GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 29, 2024

Aniema Ubom
Care First Group Living & In-Home Services, Inc.
24111 Southfield Road
Southfield, MI 48075

RE: License #: AS630416241
Investigation #: 2024A0611017
The Trevino Residence

Dear Mr. Ubom:

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 (248) 975-5053.

Sincerely,

Sheena Worthy, 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 #:	AS630416241
Investigation #:	2024A0611017
Complaint Receipt Date:	02/27/2024
Investigation Initiation Date:	02/27/2024
Report Due Date:	04/27/2024
Licensee Name:	Care First Group Living & In-Home Services, Inc.
Licensee Address:	24111 Southfield Road Southfield, MI 48075
Licensee Telephone #:	(248) 331-7444
Administrator:	Leslie Ubom
Licensee Designee:	Aniema Ubom
Name of Facility:	The Trevino Residence
Facility Address:	1192 Trevino Drive Troy, MI 48085
Facility Telephone #:	(248) 331-7444
Original Issuance Date:	12/19/2023
License Status:	TEMPORARY
Effective Date:	12/19/2023
Expiration Date:	06/18/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 2/23/2024, Resident J had a seizure and EMS was called. Resident J was not given her medication to stop the seizure because her medication was in a different location. Staff waited 11 hours to call 911.	No
Additional Findings	Yes

III. METHODOLOGY

02/27/2024	Special Investigation Intake 2024A0611017
02/27/2024	APS Referral According to the intake email, this investigation is assigned to Adult Protective Services (APS) worker Carmen Smith.
02/27/2024	Special Investigation Initiated - Letter I emailed the Adult Protective Services Worker Carmen Smith regarding the allegations.
02/27/2024	Contact - Telephone call made I made a telephone call to Carmen Smith regarding the allegations. Ms. Smit was unaware of the allegations and had no information to provide.
02/27/2024	Contact - Telephone call made I attempted to contact the reporting source however; I was told I had the wrong phone number.
02/27/2024	Contact - Telephone call made I made a telephone call to Troy Beaumont hospital. I was informed that Resident J is still in the hospital. I left a voice message for a social worker to call me back.
02/29/2024	Inspection Completed On-site I made an unannounced onsite. I interviewed Nurse Alex Albritton, Nurse Arianna Jointer, and Resident J. I attempted to interview Resident P however; he refused to talk to me. During my onsite, I was informed that none of the residents files are kept in the home. I received a copy of Resident J's hospital discharge records and her MAR.

03/05/2024	Contact - Telephone call made I made a telephone call to the clinical case manager Merima Hadzialijagic. I requested a copy of Resident J's assessment plan, staff schedule, and incident report.
03/06/2024	Contact - Document Received I received copies of the staff schedule for the month of February, Resident J's assessment plan, two separate incident reports, and an internal report entitled "incident report addendum" via email from Ms. Hadzialijagic. Ms. Hadzialijagic also chose to send Resident J's service description and physician orders.
03/08/2024	Contact - Telephone call made I made a telephone call to Nurse Alex Albritton. Nurse Alex provided additional information.
03/08/2024	Contact - Telephone call made I made a telephone call to the AFC group home. I requested to speak to Nurse Helen Coston however; she was not available. I spoke to residential supervisor Markeda Mack-Shepard regarding the allegations.
03/12/2024	Contact - Telephone call made I made a telephone call to the clinical case manager, Merima Hadzialijagic. I received additional information regarding Resident J.
03/12/2024	Contact - Telephone call made I made a telephone call to Resident J's guardian, Khalilah Coney from Siporin Associates. The allegations were discussed.
03/12/2024	Contact - Telephone call made I made a telephone call to Resident J's case manager Doreen Kresnak. The allegations were discussed.
03/14/2024	Contact - Telephone call made I made a telephone call to Nurse Helen Coston. The allegations were discussed.
03/14/2024	Contact - Telephone call made I left a voice message for Nurse Kumba Kumara requesting a call back.
03/14/2024	Contact - Telephone call received I received a return phone call from Nurse Kumba. The allegations were discussed.

03/14/2024	Contact - Telephone call made I left a message for the licensee designee Aniema Ubom requesting a call back to conduct an exit conference.
03/15/2024	Contact - Document Sent I sent an email to the licensee designee, Aniema Ubom requesting for him to contact me to conduct an exit conference.
03/15/2024	Contact – Document Received I received an email from Adult Protective Services worker Carmen Smith. Ms. Smith stated she is still investigating but she is moving in the direction of not substantiating her case.
03/15/2024	Exit Conference I completed an exit conference with the licensee designee, Aniema Ubom via telephone.

