completed *AFC Assessment Plan* for Resident B was not available for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the home, I reviewed the resident files.

A review of the file for Resident A reflected that the *Resident Care Agreement* was last reviewed in October of 2019.

Resident B and Resident C's files reflected that the *Resident Care Agreements* were current.

Regarding the missing and or outdated documents, Mr. Ogunedo stated that he was catching up and updating the forms that day.

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:	The *Resident Care Agreement* for Resident A was outdated, and it had not been reviewed annually, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

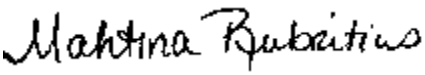
INVESTIGATION:

The *Resident Funds Part II* form for Resident C was incomplete and there was no documentation of payments received or paid for December of 2022.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	The *Resident Funds Part II* form for Resident C was incomplete.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



3/6/2023

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

3/6/2023

Ardra Hunter — Date
Area Manager