GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 2, 2024

Tema Pefok
Precious AFC Home, Inc.
7435 Silver leaf Lane
West Bloomfield, MI 48322

RE: License #: AS820414983
Investigation #: 2024A0101020
Merritt

Dear Mrs. Pefok:

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820414983
Investigation #:	2024A0101020
Complaint Receipt Date:	02/27/2024
Investigation Initiation Date:	02/29/2024
Report Due Date:	04/27/2024
Licensee Name:	Precious AFC Home, Inc.
Licensee Address:	7435 Silver leaf Lane West Bloomfield, MI 48322
Licensee Telephone #:	(248) 506-5329
Administrator:	Tema Pefok
Licensee Designee:	Tema Pefok
Name of Facility:	Merritt
Facility Address:	32116 Merritt Drive. Westland, MI 48185
Facility Telephone #:	(734) 956-6420
Original Issuance Date:	04/20/2023
License **Status:**	REGULAR
Effective Date:	10/20/2023
Expiration Date:	10/19/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• An unknown staff pushed Resident A. • An unknown staff threatened to slap Resident A. • Staff talk down to Resident A. • Resident A does not feel safe in this home.	No
On 03/27/2024, the Department received additional allegations regarding a resident residing at the Merritt Home. Twice this week a resident of the group home was in the neighbor's backyard, and he opened her door.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/27/2024	Special Investigation Intake 2024A0101020
02/27/2024	Referral received from APS and ORR
02/29/2024	Special Investigation Initiated - Telephone Home manager Kia Flowers
02/29/2024	Spoke with Resident A's guardian, Caprice McCrary, Belser's Helping Hands
03/08/2024	Inspection Completed On-site
03/27/2024	Contact - Telephone call made Licensee Designee, Tema Pefok
03/27/2024	Contact - Document Received
03/28/2024	Exit Conference Ms. Pefok
03/29/2024	Contact – Telephone received Ms. Pefok

ALLEGATION:

- An unknown staff pushed Resident A.
- An unknown staff threatened to slap Resident A.
- Staff talk down to Resident A.
- Resident A does not feel safe in this home.

INVESTIGATION: On 02/29/2024, I spoke with the home manager, Kia Flowers. Ms. Flowers denied the allegations. Ms. Flowers stated filing false accusations is Resident A's behavior.

On 02/29/2024, I spoke with Resident A's guardian, Caprice McCrary, Belser's Helping Hands. Ms. McCrary stated, "[Resident A] will file 7 to 10 complaints a day with Recipient Rights." Ms. McCrary stated Resident A has been in 30 to 40 homes and he was discharged from those homes for the same reasons, constantly making up false allegations and filing complaints. Ms. McCrary stated Resident A wants to be institutionalized. Ms. McCrary stated Resident A will say and do anything to get out of the home. She also stated Resident A has had multiple appointed guardians. Ms. McCrary stated anything new to him is fine but when he hears the word no, he perceives it as abuse.

I spoke with Resident A on 03/01/2024. He retracted all allegations of abuse.

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:	There is no evidence to determine that licensee designee, Tema Pefok, failed to protect Resident A at all times. Home manager, Kia Flowers and Resident A's guardian both stated one of Resident A's behaviors is constantly making up false allegations and filing complaints. Furthermore, Resident A retracted all allegations of abuse.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 03/27/2024, the Department received additional allegations regarding a resident residing at the Merritt AFC Home. Twice this week a resident of the group home was in the neighbor's backyard, and he opened her door.

INVESTIGATION: On 03/27/2024, I spoke with licensee designee, Tema Pefok. Ms. Pefok stated it was Resident A in the neighbor's backyard. Ms. Pefok was upset because she believes Resident A's guardian, Caprice McCrary, Belser's Helping Hands and the responsible agency deliberately withheld information regarding Resident A's behaviors. Ms. Pefok stated the following plan has been put in place. Resident A and his guardian were given a 30-day notice. Additional staff have been added to the staff schedule until then. However, Resident A's guardian and responsible agency have not restricted Resident A's ability to move independently in the community.

