GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 13, 2024

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

RE: License #: AS630380735
Investigation #: 2025A0611006
Boulan 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 #:	AS630380735
Investigation #:	2025A0611006
Complaint Receipt Date:	10/25/2024
Investigation Initiation Date:	10/31/2024
Report Due Date:	12/24/2024
Licensee Name:	Care First Group Living & In-Home Services, Inc.
Licensee Address:	24111 Southfield Road Southfield, MI 48075
Licensee Telephone #:	(248) 331-7444
Administrator:	Aniema Ubom
Licensee Designee:	Aniema Ubom
Name of Facility:	Boulan Residence
Facility Address:	1710 Boulan Drive Troy, MI 48084
Facility Telephone #:	(248) 331-7444
Original Issuance Date:	06/24/2016
License Status:	REGULAR
Effective Date:	08/03/2023
Expiration Date:	08/02/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Employee was terminated because they did not feel comfortable giving medications without proper training. Staff member Kevin has been stealing medications from residents and owners keep switching him from house to house.	Yes
Residents suffer because facility does not want to lose money by sending them to the hospital.	No

III. METHODOLOGY

10/25/2024	Special Investigation Intake 2025A0611006
10/30/2024	APS Referral An Adult Protective Services (APS) referral was made.
10/31/2024	Inspection Completed On-site I completed an unannounced onsite. I interviewed Resident Y, Resident W, staff member Lakindra Mitchell, staff member Nehderi Knowlyn, and the program director Merima Zander. I received a copy of all the resident's MAR for the month of October.
10/31/2024	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed Resident Y, Resident W, staff member Lakindra Mitchell, staff member Nehderi Knowlyn, and the program director Merima Zander. I received a copy of all the resident's MAR for the month of October.
11/01/2024	APS Referral I received an email stating Adult Protective Services denied investigating these allegations.
11/08/2024	Contact - Telephone call made I made a telephone call to PTA program director, Merima Zander. Ms. Zander provided additional information regarding Resident K and Resident W medications.
11/08/2024	Contact - Telephone call made I made a telephone call to staff member Kevin Austin. The allegations were discussed.

11/12/2024	Contact - Telephone call made I left a voice message for staff member Latricia Ward requesting a call back.
11/12/2024	Contact – Telephone call received I received a telephone call from staff member Latricia Ward. The allegations were discussed.
11/12/2024	Contact – Document received I received a copy of the medication training tracker for the month of September and October. I also received a copy of Resident Y MAR.
11/12/2024	Exit Conference I completed an exit conference with the licensee designee Aniema Ubom via telephone.

ALLEGATION:

Employee was terminated because they did not feel comfortable giving medications without proper training. Staff member Kevin has been stealing medications from residents and owners keep switching him from house to house.

INVESTIGATION:

On 10/25/24, a complaint was received and assigned for investigation alleging that an employee was terminated because they did not want to give medications to residents without the correct certification and training. Staff member Kevin Austin has been stealing medication from residents and the owners keep switching him from house to house. Residents are left to suffer because the facility does not want to lose money by sending them to the hospital.

On 10/31/24, I completed an unannounced onsite. I interviewed Resident Y, Resident W, staff member Lakindra Mitchell, staff member Nehderi Knowlyn, and the program director Merima Zander. I received a copy of all the resident's MAR for the month of October.

On 10/31/24, I interviewed Resident Y. Resident Y stated she moved into the AFC group home around this past spring. Resident Y stated the staff are wonderful. Resident Y does not like the way the program director (Cheyenne) speaks to her. The program director talks to her like she is her mother. Resident Y stated that she has voiced her concerns about the program director to management. Regarding the allegations, Resident Y stated there was a staff member by the name of Toya who left the AFC group home last month because the program director got smart with her. Toya worked at the AFC group home for a short period of time. Resident Y stated Toya was not

trained to administer medications. Resident Y confirmed that she is administered her medications every day by staff members. The staff never forget to administer Resident Y's medications. The AFC group home never runs out of Resident Y's medications. Resident Y stated the other residents are administered their medications on time as well.