ALLEGATION:

On 2/23/2024, Resident J had a seizure and EMS was called. Resident J was not given her medication to stop the seizure because her medication was in a different location. Staff waited 11 hours to call 911.

INVESTIGATON:

On 02/27/24 a complaint was received and assigned for investigation alleging that Resident J lives in a group home. Resident J is diagnosed with a seizure disorder, traumatic brain injury, spinal fusion. Resident J requires assistance with all ADLs and uses a wheelchair to get around. On 2/23/24, EMS was called to the home due to Resident J having a seizure. Resident J was transported to Troy Beaumont hospital as she had a seizure and at 5am. The seizure lasted 5-6 mins. Resident J was not given her medication to stop the seizure because her medication was at different location. The staff waited 11 hours before calling 911. Resident J had been in and out of responsiveness and was extremely altered. Resident J is normally very independent, moving around and able to communicate. Resident J was found staring off into space, unable to follow demands, and non-verbal. Staff were not able to provide any names of who was Resident J caregiver at that time.

On 02/29/24, I made an unannounced onsite. I interviewed Nurse Alex Albritton, Nurse Arianna Jointer, and Resident J. I attempted to interview Resident P however; he refused to talk to me. During my onsite, I was informed that none of the residents files are kept in the home. I received a copy of Resident J's hospital discharge records and her MAR.

On 02/29/24, I interviewed Nurse Alex Albritton. Nurse Alex explained that Resident J was currently at a rehab facility which she attends Monday through Friday. Resident J was hospitalized on 02/23/24 and discharged on 02/27/24. Resident J was transported to the hospital during the end of the dayshift around 3:15pm. The dayshift hours are 7:00am to 3:30pm. Nurse Alex was working the dayshift on the day in question. Nurse Alex never works the midnight shift. Resident J had a seizure in the morning before 7:00am which was before Nurse Alex arrived to the AFC group home. Nurse Alex stated when he arrived to the AFC group home, Resident J was lethargic. Resident J was responsive, but she was not at baseline. Nurse Alex administered all of the residents morning medications including Resident J. Resident J is prescribed Keppra to treat her seizures. Nurse Alex stated it is normal for Resident J to be lethargic post seizure. On the day in question, Resident J continued to look lethargic and groggy after she had a seizure. Resident J had not returned to baseline. Nurse Alex stated Resident J often has seizures, but this incident was the first time he witnessed the need to call EMS for Resident J. Nurse Alex started working for the AFC group home in January 2024. Nurse Alex was informed after Resident J was hospitalized that she had a UTI. Resident J seizure was triggered by her UTI. Nurse Alex stated he completed an incident report.

On 02/29/24, I spoke with Nurse Arianna Jointer. Regarding the allegations, Nurse Arianna stated she was not present on the day in question. Nurse Arianna and Nurse Alex stated the resident's medications are never not in the AFC group home. Resident J's medications go with her when she attends the rehab facility for physical therapy. I observed Resident J's medications specifically her Keppra (Levetiraceta SOL 100mg Disp. 02/28/24) and Monurol to treat her UTI. I observed Nurse Arianna and Nurse Alex in the process of organizing new medications for the residents for the month of March.

On 02/29/24, I was able to interview Resident J shortly after she returned to the AFC group home. Resident J was able to function independently as she was able to operate her motorized wheelchair. Resident J was observed to be properly groomed and dressed appropriately. Resident J stated she was feeling good and she likes living at the AFC group home. Resident J stated the staff treat her well and they make sure she has what she needs. Resident J has lived at the AFC group home for eight months. Regarding the allegations, Resident J stated she was in the hospital for four days. Resident J stated the day before she had the seizure (02/22/24), she was having trouble breathing which is not a normal symptom she has before she has a seizure. Resident J thought she was getting sick. Resident J informed the staff that she was having trouble breathing. Nurse Destiny gave Resident J a breathing treatment and her inhaler. Resident J stated this occurred during the afternoon shift around 7:00pm. Resident J stated she was still not breathing well after the breathing treatment and using her inhaler. Resident J stated she received her evening medications from Nurse Destiny and then she went to bed. Resident J thinks she slept through the night.

