GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 20, 2024

Andrew Akunne
Homestead Residences, Inc.
3879 Packard
Suite A
Ann Arbor, MI 48108

RE: License #: AS630016029
Investigation #: 2024A0991027
Homestead Res Of Beverly Hills

Dear Andrew Akunne:

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:

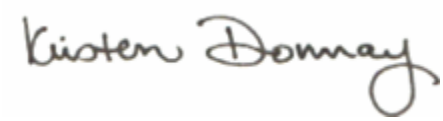
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

The issuance of a six-month provisional license was previously recommended in special investigation report #2024A0991009 dated 02/23/24, which remains in effect. You submitted documentation agreeing to the issuance of a provisional license on 03/28/24 and the 1st provisional was issued effective 03/28/24.

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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630016029
Investigation #:	2024A0991027
Complaint Receipt Date:	06/24/2024
Investigation Initiation Date:	06/25/2024
Report Due Date:	08/23/2024
Licensee Name:	Homestead Residences, Inc.
Licensee Address:	3879 Packard - Suite A Ann Arbor, MI 48108
Licensee Telephone #:	(734) 973-7764
Licensee Designee:	Andrew Akunne
Name of Facility:	Homestead Res Of Beverly Hills
Facility Address:	16252 Elizabeth Beverly Hills, MI 48025
Facility Telephone #:	(248) 839-5486
Original Issuance Date:	11/18/1994
License Status:	1ST PROVISIONAL
Effective Date:	03/28/2024
Expiration Date:	09/27/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Tykia Tyson, goes out to her car frequently during her shifts and is not attending to the needs of the residents in the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/24/2024	Special Investigation Intake 2024A0991027
06/24/2024	Referral - Recipient Rights Received from Recipient Rights
06/25/2024	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker
06/26/2024	Inspection Completed On-site Unannounced onsite inspection- interviewed residents and home manager
06/27/2024	Contact - Document Received Individual plans of service and crisis plans
06/28/2024	Contact - Telephone call made Interviewed Shanta Brown
06/28/2024	Contact - Telephone call made To Tykia Tyson- no voicemail
07/03/2024	APS Referral Referred to Adult Protective Services (APS)
07/09/2024	Contact - Telephone call made To Natalie Hall, ORR worker
07/09/2024	Contact - Telephone call made Interviewed area manager, Kim Scott

07/10/2024	Contact - Telephone call made To Natalie Hall, ORR worker
07/10/2024	Contact - Telephone call made Left message for Tykia Tyson
07/10/2024	Contact - Telephone call made Left message for home manager, Lilian Ogbu
08/05/2024	Contact - Telephone call received From Natalie Hall, ORR worker
08/05/2024	Contact - Telephone call made Left message for Tykia Tyson
08/07/2024	Contact - Document Received Disciplinary action forms for Tykia Tyson
08/12/2024	Contact - Document Received Email from assigned APS worker, Donna Dennis
08/14/2024	Contact - Telephone call made Left message for Tykia Tyson
08/14/2024	Contact - Telephone call received Interviewed Tykia Tyson
08/14/2024	Contact - Telephone call made Left message for APS worker, Donna Dennis
08/19/2024	Inspection Completed On-site Unannounced onsite inspection- interviewed residents and home manager
08/19/2024	Contact - Document Received Copies of medication logs
08/20/2024	Exit Conference Via telephone with licensee designee, Andrew Akunne

ALLEGATION:

Direct care worker, Tykia Tyson, goes out to her car frequently during her shifts and is not attending to the needs of the residents in the home.

INVESTIGATION:

On 06/24/24, I received a complaint from the Office of Recipient Rights (ORR) alleging that two of the residents at Homestead Res of Beverly Hills reported that staff, Tykia Tyson, is going out to her car frequently and is not attending to the needs of the residents. I initiated my investigation on 06/25/24, by contacting the assigned ORR worker, Natalie Hall. Ms. Hall stated that she received written complaints regarding Tykia Tyson from two of the residents in the home. She interviewed Resident B and Resident E via telephone. Ms. Hall provided the following information from her interviews with Resident B and Resident E.

