



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 #: 2024A0611018
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,

A handwritten signature in grey ink that reads "Sheena Worthy". The signature is written in a cursive style with a large, looping initial "S".

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 #:	2024A0611018
Complaint Receipt Date:	03/07/2024
Investigation Initiation Date:	03/07/2024
Report Due Date:	05/06/2024
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?
Staff refused to call 911 when Resident P requested.	No
Additional Findings	Yes

III. METHODOLOGY

03/07/2024	Special Investigation Intake 2024A0611018
03/07/2024	Special Investigation Initiated - Telephone I made a telephone call to the reporting source. The allegations were discussed.
03/19/2024	Inspection Completed On-site I made an unannounced onsite. I interviewed Nurse Alex Albritton, Nurse Arianna Jointer, house supervisor Kevin Austin, and Resident L. I attempted to interview Resident P but he refused. I received copies of Resident P hospital discharge records.
03/20/2024	Contact - Telephone call made I made a telephone call to Resident P's urologist Dr. Wilkinson. I left a message for Dr. Wilkinson to give me a call back.
03/20/2024	Contact - Document Received I received a copy of Resident P visit report from 03/06/24 when he saw Dr. Wilkinson.
03/21/2024	Contact - Telephone call received I received a return phone call from Whitney from Dr. Wilkinson office. Information was provided regarding Resident P.
03/21/2024	Contact - Telephone call made I left a voice message for Resident P's guardian requesting a call back.
03/22/2024	Exit Conference I completed an exit conference with the licensee designee Aniema Ubom via telephone.

ALLEGATION:

Staff refused to call 911 when Resident P requested.

INVESTIGATION:

On 03/07/24, a complaint was received and assigned for investigation alleging that Resident P suffers from: Quadriplegic from car accident, hypertension, and urinary retention. Today, Resident P was at the urologist, he has been having problems for a few weeks with urinary retention. On an unknown date, Resident P asked someone at the facility to call 911, and they refused to call for help for Resident P. It is unknown if Resident P had asked the staff or his guardian to call 911. Resident P vitals were stable. The doctor reported that there was significant blockage and Resident P needed to be brought to the hospital. Resident P was brought to Ascension Macomb Oakland in Madison Heights

On 03/07/24, I made a telephone call to the reporting source. The reporting source stated he has only been to the AFC group home one time. On 03/06/24, Resident P was transferred to his urologist appointment at Dr. Wilkinson's office. The doctor assessed Resident P and determined that he needed to go to the hospital to get a catheter put in due to urinary retention. Resident P was transferred to Ascension Madison Heights. The reporting source stated that Resident P stated while he was at the AFC group home, he tried to call 911 regarding his urinary retention. The reporting source stated he is unsure if the staff, or Resident P's guardian interfered with Resident P calling 911. The reporting source is also unsure if Resident P asked a staff member to call 911. The reporting source does not know what day this allegedly happened. The reporting source stated Resident P told him that he has been having an issue with his urinary retention for about 3-4 weeks. The reporting source does not know how long Resident P had to stay in the hospital to receive a catheter.

On 03/19/24, I made an unannounced onsite. I interviewed Nurse Alex Albritton, Nurse Arianna Jinter, house supervisor Kevin Austin, and Resident L. I attempted to interview Resident P but he refused. I received copies of Resident P's hospital discharge records.

On 03/19/24, I interviewed Nurse Alex Albritton. Nurse Alex advised that Resident P is present in the AFC group home. However, he is on a contact precaution as something was found in his urine while he was at the hospital that is contagious. Nurse Alex denied Resident P ever asking him or requesting to call 911. Resident P will push his call button and tell Nurse Alex that he feels like he has to urinate. Nurse Alex will then complete a straight cath procedure. Resident P would no longer complain of any pain because all of the pressure he was feeling has been relieved.

On 03/19/24, I attempted to interview Resident P by speaking to him on the AFC group home house phone. Nurse Alex presented the house phone to Resident P in his bedroom. However, Resident P stated he did not want to speak to me.

On 03/19/24, I interviewed the house supervisor Kevin Austin. Mr. Austin stated Resident P returned to the AFC group home yesterday after being discharged from the hospital. Resident P was admitted into the hospital on 03/06/24 and discharged 03/18/24. Mr. Austin stated he became the house supervisor this past Saturday. Mr. Austin stated for the past four months he has been working as a behavioral technician and he does not provide hands on care for Resident P. Mr. Austin stated Resident P has never complained of any health issues to him.

On 03/19/24, I interviewed Nurse Arianna Jointer. Regarding the allegations, Nurse Arianna stated Resident P was admitted into the hospital directly following his appointment with the urologist. Resident P was diagnosed with an urethral stricture. Resident P was in the hospital for so long because he became septic. Resident P received a suprapubic catheter while in the hospital.

Nurse Arianna stated before Resident P left for his urologist appointment on 03/06/24, she completed a straight cath procedure which emptied out his bladder. Nurse Arianna stated at times, Resident P would become frustrated with staff members for not being able to complete a straight cath procedure due to there being a blockage. Nurse Arianna stated sometimes staff would be successful with completing a straight cath procedure and sometimes they would not. Nurse Arianna stated whether or not a straight cath procedure was successful, Resident P was still voiding urine into his brief. Resident P's frustration with staff not being successful with completing a straight cath procedure started a few days after his indwelling foley catheter came out on its own. Resident P has bladder spasms that causes his body to resist the foley catheter. The reason why the staff had to start completing straight cath procedures is due to Resident P's indwelling foley catheter coming out. Resident P's indwelling foley catheter was supposed to be replaced at his urologist appointment.