Resident J stated she does not remember anything that transpired the next morning (02/23/24). Resident J only remembers being at the hospital. Resident J does not remember if she took her morning medications on 02/23/24. Resident J stated normally

the staff make sure she gets her medications every day and night. Resident J stated she is always given her Keppra twice a day. Resident J denies ever missing a dosage of her Keppra. Resident J stated she does not know why her seizure was so bad. Resident J was informed by the hospital that her UTI may have caused her seizure. Resident J was unaware that she had a UTI before she was hospitalized.

Resident J stated as far as she knows all of the residents are administered their medications and they are taken care of. Resident J stated when she attends the rehab facility the staff sends her medications with her to take at the required time. Resident J stated when she is at the rehab facility, she takes her blood pressure medication and nicotine gum. Resident J takes her Keppra before she leaves the AFC group home. Resident J stated sometimes she misses some medications because the staff are waiting for the pharmacy to deliver the medications. Resident J stated this does not occur often. Resident J stated it does not take the pharmacy more than a day to deliver medications. Resident J stated the medication she has missed before was her nicotine gum and Robaxin for muscle spasm. Resident J is not prescribed Robaxin anymore. Resident J confirmed that she has never ran out of Keppra.

On 02/29/24, I attempted to interview Resident P however; he refused to talk to me.

On 02/29/24, I received a copy of Resident J's MAR for the month of February and a copy of her hospital discharge record. According to Resident J's hospital discharge record, she was admitted into the hospital on 02/23/24 and discharged on 02/27/24. There were two medications changes made for Resident J which consist of being prescribed Fosfomycin tromethamine (Monurol) and changes were made to her Levetiracetam (Keppra). Resident J is now prescribed to take Keppra 7.5ml every 12 hours. The hospital records indicate that Resident J's primary diagnosis was breakthrough seizures. Resident J was also diagnosed with urinary tract infection with history of multidrug-resistant organisms, altered mental status, metabolic encephalopathy, obesity, Bipolar 1 disorder, generalized anxiety disorder, history of spinal cord injury, neurogenic orthostatic hypotension, tobacco dependence syndrome, obstructive sleep apnea syndrome, generalized epilepsy, and tardive dyskinesia. Resident J's follow up appointments include a follow up with Dr. Pradep Nagaraju for urology, a follow up with Dr. Victor Ubom within one week of discharge, follow up with Dr. Esther Young for neurology within two weeks of discharge, and follow up with Dr. Christopher Dado on 04/17/24 at Corewell health William Beaumont University hospital pulmonary and sleep medicine.

According to Resident J's MAR, she is prescribed Fosfomycin powder 3mg (Monurol) since 02/28/24 and; ordered to discontinue on 03/03/24. Resident J was prescribed to take Monurol every other day. Resident J is also prescribed Levetiraceta SOL 100mg (Keppra) twice a day. Resident J was prescribed Keppra on 11/13/23 and this dosage/frequency was discontinued on 02/28/24. Resident J's MAR indicated that Resident J was administered Keppra twice a day with the exception of 9:00pm on 02/23/24, and 02/24/24 through 02/26/24 due to her hospitalization.

On 03/06/24, I received copies of the staff schedule for the month of February, Resident J's assessment plan, two separate incident reports, and an internal report entitled "incident report addendum" via email from Ms. Hadzialijagic. Ms. Hadzialijagic also chose to send Resident J's service description and physician orders.

According to the staff schedule, 12 staff members worked on 02/22/24. On 02/23/24, 10 staff members worked at the AFC group home. A list of the staff members are provided below:

Schedule for 02/22/24

- Antoinette Fairley- Nurse
- Markeda Mack- Residential Supervisor
- Arianna Jointer- Nurse
- Kierstyn Lewis- DCW
- Jameela Johnson- DCW
- Myana Lowllun- Rehab Technician
- Destiny Burke- Nurse
- Kelly Jefferson- DCW
- Cani Watkins- Nurse
- Terri Hall- DCW
- Lakeshia Webster- DCW
- Dangela Hayes- Residential Supervisor

Schedule for 02/23/24

- Amari Woodard- DCW
- Tanyejah Warren- DCW
- Alex Albritton- Nurse
- Markeda Mack-Shepard- Residential Supervisor
- Helen Coston- Nurse
- Katrina Howell- DCW
- Kayla Ray- DCW
- Lenya Boykin- DCW
- Trinity Gass- DCW
- Stacy Sharpe- Nurse

According to Resident J's assessment plan, the licensee designee Aniema Ubom signed the assessment plan on 06/14/23. Richard Lyons signed the assessment plan as Resident J's guardian on 06/14/23. The assessment plan does not include any medical follow up appointments.