During Ms. Hall's phone interview with Resident B on 06/18/24, Resident B stated, "Tykia does nothing but sit on the couch or go out to her car." Resident B was unable to give specific dates for when this occurred, but she stated that it has happened more than once. Resident B said, "Sometime, maybe about a month ago, Tykia yelled at me not to get out of bed until she woke me up." She stated that Tykia "gets nasty with people when they ask her for something. She has a bad disposition."

Resident B stated that Resident D requires "constant redirection." She stated that she has had to provide redirection for Resident D when Tykia Tyson was in her car, as there is only one staff on shift in the home. She stated that the redirection given to Resident D was to prevent her from sitting on the couch in a spot that causes difficulties with Resident E. She could not give specific dates when this occurred.

Resident B also stated that on an unspecified date in the past couple weeks, there was an occasion when she couldn't find staff, Tykia Tyson, in the house. She realized Tykia was in her car, so she called Tykia on her phone. Resident B stated, "She got mad at me for calling her in her car." Resident B said, "Sometimes staff call me to have me get Tykia when she's in her car because they can't reach her." Resident B stated that she feels it's not right that she has to act like the staff person when Tykia is working.

During Ms. Hall's phone interview with Resident E on 06/18/2024, Resident E stated that Resident D needs constant supervision, but on several unspecified dates, Resident D was left without staff supervision while staff, Tykia Tyson, was in her car. Resident E stated that on one of these occasions three of the housemates were eating at the table, Resident D was in her room, and Tykia Tyson was in her car by herself on her phone, eating and drinking "I don't know what."

Resident E stated that on another occasion, while Tykia Tyson was in her car, Resident B came to her room to report that Resident D was sitting on a couch in the living room alone. Resident E stated that when Tykia Tyson returned to the home, she walked past Resident D and Resident E, and she continued to leave Resident D unattended.

Resident E also stated that recently, on an unknown date, Resident C needed help cleaning up from her period. Resident E said that it was close to the time Resident C would be picked up for her day program and she was soiled and in need of assistance

to clean up and get ready for her pick up. Resident E asked Tykia Tyson if she knew what to do to help Resident C and Tykia Tyson stated, "no" and then left the room. Resident E stated that she took it upon herself to assist Resident C to get her cleaned up for day program. Resident E stated that she doesn't feel it's right that she's having to do a staff person's responsibilities.

On 06/26/24, I conducted an unannounced onsite inspection at Homestead Res of Beverly Hills with the assigned ORR worker. I interviewed Resident B. Resident B was hesitant to answer questions. She stated that staff, Tykia Tyson, has changed and is “doing a lot better now.” She stated that when the power went out recently, Ms. Tyson helped to coordinate things and got them to a place with power. She stated that Ms. Tyson was going out to her car “quite a bit” but she does not do this anymore. She stated that this was occurring on at least half of Ms. Tyson’s shifts. Resident B stated that she was not sure how long Ms. Tyson was in her car when she sat in her car. Resident B stated that Resident D has a hard time and staff are supposed to be with her. There have been times when Resident B had to “keep the peace.” She stated that Ms. Tyson has been doing better for at least a week and she regrets making a complaint. Resident B said that this is the best home she has lived in, and Lilian is the best manager. Nobody told her to retract her complaint.

On 06/26/24, I interviewed Resident E. Resident E stated that she wants to take back what she said about Ms. Tyson. She stated that Ms. Tyson has “learned her lesson.” She said that she was frustrated because Ms. Tyson was not doing her job, but this has improved. Ms. Tyson is “really good” with Resident C now and they have a good rapport. She stated that Ms. Tyson was threatened with losing her job, so she is doing better now. She further stated that Ms. Tyson “messed up” and realized what she was doing was wrong, so she decided to change. Resident E stated that what Ms. Tyson was doing previously was wrong. She stated that there was one occasion about two and a half weeks ago when Resident C needed help because she was on her period. Resident E asked Ms. Tyson to help Resident C, but Ms. Tyson said no. Resident E stated that she helped Resident C take her pants down and put a sanitary pad on, because she was going to be getting picked up for day program soon. Resident E stated that she has professional experience, so she can help. She stated that there were four times when Ms. Tyson was negligent in a one to one and a half week timeframe. Resident E stated that Ms. Tyson would sit in her car for “30-45 minutes, no more and no less.” She stated that there are two residents in the home who require close supervision, as one has the mind of a toddler, and one has the mind of a five- or six-year-old child. Resident E stated that nobody told her to retract her statement or change what she was saying.

