GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 11, 2024

Precious Reed
Divine Needs Assisted Living LLC
3139 Pine Run Drive
Swartz Creek, MI 48473

RE: License #:	AS250413989
Investigation #:	2024A0872011
	Divine Needs Assisted Living

Dear Precious Reed:

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250413989
Investigation #:	2024A0872011
Complaint Receipt Date:	12/01/2023
Investigation Initiation Date:	12/04/2023
Report Due Date:	01/30/2024
Licensee Name:	Divine Needs Assisted Living LLC
Licensee Address:	3139 Pine Run Drive Swartz Creek, MI 48473
Licensee Telephone #:	(810) 814-1265
Administrator:	Tamika Lang
Licensee Designee:	Precious Reed
Name of Facility:	Divine Needs Assisted Living
Facility Address:	4064 Sheraton Dr Flint, MI 48532
Facility Telephone #:	(810) 814-1265
Original Issuance Date:	02/01/2023
License Status:	REGULAR
Effective Date:	08/01/2023
Expiration Date:	07/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 11/29/23, Resident A was not given his insulin.	No
Additional Findings	Yes

III. METHODOLOGY

12/01/2023	Special Investigation Intake 2024A0872011
12/01/2023	APS Referral This complaint was referred by APS. Shwanda Lee is the APS Worker
12/04/2023	Special Investigation Initiated - Letter I exchanged emails with APS Lee
12/06/2023	Inspection Completed On-site Unannounced
12/08/2023	Contact - Telephone call received I spoke to the licensee designee, Precious Reed
01/10/2024	Inspection Completed-BCAL Sub. Compliance
01/11/2024	Exit conference – I conducted an exit conference with the licensee designee, Precious Reed

ALLEGATION: On 11/29/23, Resident A was not given his insulin.

INVESTIGATION: On 12/04/23, I exchanged emails with Adult Protective Services Worker (APS), Shwanda Lee. APS Lee said that she interviewed Resident A on 12/01/23. He told her that he did not receive his medication the day he was admitted to Divine Needs Assisted Living facility because it was not delivered by the pharmacy until 11pm that night.

On 12/06/23, I conducted an unannounced onsite inspection of Divine Needs Assisted Living Adult Foster Care facility. I interviewed Resident A and staff Ashyra Jones. I also took pictures of AFC documentation related to Resident A.

Resident A told me that he was admitted to Divine Needs AFC on the morning of 11/29/23. Resident A said that prior to this placement, he was in a nursing home. According to Resident A, when he was first admitted to Divine Needs AFC, his medications were not delivered. Resident A said that he takes long-acting and short-acting insulin medications, but they were not delivered by the pharmacy until after Resident A went to bed on 11/29/23. Resident A said that staff did check his blood sugar on 11/29/23 and it was at 275. However, they were unable to administer Resident A medication because the pharmacy had not delivered it. Resident A stated that on 11/30/23, staff checked his blood sugar again and since it was still high, they administered his insulin. According to Resident A, staff has been administering his medications since that date and he has not had any problems with his blood sugar being too high.

Staff Ashyra Jones confirmed that Resident A moved into this facility on 11/29/23. She said that she was not working on that date, but she was told that when Resident A was admitted, his insulin was not delivered until later that night. According to Staff Jones, to her knowledge, Resident A has been administered all his medications as prescribed since 11/30/23. Staff Jones showed me Resident A's electronic medication administration log (EMAR) and the prescription orders from his doctor.

I reviewed these documents and noted that Resident A's doctor ordered that his insulin medications to be started on 11/29/23. I reviewed the EMAR and noted that staff did not administer his medications on 11/29/23 noting that the medications were unavailable. Staff began administering his medications on 11/30/23 according to doctor's orders.

While at the facility, I observed four other residents who were finishing lunch. All four residents appeared clean, dressed appropriately, and were being properly supervised by staff.

On 12/08/23, I spoke to the licensee designee (LD), Precious Reed via telephone. LD Reed confirmed that Resident A was admitted to her facility on the morning of 11/29/23 but his medications were not delivered at that time and the medication orders were not entered into the EMAR. On 11/29/23 at approximately 11pm, Resident A's medications were delivered to the facility, but the orders were still not entered by the doctor into the EMAR.

LD Reed said that on the morning of 11/30/23, the orders were still not in the EMAR so the administrator, Tamika Lang contacted the pharmacy. On 11/30/23 at approximately 2pm, the pharmacy finally released the orders into Resident A's EMAR and staff began administering his medications as prescribed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A moved into Divine Needs Assisted Living AFC on the morning of 11/29/23. According to Resident A, staff Ashyra Jones, and the licensee designee, Precious Reed, Resident A's medications were not delivered by the pharmacy until that night, after Resident A went to bed. According to Resident A's electronic medication log (EMAR), his doctor put in his insulin orders on 11/29/23 but LD Reed said that the pharmacy did not input the doctor's orders until 11/30/23 at which time staff began administering Resident A's medications. Resident A, Staff Jones, and LD Reed said that Resident A has been administered his medications as prescribed since 11/30/23. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my onsite inspection on 12/06/23, I noted that there was a box of medications in bubble packs sitting in the dining room/living room area. Staff Jones told me that the medications were not locked up yet because they had not been inventoried by staff yet. Staff Jones said that all resident medications are usually kept in the locked medication cabinet.

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

	S333.1101 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:	During my onsite inspection on 12/06/23, I noted that there was a box of medications in bubble packs sitting in the dining room/living room area. Staff Jones told me that the medications were not locked up yet because they had not been inventoried by staff yet. Staff Jones said that all resident medications are usually kept in the locked medication cabinet. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable action plan, I recommend no change in the license status.

Susan Hutchinson January 11, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton January 11, 2024

Mary E. Holton Area Manager	Date