The first incident report I received was from the licensee designee Animea Ubom dated 02/23/24. The time of the incident occurred on 4:19pm. According to the incident report, "At 4:19 p.m. resident was less responsive than usual. Knowing there is a history of seizure activity, we instituted non-stop observation. No response to yes/no questions. No respiratory distress. Bilateral hands noted with slight tremors. Would look at ceiling,

then close eyes. BP 119/76, P94". Under the section entitled action taken by staff, the incident report indicates "Temp 97.3, 02 93% on RA R16. - In an abundance of caution, sent resident to Beaumont Hospital via ambulance immediately. Remained at bedside until EMTs arrived. Updated EMTs as necessary". Mr. Ubom signed this incident report on 02/24/24. Helen Coston name was typed on the incident report as the person who completed the incident report however; Nurse Helen did not sign the incident report.

The second incident report I received was from Ms. Hadzialijagic. This incident report included the exact information written in the incident report provided by Mr. Ubom. However, this incident report was not signed by Mr. Ubom or by the person who completed the incident report.

The internal report entitled "incident report addendum" included the exact verbiage from the incident reports regarding the incident. This report also included Resident J's medical information. This report was not signed.

On 03/08/24, I made a telephone call to Nurse Alex Albritton. I asked Nurse Alex who he submitted the incident report to once he completed it. Although Nurse Alex reported that he completed an incident report during his first interview, he now stated that he didn't complete the incident report, but Nurse Helen Coston did. Nurse Helen arrived to the AFC group home on 02/23/24 around 3:00pm. Nurse Alex initially stated in his first interview, that Resident J was transported to the hospital around 3:15pm but, now he stated she was transported around 3:40pm. Nurse Helen called EMS. Nurse Alex does not know why Nurse Helen called EMS as he was in another room with another resident.

The nurse practitioner Kumba Kamara was present at the AFC group home the morning of 02/23/24. Nurse Alex was unsure if Nurse Kumba was at the AFC group home by happenstance or to see Resident J regarding her seizure. Nurse Alex could not recall if Nurse Kumba gave instructions pertaining to treating and/or monitoring Resident J. Nurse Alex stated he remembers completing neuro checks on Resident J and observing her every 15 minutes in her bedroom. Neuro checks include checking dilation of the eyes, alertness and orientation status, range of motion, and checking for any change in facial symmetry. Nurse Alex stated if there were any changes, he would have contacted Nurse Kumba. Nurse Alex ensured Resident J was given her medications and he documented the administration in her MAR.

On 03/08/24, I made a telephone call to the AFC group home. I requested to speak to Nurse Helen Coston however; she was not available. I spoke to residential supervisor Markeda Mack-Shepard regarding the allegations. Ms. Shepard stated on 02/22/24 she worked from 7:00am to 3:00pm. Ms. Shepard stated she went into Resident J's bedroom to get her up to take a shower. Resident J informed Ms. Shepard that she had a seizure. Ms. Shepard could see that Resident J was tired disoriented. Ms. Shepard allowed Resident J to stay in bed for about 30 to 60 minutes. Ms. Shepard informed Nurse Arianna that Resident J told her that she had a seizure. This occurred between 8:00am and 9:00am. Resident J did not tell Ms. Shepard when she exactly had the

seizure. Nurse Arianna went into Resident J's bedroom and examined her. Nurse Arianna instructed Ms. Shepard to take her vitals. Ms. Shepard stated between 30 to 60 minutes later, she got Resident J up for a shower. Resident J was now alert and was at the dining table talking. Ms. Shepard stated Resident J did eat something, but she cannot recall exactly what she ate. Nurse Arianna administered Resident J her morning medications. Ms. Shepard does not know what transpired after 12:00pm as she left the AFC group home to go to the main office. Ms. Shepard did not work at the AFC group home on 02/23/24.