Resident E provided copies of written notes she had made regarding the incidents with Tykia Tyson. The notes indicated the following:

- 1st Incident: Clients were sitting at the table eating. (Resident D) was in her room. Tykia was sitting in her car eating, drinking, and scrolling on her phone in the driveway.
- 2nd Incident: Tykia was out in her car doing I don't know what. (Resident B) came to my door stating that (Resident D) had come out of her room and was sitting on one of the couches, the one across from the big screen tv, by herself alone.
- 3rd Incident: Tykia left (Resident D) while she was sitting in her car. Came back in, walked right past me into the kitchen, still leaving me with (Resident D) who obeyed me and stayed on her private couch across from her private tv set too.
- 4th Incident: (Resident C) was bloody with her period bad. I asked Tykia if she knew what to do for her. She said no and went into (Resident D)'s room. I grabbed a period pad from (Resident C)'s room, grabbed (Resident C), took her into the bathroom, and changed (Resident C)'s pad right then and there. She still had blood in her panties. I couldn't change them too. (Resident C) was nearly late for her program over this incident too.

On 06/26/24, I interviewed the home manager, Lilian Ogbu. Ms. Ogbu stated that Resident C and Resident D were currently at workshop. She stated that they both have limited verbal abilities and would not be able to participate in an interview. Ms. Ogbu stated that she was working at another home and just came to Homestead Res of Beverly Hills as the home manager in the beginning of May. The previous acting home manager, Shanta Brown, stepped down to a worker position and subsequently quit. She stated that Shanta Brown and Tykia Tyson did not get along and were "involved in a cold war." She believed that Ms. Brown helped the residents write their complaints to ORR and pushed them to make a report. Ms. Ogbu stated that they have one staff per shift at the home. Staff are required to be in the home at all times. Staff can eat their meals in the dining room or living room. They should not be going out to their cars to eat. Ms. Ogbu stated that Resident D should be in eyesight when she is in the home. Resident D cannot speak verbally and has the mind of a five-year-old. Resident D requires frequent redirection and supervision.

Ms. Ogbu stated that she could not recall the date, but on one occasion, Resident B called her on the phone and told her that Ms. Tyson was outside in her car and had left her with Resident D. Ms. Ogbu stated that she called the home's landline and called Ms. Tyson on her cell phone, but she did not answer. She stated that she called Resident B and told her to go give Ms. Tyson the phone. She assumed Resident B went outside and gave Ms. Tyson the phone. She spoke to Ms. Tyson and asked her where was she. Ms. Tyson told her that she was eating dinner. Ms. Ogbu stated that when she came into work for her next shift, Resident E also told her that Ms. Tyson left them alone in the home. She stated that Resident B was not around when Resident E pointed at Ms. Tyson and gave her a signal. Resident E

then came into the office area and told Ms. Ogbu that Ms. Tyson left Resident D alone and she was the one taking care of her. Resident D walked up to Resident E and Resident E had to take her by the hands. Ms. Tyson was in her car during this time. Ms. Ogbu stated that she told the area manager, Kim Scott, and Ms. Tyson was written up. She was given a three-day suspension and was put on a two-month probationary period.