APPLICABLE RULE	
R 400.14206	**Required personnel policies.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years. 2) The written policies and procedures identified in subrule (1) of this rule shall be given to employees and volunteers at the time of appointment. A verification of receipt of the policies and procedures shall be maintained in the personnel records.
ANALYSIS:	The ratio of direct care staff to resident was not adequate. Ms. Pefok stated it was Resident A in the neighbor's backyard. Trespassing places Resident A risk of harm and it happened twice. Due to Resident A's history, the department has determined that adequate staffing was not provided to Resident A while in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Licensee designee, Tema Pefok accepted and retained Resident A for care and did not complete a written assessment to determine if he was suitable. On 03/08/2024, I reviewed Resident A's resident record. A pre-assessment was not contained in the resident record.

On 03/28/2024, I conducted an exit conference with Ms. Pefok. Ms. Pefok initially stated the agency completed the assessment. I provided Ms. Pefok technical assistance with licensing rule 301 (2). It is the licensee's responsibility to determine if a resident is suitable.

On 03/28/2024, Ms. Pefok forwarded me a copy of Resident A's treatment plan, that she received at the time of Resident A's placement, 02/09/2024. The treatment plan was dated 10/27/2023. The treatment plan addresses services, goals and interventions that would be provided by the responsible agency. It does not address services, goals, or interventions for the group home staff. Furthermore, Ms. Pefok or a representative on her behalf did not attend that meeting. The treatment plan referenced some red flags that should have been a concern for Ms. Pefok and used to determine if the home could meet Resident A's needs. For example, Resident A needs assistance with following the "activities of the court order." The treatment plan addressed interventions for how the responsible agency will deal with Resident A's behaviors, therapy, medication, etc., but it did not state what those behaviors are.

On 03/29/2024, Ms. Pefok called me stating that she does not want to be cited. I reiterated my findings and the reasons she is in violation. Ms. Pefok reluctantly agreed with my finding. Later that day home manager, Kia Flowers contacted me. Ms. Flowers stated the home was "blindsided because when she picked Resident A up from the hospital, they did not disclose his behaviors." I explained to her it is the licensee's responsibility to determine if a resident is suitable.

On 03/29/2024, Ms. Pefok and Ms. Flowers stated that there was an assessment completed to determine Resident A is suitable and is in his resident record. A copy of the assessment was e-mailed to me. The assessment plan that was emailed was not an assessment completed to determine Resident A's suitability for placement. The assessment plan that was emailed had additional violations. The assessment plan was not completed at the time of placement, and it is incomplete. Ms. Pefok and Resident A's guardian signed the assessment plan on 02/15/2024. Resident A's date of placement is 02/09/2024. The assessment plan is also incomplete, the name of the designated person is missing, there is missing information in the medical section, sections VIII, IX and X are not filled in and the assessment plan does not contain the signature of a representative from the responsible agency.

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. (b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home. (c) The resident appears to be compatible with other residents and members of the household. (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:	Ms. Pefok accepted and retained Resident A for care and did not complete a written assessment to determine if he was suitable. On 03/08/2024, I reviewed Resident A's resident record. An assessment of Resident A to determine that he is suitable was not contained in the resident record. Ms. Pefok also failed to complete Resident A's assessment plan at the time of placement and his assessment plan is incomplete. Ms. Pefok and Resident A's guardian signed the assessment plan on 02/15/2024. Resident A's date of placement is 02/09/2024. Resident A's assessment plan is also incomplete, the name of the designated person is missing, there is missing information in the medical section, sections VIII, IX and X were not filled in and the assessment plan does not contain the signature of a representative from the responsible agency.
CONCLUSION:	**VIOLATIONS ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

03/29/2024

Edith Richardson — Date
Licensing Consultant

Approved By:

04/02/2024

Ardra Hunter — Date
Area Manager