Nurse Arianna stated Resident P did call the police during this month, but she was not present. The police and EMS arrived to the AFC group home. The EMS evaluated Resident P and took his vitals. Resident P complained because he thought he had a UTI. Nurse Arianna stated Resident P was scheduled to start taking antibiotics the next day for a UTI. Prior to EMS coming to the home, the staff obtained a urine sample from Resident P and sent it to Orchard laboratories. Meanwhile, the nurse practitioner Kumba Kamara prescribed a prophylactic for Resident P as a preventive measure for a UTI. However, the lab results indicated that Resident P did not have a UTI.

Nurse Arianna, Mr. Austin, and Nurse Alex confirmed that Resident P has a cell phone, iPad, and apple watch in his bedroom. Resident P has had these devices since his admission into the AFC group home. Resident P can use Siri to activate his devices. Resident P can also swipe his devices as well as send text messages. Resident P often sends text messages to the administrator. Nurse Arianna stated a resident only has to ask in order to use the house phone.

Nurse Arianna stated today Resident P refused to take his morning medications. It is common for Resident P to tell staff he is not ready to take his medications as opposed to refusing to. Resident P is prescribed Baclofen and Oxybutynin to treat his bladder. Nurse Arianna and Nurse Alex have a good rapport with Resident P therefore; for him to refuse to take his medications means he does not want to be bothered. Resident P is known to be an unhappy person who complains a lot.

On 03/19/24, I interviewed Resident L. Resident L has lived at the AFC group home for five days. Resident L stated so far she likes living at the AFC group home. Resident L stated she is administered medications daily by staff. Resident L stated the staff has never missed a day of administering her medications. Resident L stated if she has any medical issues or concerns the staff will address it. Resident L stated if she needs medical attention or wants to call 911 she can do so right away. Resident L has a cell phone that was observed in her bedroom. Resident L is aware that she has the option of using the house phone as well. Resident L stated it appears that the staff take care of all of the residents.

On 03/19/24, I received a copy of Resident P's hospital discharge paperwork. According to the medical records, Resident P was admitted on 03/06/24. Resident P was diagnosed with Urethral stricture. Resident P's problems are listed as: acute renal failure, acute sepsis, severe systemic inflammatory response syndrome, UTI due to urinary indwelling catheter. On 03/07/24, Resident P received a catheter insertion suprapubic, and a prostatectomy suprapubic on 03/09/24.

On 03/20/24, I received a copy of Resident P's visit report from 03/06/24 when he was seen by his urologist Dr. Wilkinson. According to the visit report, Resident P was seen for a urethral stricture. Resident P's symptoms were retention and slow stream. A flexible cystoscopy procedure was performed. The lower urinary tract was carefully examined. The procedure was well-tolerated without complications. Resident P next scheduled appointment is 04/08/24.

On 03/21/24, I received a return phone call from Whitney on behalf of Dr. Wilkinson's office. During Resident P's urologist appointment on 03/06/24, they were unable to insert a Foley catheter due to there being built up tissue in Resident P's urethra that prevented the tube to go through. As a result, Resident P was sent to the hospital because the procedure could not be performed at the doctor's office. Whitney stated there were no reports of concerns regarding abuse or neglect from the AFC group home.

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 the information gathered, there is no evidence to support this allegation. On 03/6/24, Resident P attended his scheduled urologist appointment with Dr. Wilkinson. Dr. Wilkinson's visit report did not indicate any concerns regarding the care or treatment at the AFC group home. On 03/21/24, I spoke to Whitney from Dr. Wilkinson's office and, she confirmed that Dr. Wilkinson does not have any concerns of abuse or neglect from the AFC group home. Resident P did not confirm the allegations as he refused to be interviewed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/19/24, Resident L stated that her only complaint is that her bedroom is not big enough to fit her power wheelchair due to the size of her hospital bed. I did not observe a chair in Resident L's room and/or closet. I did observe that Resident L's closet door handle is falling apart.

On 03/22/24, I completed an exit conference with the licensee designee Aniema Ubom via telephone. Mr. Ubom was informed of which violations he will be cited for and that a corrective action plan will be required.

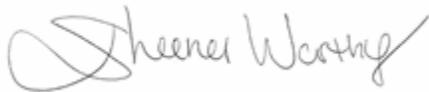
R 400.14410	Bedroom furnishings.
	(1) The bedroom furnishings in each bedroom shall include all of the following: (d) At least 1 chair.
ANALYSIS:	On 03/19/24, Resident L confirmed that her power wheelchair does not fit inside her bedroom. I did not observe a chair in Resident L's bedroom.
CONCLUSION:	VIOLATION ESTABLISHED

R 400.14403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	On 03/19/24, I observed Resident L's bedroom closet door handle to be falling apart.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

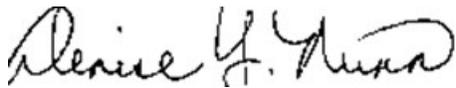


Sheena Worthy
Licensing Consultant

03/22/2024

Date

Approved By:



03/29/2024

Denise Y. Nunn
Area Manager

Date