Ms. Ogbu stated that about two weeks ago, Resident E also told her that she had to help Resident C when Resident C was on her period. Resident E told her that Resident C woke up in the morning and was on her period and had stains on her clothes. Resident E told Ms. Ogbu in front of Ms. Tyson that she had to help Resident C change her pad and clothes. Ms. Ogbu stated that she told Ms. Tyson that it is their responsibility to make sure the residents are clean and well cared for. Ms. Tyson told her that she did change Resident C. Ms. Ogbu stated that she did not see any stained or soiled clothes with Resident C's laundry. She stated that Resident E is "like a mama" and takes care of everyone.

I asked Ms. Ogbu for a copy of the disciplinary action form from when Ms. Tyson was suspended for three days. She provided a form dated 05/20/24 which indicates an infraction date of 05/17/24. It states that on 05/17/24, medication was out of the bubble pack and was not signed for Resident C and Resident D. Staff was previously in-serviced on medications. The form indicates that Ms. Tyson was suspended on 05/21/24, 05/22/24, and 05/25/24 and will return to work on 05/26/24. Ms. Ogbu stated that this suspension was also related to Ms. Tyson leaving the residents unattended in the home, but that was not included on the disciplinary action form. She provided an employee probationary form dated 05/20/24, which indicates that Tykia Tyson was placed on a 60-day probation due to multiple write-ups and warnings. It indicates that due to being on probation previously, Ms. Tyson is now on a second probation starting 05/20/24 until 07/20/24. Any type of infraction regarding medication or insubordination could or will result in removal from the Beverly Hills Homestead location.

On 06/28/24, I interviewed direct care worker, Shanta Brown, via telephone. Ms. Brown stated that she was previously the home manager at Homestead Res of Beverly Hills. She stepped down to assistant manager/med tech, then to direct care worker, and then she quit. Her last day working in the home was 06/23/24. Ms. Brown stated that she did help two residents write complaints to ORR, but the complaints were written in their own words. She did not tell them what to say and they each wrote their complaints separately. She stated that management got upset with her because she allowed the residents to file complaints. Ms. Brown stated that staff, Tykia Tyson, was previously written up for her behavior and then continued to go on with neglecting the residents. She stated that they have one staff per shift at the home. Resident B and Resident E were complaining to her that they have to take care of other residents in the home, because Ms. Tyson keeps leaving the home. She stated that she reported this issue to upper management, but nothing was done,

so she told the residents that they could file a complaint with ORR. Ms. Brown stated that staff are required to be in the home at all times, unless they are taking out the trash or checking the mail. Ms. Brown stated that Resident D needs to be checked on at least every 10 minutes. Resident D is non-verbal and gets up and moves around a lot. She makes sounds if she wants assistance. Resident D likes to bounce up and down on the couch, so she has her own spot on the couch. Staff have to frequently redirect Resident D to her spot, because the other residents get annoyed if she goes to the other side of the couch. She stated that Resident C leaves when Resident D comes into the room. They have to be kept in separate areas in order to avoid conflicts. Ms. Brown stated that Resident E told her that she had to help Resident C change her pad when she was on her period because staff would not help her. She stated that Resident B also called the home manager, Lilian Ogbu, several times about Ms. Tyson not doing her job and having to take care of Resident C. She stated that Resident B got skeptical after making the complaint, because she thought the home manager, Lilian, was not very happy about it.

Ms. Brown stated that every time she pulled up to the home for her shift, Ms. Tyson was sitting in her car and there was no staff in the home. She later stated that it was “the majority of the time” rather than every time. She stated that she reported this to the area manager, Kim Scott, but Ms. Scott never did anything about it. Ms. Brown stated that there was one occasion when Resident B was having a medical emergency because her blood sugar was low. The midnight staff was with Resident B and the ambulance was at the home. Ms. Tyson arrived for her shift, but did not come into the home, because she was waiting for the commotion to die down. Ms. Brown stated that Ms. Tyson is hostile and is not approachable. Ms. Tyson was written up for her behavior when Ms. Brown was the home manager, but she could not recall if it was for sitting in her car. The paperwork was sent to the main office. She stated that her relationship with Ms. Tyson started out great, but Ms. Tyson responded in a negative way when given feedback from Ms. Brown as the home manager. Ms. Brown stated that she would talk to her about not changing Resident C’s linens or about needing to clean on the midnight shift and Ms. Tyson would argue and state that people were getting on her back about things.