Resident Y stated Kevin Austin is a supervisor and he works at the AFC group home more than once a week. Mr. Austin does administer medications when there isn't a medication passer on shift. The last time Resident Y saw Mr. Austin at the AFC group home was last week.

On 10/31/24, I interviewed Resident W. Resident W was wearing a Halloween costume and it was hard to understand him through the mask he was wearing. Resident W stated he has lived at the AFC group home for four years. Resident W stated it was ok living at the AFC group home but he does not like Resident Y's attitude. Regarding the allegations, Resident W stated the staff ensures that he gets his medication every day. Initially, Resident W stated the AFC group home runs out of his medications once in a while but, when asked to elaborate, Resident W stated the home never runs out of his medications.

Resident W stated Mr. Austin works at the AFC group home and; he sometimes administers medications. Resident W stated when Mr. Austin administers his medications, he gives him his medications as prescribed. Resident W ended the interview as he did not want to answer any more questions.

I interviewed the supervisor, Lakindra Mitchell. Ms. Mitchell stated there are four residents in the AFC group home. Resident K is non-verbal and Resident D is not present at the home. Regarding the allegations, Ms. Mitchell stated normally a medication passer or rehab technician will administer the resident's medications. A supervisor will administer medications if a medication passer or rehab technician is not working. Ms. Mitchell stated when a staff member is hired, they are considered a direct care staff for the first 30 days. When an employee has worked for 30 days, they then become a medication passer. After 90 days of employment, the employee is fully trained and then becomes a rehab technician.

Ms. Mitchen stated Mr. Austin is a supervisor at another AFC group home (The Tutbury Residence AS630406615). Ms. Mitchell stated Mr. Austin does not work at Boulan Residence unless he is needed. Ms. Mitchell is not aware of any employee being terminated. The staff schedule rotates daily between five different AFC group homes. There is not a set number of staff that works at the AFC group. Ms. Mitchell does not know who is scheduled to work at the AFC group home until the day of.

Ms. Mitchell is not aware of any staff member stealing medications. Ms. Mitchell stated she has not worked with Mr. Austin in a long time. Ms. Mitchell stated when a resident is administered a narcotic, the staff complete a narcotic medication count form. Ms. Mitchell was unable to print off a copy of the narcotic medication count form.

On 10/31/24, I reviewed all of the oral medications for every resident. All of the medications, appeared to have been administered correctly for the month of October. However, I observed that Resident Y's Lorazepam .5mg expired on 08/27/24. This medication is a PRN. The PTA program director, Merima Zander arrived to the home and provided an electronic copy of the MAR for all the residents. According to the MAR for Resident K, the medications appear to be administered correctly with the exception of there not being any staff initials on 10/5/24 at 6:00pm regarding Resident K's flush tube. Per the MAR, Resident K's tube should be flushed with 240ml three times a day.

According to the MAR for Resident W, there is a missing staff initial on 10/17/24 on 12:00pm for Resident W's oral mist spray. Resident W was prescribed Cephalexin 500mg on 10/24/24. It is documented on the MAR, that this medication was not available on 09/28/24, 10/30/24/, or 10/31/24. However, there is no documentation stating the medication is unavailable on 10/29/24 and staff initialed both doses on 10/29/24. It is also documented on the MAR that Resident Phenazophridine was not available on 10/29/24 or 10/30/24. This medication was prescribed on 10/24/24 three times a day. However, the staff initialed the MAR on 10/31/24 for the 5:00am dose as if it was given.

According to the MAR for Resident D, he is prescribed Refresh Liquigel 1% drop daily at bedtime. On 10/19/24, there is a comment on the MAR stating an immediate refill is needed. The initials "PJ" is documented on the MAR for 10/19/24. There are comments on the MAR dated 10/20/24 and 10/26/24 stating this medication is not available. The rest of the month is initialed by staff as if this medication was given. I was missing the MAR for Resident Y.