On 03/12/24, I made a telephone call to the clinical case manager, Merima Hadzialijagic. Ms. Hadzialijagic stated Resident J did attend her follow up urology appointment with Dr. Nagaraju on 03/01/24. Ms. Hadzialijagic stated Resident J's case manager Doreen Kresnak was present at this doctor's appointment. Ms. Hadzialijagic stated Resident J was also seen either by their in-home doctor Dr. Victor Ubom or his nurse practitioner Kumba Kamara. Ms. Hadzialijagic could not provide a date to confirm if either Dr. Ubom or Ms. Kamara saw Resident J within a week of her discharge from the hospital. Ms. Hadzialijagic stated Resident J does have a neurology appointment with Dr. Tessy Jenkins on 05/14/24.

On 03/12/24, I made a telephone call to Resident J's guardian, Khalilah Coney from Siporin Associates. Regarding the allegations, Ms. Coney stated the allegations are not true. Ms. Coney has been Resident J's guardian since 09/19/17. Ms. Coney initially stated she signed Resident J's assessment plan. However, when I mentioned that someone else signature was observed on the assessment plan, Ms. Coney confirmed that Richard Lyons is one of her associates at Siporin Associates. Ms. Coney stated she is required by the court to visit Resident J once every quarter. Ms. Coney stated typically she visits Resident J once a month but, she has also visited Resident J weekly either at the AFC group home or at her doctor's appointments.

Ms. Coney communicates often with the administrator Leslie Ubom, Ms. Hadzialijagic, and Resident J's case manager Doreen Kresnak. Ms. Coney was notified of Resident J's seizure from Mrs. Ubom on 02/23/24. Mrs. Ubom stated Resident J had a seizure earlier that day and she was being monitored. Resident J was not feeling well that afternoon and she had a second seizure, which lead to EMS being called. Ms. Coney stated she was received an incident report on 02/24/24. Ms. Coney stated Resident J has seizures on a regular basis. Resident J also hallucinates which has resulted in her being hospitalized. Ms. Coney stated it is normal for Resident J to be tired after having a seizure. When Resident J has a seizure, the staff will notify her PCP to determine if a follow up appointment is necessary. Ms. Coney stated if Resident J's vitals are not within normal range after a seizure the staff will contact EMS.

Ms. Coney stated as far as she knows Resident J gets her medications as prescribed. Resident J has never told Ms. Coney that she has not received her medications. Ms. Coney stated Resident J is good at notifying her if she doesn't get her medications or if she has any medical concerns. Ms. Coney stated she attended Resident J's psychiatrist appointment on 02/28/24 with Dr. Ruza for a medication follow up. Ms. Coney was

contacted by Ms. Kresnak after Resident J's urology appointment. Ms. Coney was informed that this appointment was regarding a consult pertaining to Resident J getting a catheter to prevent further UTI's.

On 03/12/24, I made a telephone call to Resident J's case manager Doreen Kresnak. Ms. Kresnak has been Resident J's case manager since 2016. Ms. Kresnak is an independent case manager, and her role is to advocate for Resident J and coordinate with her insurance company. Regarding the allegations, Ms. Kresnak stated she was present for Resident J's urology appointment via telephone. Ms. Kresnak stated she does not know the name of the nurse that was present with Resident J at her urology appointment but, the nurse discussed Resident J's hospitalization. Resident J's UTI caused her medications to become less effective which ultimately lead to her seizure. Resident J receives a Botox injection into her bladder every six months and; she is due for her next injection. During the urology appointment, the doctor discussed Resident J getting a supra pubic catheter to prevent her from receiving additional UTI" s. Ms. Kresnak stated if Resident J gets the supra pubic catheter, she will not need to the Botox injections anymore.

Ms. Kresnak visits Resident J at the home or at therapy once a month. Ms. Kresnak stated she does not have any concerns about the care Resident J is receiving at the AFC group home. Ms. Kresnak stated this is the best home Resident J has ever lived in. Resident J has reported to Ms. Kresnak that the staff treat her like an adult and they are kind to her. Ms. Kresnak does not have any concerns that Resident J is not getting her medications. The home has a professional team. Ms. Kresnak stated this is the first home Resident J has done extremely well in. Ms. Kresnak stated Dr. Victor Ubom visits the AFC group home weekly or at the therapy center. Ms. Kresnak thinks Dr. Ubom saw Resident J a week after she was discharged from the hospital, or it could have been his nurse practitioner Nurse Kumba. Ms. Kresnak spoke with Nurse Kumba about Resident J's medications on 03/04/24. Nurse Kumba saw Resident J on 03/04/24. Ms. Kresnak stated it was determined that it was appropriate to keep Resident J's neurology appointment scheduled for 05/14/24 and to not move it up because her medication levels were adjusted in the hospital.