On 07/09/24, I interviewed the program manager, Kim Scott. Ms. Scott stated that she was aware of some issues with Tykia Tyson that were brought to her attention by the previous home manager, Shanta Brown. She stated that Ms. Brown had a lot of complaints about Ms. Tyson, and she advised her that she would have to write Ms. Tyson up and put her on probation. She stated that she heard another resident was taking care of Resident D because Ms. Tyson was sitting in her car. She was not sure if Ms. Tyson was written up for this. She stated that there was another incident that Ms. Brown reported when the police and paramedics were at the home for a medical emergency and Ms. Tyson did not come into the home until it was over. She stated that there was a lot of back and forth between Ms. Brown and Ms. Tyson, as they had a big conflict and did not get along. She advised Ms. Brown on what to write up, as it is the home manager’s responsibility to write up staff. Ms.

Scott stated that Ms. Tyson's biggest problem is that she does not take direction from staff. She screams at staff and does not take redirection. Ms. Scott stated that she could not even speak to Ms. Tyson. She stated that Ms. Tyson was put on probation following a medication error, in which she did not sign for medications, and then she submitted her resignation from the home. The new home manager, Lilian Ogbu, felt that she would be able to work with Ms. Tyson and asked her to stay. Ms. Scott stated that she does pop-in visits at the house regularly between 8:00am-4:00pm. She stated that there has been a lot of turn over with management, as the home has had three new managers in the last three to four months. She stated that she never did a pop-in visit when Ms. Tyson was working, as she typically works midnights. She stated that there have not been any major issues with Ms. Tyson since Ms. Ogbu took over as manager.

On 08/14/24, I interviewed direct care worker, Tykia Tyson, via telephone. Ms. Tyson stated that she worked in the home for six or seven months. She stated that she is no longer working in the home or for the company. When asked if she quit or was fired from her position she stated, "maybe both." Ms. Tyson denied sitting in her car to eat dinner or take a break. She stated that she never sat in her car. She would eat meals in the same house as the residents and would go to another part of the home if she needed a break. She stated that there was never a time when she was not in the house and the residents could not find her. She stated that she was not written up for sitting in her car.

Ms. Tyson stated that Resident C and Resident D require visual checks every 15 minutes and need more hands-on assistance. Ms. Tyson stated that she never refused to help Resident C when she was on her period. She stated that Resident C had her period every month for the six months she worked in the home, and she always dealt with it, so she had no reason to tell her no on one occasion. She was not aware of the other residents helping to care for Resident C or Resident D. She stated that Resident C has meltdowns, so the other residents try to calm her down sometimes. The other residents might hand her a sanitary pad or give her encouragement, but they never provide hands on assistance. Ms. Tyson stated that there was an occasion when she arrived for her shift and an ambulance was at the home. She stated that this was happening during shift change, so she waited in her car until everything was clear so she could speak to staff about what was going on. She stated that this happened within a day or two of another resident passing away in the home during her shift, so she was still going through a lot. Ms. Tyson could not recall a time when the home manager, Lilian Ogbu, tried to call her and a resident came to her car with the phone. She stated that she was never in her car when Ms. Brown came to work.

Ms. Tyson denied being rude to the residents and stated that she never told anyone that they had to stay in bed until she woke them up. She stated that she was one of the best workers in the home. She admitted that she was suspended for a few days. She thought the suspension was for insubordination, because she told the home

manager how she felt. She stated that she did not think she was written up for a medication error or for sitting in her car. She stated staff are supposed to sign and acknowledge their write-ups, but she had no clue about her write-ups until “someone got mad and wanted to do the most.”

Ms. Tyson stated that she knew Shanta Brown made the complaint against her to be spiteful, because she lost her management position, and they did not get along. She stated that Ms. Brown was always trying to take her hours and kept moving her around on the schedule. She stated that none of the allegations were true.