Ms. Zander stated the allegations are not true. Ms. Zander stated all staff are trained before they are permitted to administer medications. The staff are required to complete a rigorous training process for 30 days in order to administer medications. The staff are trained onsite by a supervisor and a nurse. In order to complete the training, the staff have to pass three checks without making any mistakes or receiving any assistance. Ms. Zander stated she will provide a copy of their medication training log.

Ms. Zander stated there is a high turnover regarding staff however; she does not know if anyone was recently terminated. Ms. Zander is not aware of Mr. Austin stealing medications.

On 10/31/24, I interviewed staff member Nehderi Knowlyn. Ms. Knowlyn has worked at the AFC group home since 08/05/24. Ms. Knowlyn stated she is trained to administer medications. Ms. Knowlyn stated she was not allowed to administer medications until she was fully trained. Ms. Knowlyn stated Mr. Austin does not work at this AFC group home but he does work at other AFC group homes within the company. Ms. Knowlyn stated she has heard other staff and a resident from the Tutbury Residence whisper about Mr. Austin stealing medications while they were at workshop. Ms. Knowlyn stated she heard this about Mr. Austin about a month ago and; he was later moved from

working at The Trevino Residence (AS630416241) to Tutbury. Ms. Knowlyn stated The Trevino Residence has residents that are prescribed a lot of narcotics. Ms. Knowlyn stated she does not know if what she heard about Mr. Austin stealing medications is true. Ms. Knowlyn stated she has never witnessed Mr. Austin stealing medications.

On 11/08/24, I made a telephone call to PTA program director, Merima Zander. Ms. Zander provided additional information regarding Resident K and Resident W medications. Ms. Zander explained that the QuickMAR system that is used by the AFC group home, populates treatment care instructions along with the residents prescribed medications. Ms. Zander stated Resident K's flush tube instructions on her MAR is not a prescribed medication. Resident W's oral mist spray is water as he uses a peg tube and has dry mouth. Resident W's oral mist spray is considered treatment care and not a medication. Resident W was prescribed Cephalexin and Phenazopyridine for three days only following a hospitalization. Ms. Zander stated there was a system failure concerning QuickMAR and she spoke with QuickMAR directly to get Cephalexin and Phenazopyridine removed from the MAR. Although staff were not administering these medications after the supply ran out after three days, staff were still initialing the MAR as if the medication was being given after the three-day timeframe. Ms. Zander stated the staff made an error by initialing the MAR instead of selecting the exception box explaining the medication is no longer needed.

On 11/08/24, I made a telephone call to staff member Kevin Austin. Regarding the allegations, Mr. Austin stated he is a home manager at another AFC group home by the name of Tutbury Residence (AS6304066150). Mr. Austin stated he no longer works at Boulan. The last time Mr. Austin worked at Boulan Residence was last year. Mr. Austin is not aware of any recent termination at Boulan Residence. Mr. Austin denied stealing any medications. Mr. Austin does not know why anyone would accuse him of stealing medications. Mr. Austin has worked for the company for four years and he does not know why anyone would complain about him because he is a good worker. Mr. Austin denies being bounced around between different group homes.

On 11/12/24, I received a return telephone call from Latricia Ward. Ms. Ward works in the HR department. Regarding the allegations, Ms. Ward stated that an employee being terminated for being asked to administer medications without being trained does not ring any bells. Ms. Ward confirmed that the employees partake in an extensive training program. Ms. Ward stated when an employee is terminated there is documentation providing the reason for the termination. Ms. Ward stated there is no records concerning Mr. Austin stealing medications. Ms. Ward stated stealing medication is not tolerated and is grounds for immediate termination. Ms. Ward stated Mr. Austin has not worked at Boulan Residence. Ms. Ward stated Mr. Austin did reach out to her about the allegations as he was concerned. Ms. Ward stated there has only been issues with Mr. Austin regarding employee relation matters as he was having trouble training other employees.