On 03/14/24, I made a telephone call to Nurse Helen Coston. Regarding the allegations, Nurse Helen stated on the day in question she arrived to the home around 3:10pm or 3:15pm. Nurse Helen stated she completed rounds with Nurse Alex Albritton. Nurse Helen stated they started at Resident P's bedroom and Resident J's bedroom was the last room they went into. Nurse Helen stated before they entered Resident J's bedroom, Nurse Alex informed her that he has been speaking to the nurse practitioner Kumba Kamara several times that day about Resident J not returning to baseline. Nurse Kumba was aware that Resident J had a seizure the night before. Nurse Helen stated she had not seen Resident J in two days. Nurse Alex informed Nurse Helen that Resident J was very lethargic, and she was delayed with responding to questions. Nurse Alex informed Nurse Helen that Resident J was given her medications. Nurse Helen entered Resident J's bedroom and her observed her affect to be very low. Resident J normally has a bubbly personality, and she is very independent. Nurse Helen stated she observed

Resident J to be breathing but not responsive. Nurse Helen rubbed her fist against Resident J's chest to stimulate her but there was no response.

Nurse Helen asked Resident J if she could hear her, and she faintly stated yes. Nurse Helen asked Resident J to follow her finger with her eyes but, she could not. Nurse Helen stated Resident J's arms were in a fixed upright position and they were trembling. Nurse Helen tried to put Resident J's arms down, but they went right back up. Nurse Helen contacted Nurse Kumba. Nurse Kumba stated she is aware of what is currently going on with Resident J including the seizure she had the night before. Nurse Kumba advised Nurse Helen that the staff had to feed her earlier that day. Nurse Helen explained to Nurse Kumba that she thinks something neurological is going on with Resident J. Nurse Kumba was not aware of the positioning of Resident J's arms. Nurse Helen informed Nurse Kumba that she wanted to send Resident J to the hospital.

Nurse Helen stated she contacted 911 and then she sent a text message to the administrator Leslie Ubom. Mrs. Ubom contacted Nurse Helen and stated she spoke to Nurse Kumba, and she thinks it's a good idea for Resident J to go to the hospital. Nurse Helen stated she had two staff members in Resident J's bedroom observing her. Nurse Alex was one of the staff members in Resident J's bedroom. Nurse Helen could not remember who the second staff member was in Resident J's bedroom. The police arrived to the home and Nurse Helen provided them with information. The EMS arrived to the home next. Nurse Helen stated she completed the required BCAL incident report by hand. Nurse Helen stated she also signed the incident report. Nurse Helen emailed a copy of the incident report to Mrs. Ubom and Nurse Kumba. Nurse Helen stated it was not reported to her that Resident J had more than one seizure that day or the day before. Nurse Helen stated she was informed that Resident J had a seizure about two weeks prior while Nurse Alex was present at the home. At that time, Resident J returned to baseline following her seizure. Nurse Helen stated she is not aware of any instances where Resident J was not administered her medications. Nurse Helen stated Resident J is very aware of the medications she is prescribed and when she is supposed to take them. Nurse Helen stated it has never been reported to her by a staff or resident that a resident has missed their medications.

On 03/14/24, I received a return phone call from Nurse Kumba. Regarding the allegations, Nurse Kumba stated normally when Resident J has a seizure, she returns to baseline within 20-30 minutes. On 02/23/24, Nurse Kumba arrived to the AFC group home early in the morning after Resident J had a seizure. Nurse Kumba was contacted by Nurse Alex regarding Resident J's seizure. Nurse Kumba stated Resident J had already returned to baseline and completed her normal routine before she arrived to the AFC group home. Nurse Kumba stated around 3:30pm or 4:00pm she received a call from Nurse Helen. Nurse Helen advised Nurse Kumba that Resident J had not returned to baseline after having another seizure. According to Nurse Kumba, Resident J did not have a seizure the night before but, she did have two seizures on 02/23/24. Nurse Kumba agreed with Nurse Helen to send Resident J to the hospital.

Nurse Kumba denied having any concerns regarding Resident J not receiving her medications. Resident J has frequent seizures and her dosage for Keppra has been adjusted. Nurse Kumba stated it has never been reported to her that Resident J has received her medications late.