I received and reviewed a copy of Resident C’s Crisis Prevention and Safeguard Plan effective 12/01/2023. The plan notes that caregivers should be within visual contact of Resident C every 15 minutes. It notes that staff should monitor Resident C’s mood, as she may harm herself when alone. Resident C is a risk for elopement and eloped from a second story window in March 2020. I reviewed a copy of Resident C’s Individual Plan of Service (IPOS) Periodic Review dated 04/23/24. It notes caregivers will assist with all basic care so as to promote Resident C’s physical health and well-being including, but not limited to, assisting with toileting, hand washing, oral hygiene, etc.

I reviewed a copy of Resident D’s Crisis Prevention and Safeguard Plan effective 06/01/2024. The plan notes that Resident D is not able to stay at home alone because she lacks safety, personal care, and cognitive skills and has an unsteady gait. When not in eyesight of caregivers, visual checks will be completed every 15 minutes to assure health and safety. The plan notes that situations to avoid or limit that may trigger a crisis include being unable to complete a desired activity, perceiving an immediate need being unfulfilled, and being ignored or left alone.

On 08/19/24, I conducted an unannounced onsite inspection at Homestead Res of Beverly Hills. I interviewed Resident E. Resident E stated that things are going well at the home. She stated that Tykia Tyson is no longer working at the home. The new staff in the home are excellent and she did not have any complaints.

On 08/19/24, I attempted to interview Resident C. Resident C has limited cognitive abilities and answered “yeah” or “what?” to most questions. When asked if she ever had problems with staff, Tykia, Resident C said, “yeah.” When asked what kind of problems she had, Resident C responded, “across the street.” She could not elaborate or provide additional information. When asked who helps her when she is on her period, Resident C stated, “I do.” When asked if Resident E has ever helped her while she was on her period, Resident C said, “yeah.” When asked what kind of help Resident E gave her, Resident C said, “put a pad on.”

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 the information gathered through my investigation, there is sufficient information to conclude that staff did not attend to the personal needs, including protection and safety, of the residents at all times. Direct care worker, Tykia Tyson, denied the allegations that she sat in her car during her shift and did not attend to the needs of the residents. However, Resident B and Resident E both stated that Tykia Tyson sits in her car during her shifts, leaving the residents alone in the home. Resident B and Resident E have been responsible for looking after the other residents in the home while Ms. Tyson was in her car. The previous home manager, Shanta Brown also stated that Ms. Tyson was frequently in her car when she arrived for her shift. The current home manager, Lilian Ogbu, stated that Resident B and Resident E have come to her about Ms. Tyson leaving them alone in the home during her shift. On one occasion, Ms. Ogbu tried to reach Ms. Tyson by telephone during her shift. She was unsuccessful and had to ask Resident B to go outside and give Ms. Tyson the phone.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0991009 dated 02/23/24; CAP dated 03/20/24**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that supervision, protection, and personal care as specified in the resident's written assessment plan was not provided when Tykia Tyson left the residents unattended and sat in her car. Resident E stated

	that there were occasions when Ms. Tyson sat in her car for 30-45 minutes during her shift. Resident C and Resident D's crisis plans note that staff must complete visual checks every 15 minutes. Resident C's plan notes that she requires caregiver assistance with toileting and hygiene. Resident E and Resident C stated that there was a time when Resident E had to assist Resident C with changing her sanitary pad when she was on her period, as Ms. Tyson did not provide assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my investigation, I requested copies of the disciplinary action forms for direct care worker, Tykia Tyson. I received and reviewed an employee disciplinary action form dated 04/18/24 for a violation related to medication documentation. The disciplinary action form notes that the count for Resident B's controlled medication Neurontin was found to be inaccurate on the morning of 04/12/24. Tykia Tyson had counted the medications the night before and initialed the count with another staff's initials. The other staff told the home manager that she was not aware of having to count any medications and that she never counted the medications with Ms. Tyson or signed her name to the count. Staff, Tykia Tyson, forged the staff's name on the medication record. The write up also states that on 04/17/24 staff, Tykia Tyson, did not initial some of the boxes on the MAR (medication administration record) sheets for Resident B's 8:00am morning medications after passing each medication. Tykia Tyson did not initial Resident C's MAR sheet for three days on 04/15, 04/16, and 04/17 for her birth control medications. The program manager spoke to Ms. Tyson and she stated that she forgot. Ms. Tyson attended an in-service on medications by the office staff prior to this. The disciplinary action form notes that Ms. Tyson was suspended for one day on 04/18/24 for the 12-8 shift due to the infraction. It notes that an in-service was done prior to this on medications and that Ms. Tyson's position at the Beverly Hills home may be re-evaluated if there are further violations, as there are no other staff to pass medications since there is only one staff per shift.