On 11/12/24, I received a copy of the medication training tracker for the month of September and October. According to the medication training tracker, there are eight staff members that have completed two out of three check offs from being fully trained. There are four staff members who have completed all three check offs. I also received the MAR for Resident Y for the month of November. According to the MAR, medications appear to be administered correctly.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation and the information gathered, there is sufficient evidence to support this allegation. Resident D is prescribed Refresh Liquigel 1% drop daily at bedtime. On 10/19/24, there is a comment on Resident D MAR stating an immediate refill is needed. There are comments on the MAR dated 10/20/24 and 10/26/24 indicating this medication is not available. The rest of the month is initialed by staff as if this medication was given. Therefore, there were at least three days during the month of October where Resident D was not administered this medication because it had not been refilled.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on the information gathered, there is no sufficient information to confirm this allegation. Verification of medication training was confirmed for the newly hired staff for the past two months.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	There is sufficient evidence to support this allegation. On 10/24/24, Resident W was prescribed Cephalexin 500mg and Phenazophridine for three days only. Ms. Zander stated there was a system failure concerning QuickMAR which is why these medications were not removed from the MAR after the prescription ended. Although staff were not administering these medications after three days had passed, staff were still initialing the MAR as if the medication was being given after the three-day timeframe. Ms. Zander confirmed the staff made an error by initialing the MAR instead of selecting the exception box explaining the medication is no longer needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	During the onsite, I observed that Resident Y's Lorazepam expired on 08/27/24. This medication had not been properly disposed of.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents suffer because facility does not want to lose money by sending them to the hospital.

INVESTIGATION:

Resident Y stated if she needs medical attention or needs to go to the hospital, the staff will transport her. Resident Y stated she had a knot on her foot and the staff took her to urgent care and then the hospital. The AFC group home also has wound nurses that work at the AFC group home. Resident Y confirmed if any of the other residents need medical care the staff will transport them to the hospital. Resident Y denied there ever being an instance when medical care was needed and the staff did not provide it.

Resident W stated if he is sick or need to see a doctor, the staff will ensure he gets medical attention.

Ms. Zander stated the staff do not avoid taking any resident to the hospital.

Ms. Knowlyn stated she is not aware of any resident needing medical care and the staff refused to take them to the hospital.

Mr. Austin does not know anything about staff not allowing medical care for any residents to save the company money.

On 11/12/24, I completed an exit conference with the licensee designee Aniema Ubom via telephone. Regarding the allegations, Mr. Ubom stated Mr. Austin is trained to work at Boulan Residence in the event he needs to administer medications to a resident with a peg tube. However, Mr. Ubom stated Mr. Austin does not work at Boulan Residence. Mr. Austin has worked at Trevino Residence (AS630416241) but, he currently works at Tutbury Residence. Mr. Ubom has never been made aware of Mr. Austin stealing medications. Mr. Ubom stated Boulan Residence has a nurse on shift 24/7. Mr. Ubom is not aware of any staff member being recently terminated at Boulan Residence. Mr. Ubom stated he is not involved with staffing. Mr. Ubom stated Latrica Ward is the lead HR team member who handles disciplinary actions. Mr. Ubom provided contact information for Ms. Ward. Mr. Ubom was informed of which violations he will be cited on and that a corrective action plan will be required.

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 above, there is no sufficient information to confirm this allegation. Each staff member and resident interviewed denied the AFC group home denying any resident medical care.
CONCLUSION:	VIOLATION NOT ESTABLISHED

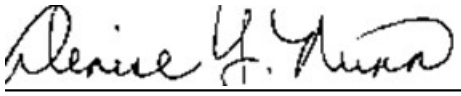
IV. RECOMMENDATION

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

Sheena Worthy
Licensing Consultant

11/12/24
Date

Approved By:



11/13/2024

Denise Y. Nunn
Area Manager

Date