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:	Based on my findings there is not sufficient information to confirm that Resident J's protection and/or safety was not attended to at all times. During the morning of 02/23/24, Nurse Kumba confirmed she observed Resident J and saw she had returned to baseline following her seizure. Nurse Alex completed neuro checks on Resident J and observed her every 15 minutes following her seizure throughout the dayshift. Resident J's case manager, Ms. Kresnak does not have any concerns about the care Resident J is receiving at the AFC group home. Ms. Kresnak stated this is the best home Resident J has ever lived in.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 and the information gathered, there is insufficient evidence to support this allegation. Resident J stated the day before she had the seizure (02/22/24), she was having trouble breathing which is not a normal symptom she has before she has a seizure. Resident J thought she was getting sick. Resident J informed the staff that she was having trouble breathing. The staff provided Resident J with a breathing treatment and her inhaler. Resident J then took her evening medications and went to bed. Resident J stated she does not remember anything that transpired the next morning.

	On 02/23/24, Nurse Kumba arrived to the AFC group home early in the morning after Resident J had a seizure. Nurse Kumba stated Resident J had already returned to baseline and completed her normal routine before she arrived to the AFC group home. When Nurse Alex arrived on day shift on 02/23/24, he observed Resident J to be lethargic. Resident J was responsive, but she was not at baseline. Nurse Alex stated it is normal for Resident J to be lethargic post seizure. Nurse Alex completed neuro checks on Resident J and observed her every 15 minutes following her seizure. During the onset of the afternoon shift, Nurse Helen arrived to the home and observed Resident J and noticed Resident J's arms were in a fixed upright position and they were trembling. Nurse Helen tried to put Resident J's arms down, but they went right back up. Nurse Helen contacted 911 to have Resident J transported to the hospital.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 02/29/24, I observed Resident J's medications specifically Keppra to treat her seizure disorder (Levetiraceta SOL 100mg Disp. 02/28/24). Resident J's MAR indicated that Resident J was administered Keppra twice a day with the exception of 9:00pm on 02/23/24, and 02/24/24 through 02/26/24 due to her hospitalization. Resident J stated she is always given her Keppra twice a day. Resident J denies ever missing a dosage of her Keppra.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my onsite, I was informed that none of the residents files are kept in the home. Nurse Arianna contacted Merima Hadzialijagic who is the clinical case manager for the AFC group home. Ms. Hadzialijagic confirmed that there are no physical residents files in the home. Ms. Hadzialijagic had to provide instructions to Nurse Alex and Arianna on

how to print a copy of Resident J's hospital discharge record and MAR. I informed Ms. Hadzialijagic that I would contact her at a later date to request documents regarding the investigation that are missing from the AFC group home.

On 03/15/24, I completed an exit conference with the licensee designee Aniema Ubom via telephone. Regarding the allegations, Mr. Ubom stated he has a nurse scheduled for each shift every day. Resident J is diagnosed with a seizure disorder, and she has been treated for her seizure disorder by her neurologist since she has been admitted into the AFC group home. Mr. Ubom stated per instructions from Resident J's neurologist (Dr. Jenkins) staff are expected to assess Resident J after she has a seizure and; if she does not return to baseline then the staff should send Resident J to the hospital. Mr. Ubom does not know if there is a specific timeframe allotted for Resident J to return to baseline. On the day in question, Resident J was being assessed throughout the day. Mr. Ubom stated a nurse indicated that Resident J had returned to baseline. At that time, Resident J was eating, talking, and didn't have any complaints. Nurse Kumba was in communication with the nursing staff at the AFC group home. Resident J had a second seizure and staff observed her to be more lethargic and less talkative which is why EMS was called. Mr. Ubom was informed that the allegations will not be substantiated but, he will be cited for not having any of the residents files in the home. A corrective action plan will be required.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.**

	(c) Date of discharge and the place to which the resident was discharged. **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**
ANALYSIS:	During my onsite on 02/29/24, I requested to review Resident J's file. However, I was unable to review Resident J's file because the AFC group home does not maintain any of their resident's file in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

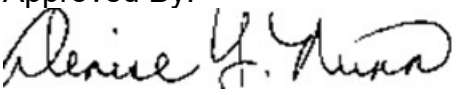
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

03/15/24

Sheena Worthy
Licensing Consultant

Date

Approved By:



03/29/2024

Denise Y. Nunn
Area Manager

Date