I also received and reviewed an employee disciplinary action form dated 05/20/24 which notes an infraction date of 05/17/24. It states that on 05/17/24, medication was out of the bubble pack and was not signed for Resident C and Resident D. Staff was previously in-serviced on medications. The form notes that Ms. Tyson was suspended on 05/21/24, 05/22/24, and 05/25/24 and will return to work on 05/26/24. I reviewed an employee probationary form dated 05/20/24, which notes that Tykia Tyson was placed on a 60-day probation due to multiple write-ups and warnings. It notes that due to being on probation previously, Ms. Tyson is now on a second probation starting 05/20/24 until

07/20/24. Any type of infraction regarding medication or insubordination could or will result in removal from the Beverly Hills Homestead location.

On 08/19/24, I conducted an unannounced onsite inspection at Homestead Res of Beverly Hills. I reviewed the medication administration records (MARs) and medications for all of the residents in the home from April 2024-August 2024. I noted that Resident B's April 2024 MAR was initialed by Tykia Tyson on 04/17/24 and Resident C's April 2024 MAR was initialed showing that Tykia Tyson administered her birth control pill on 04/15/24, 04/16/24, and 04/17/24. Resident C and Resident D's May 2024 MARs were also initialed by Tykia Tyson on 05/17/24.

The home manager, Lilian Ogbu, stated that if staff forget to initial the MAR, they are called back to the home to come initial the medication logs. She stated that she was not the home manager in April, but when the medication documentation error happened in May, she called Ms. Tyson back to the home to in initial the medication book. Ms. Tyson was written up and a note was made in the staff log, reminding all staff to initial the MARs. Ms. Ogbu stated that she verified that the medication was passed, as staff also initial the back of the medication bubble packs at the time they pass the medication. I did not note any additional medication errors.

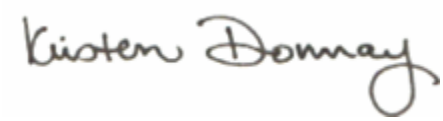
On 08/20/24, I conducted an exit conference via telephone with the licensee designee, Andrew Akunne. Mr. Akunne stated that staff, Tykia Tyson, had been giving them problems, but she is no longer working in the home. He stated that they have been struggling with being short staffed, so it makes it difficult to terminate staff. I advised Mr. Akunne that any additional quality of care violations would result in disciplinary action, and he expressed an understanding.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff, Tykia Tyson, did not initial the medication log at the time medication was given on 04/15/24, 04/16/24, 04/17/24, and 05/17/24. Ms. Tyson was written up and suspended for medication documentation errors after she failed to initial the medication logs on these

	dates. My review of the medication administration records on 08/19/24 showed that they were initialed. However, the home manager, Lilian Ogbu, stated that they have staff come back and initial the medication logs after they identify the error.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommended the issuance of a 1st provisional license in special investigation report # 2024A0991009, dated 02/23/24. Contingent upon the receipt of an acceptable corrective action plan, the recommendation for a provisional license remains in effect.



08/20/2024

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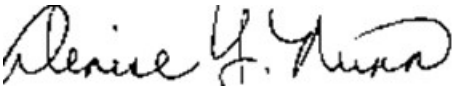
Kristen Donnay Date
Licensing Consultant

Approved By:



08/20/2024

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Denise Y. Nunn Date
Area Manager