



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 11, 2024

Betty Mackie
Bowers Adult Foster Care Inc
PO Box 19286
Detroit, MI 48219

RE: License #: AS820280351
Investigation #: 2025A0778001
Bowers III AFC, Inc.

Dear Ms. Mackie:

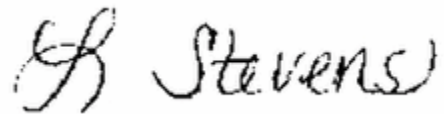
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in black ink that reads "LaKeitha Stevens". The first name is written in a stylized, cursive script, and the last name is written in a more legible, slightly cursive font.

LaKeitha Stevens, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3055

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820280351
Investigation #:	2025A0778001
Complaint Receipt Date:	10/11/2024
Investigation Initiation Date:	10/17/2024
Report Due Date:	12/10/2024
Licensee Name:	Bowers Adult Foster Care Inc
Licensee Address:	1929 Chalmers Drive West Rochester Hills, MI 48309
Licensee Telephone #:	(248) 608-8591
Administrator:	Shelia Hawkins, Administrator
Licensee Designee:	Betty Mackie
Name of Facility:	Bowers III AFC, Inc.
Facility Address:	22745 Cambridge Detroit, MI 48219
Facility Telephone #:	(313) 533-6348
Original Issuance Date:	07/17/2006
License Status:	REGULAR
Effective Date:	12/08/2023
Expiration Date:	12/07/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident did not receive medication for days.	Yes

III. METHODOLOGY

10/11/2024	Special Investigation Intake 2025A0778001
10/11/2024	Referral - Recipient Rights Referral received
10/11/2024	APS Referral Referral generated via ORR
10/17/2024	Special Investigation Initiated - On Site Unannounced onsite inspection. No one was home.
10/24/2024	Contact - Telephone call made Telephone call made to staff Pennie Ohia
11/15/2024	Contact - Telephone call made Telephone call made to staff Timothy Morgan
11/15/2024	Contact - Telephone call made Telephone call made to administrator Shiela Hawkins
12/05/2024	Contact - Telephone call made Telephone call made to Resident A
12/05/2024	Contact - Telephone call made Telephone call made to Guardian A

12/05/2024	Exit Conference Exit conference with licensee designee Betty Mackie
12/05/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident did not receive medication for days.

INVESTIGATION: On 10/17/2024, I completed an unannounced onsite inspection. No one was home.

On 10/24/2024, I completed a telephone interview with staff Pennie Ohia. According to Ms. Ohia, she worked Monday September 30, 2024, and staff Timothy Morgan asked her to review the bubble pack of medication for Resident A. According to Ms. Ohia, one specific pill did not match the picture shown on the pack. She stated the name was the same, however, the pill did not look like the previous months pill or the current description. Ms. Ohia stated she did not administer the pill and told staff Timothy Morgan to ask the pharmacist about the medication. Ms. Ohia stated she called the facility and spoke with Mr. Morgan several days later to see if the medication issue was resolved and she was told it was not. According to Ms. Ohia it was verified several days later that the pill was accurate.

On 11/15/2024, I completed a telephone interview with staff Timothy Morgan. Mr. Morgan stated he received a note from Ms. Ohia stating one of Resident A's medications was a different size and color. He stated he told her he would take it the pharmacist to verify its authenticity. According to Mr. Morgan the pharmacist informed him it was the same pill but a different distributor. Mr. Morgan stated Resident A went several days without receiving one of her medications due to waiting for the pharmacist to verify and Ms. Ohia refusing to administer after the pharmacist verified. Mr. Morgan stated Ms. Ohia was the only staff on the am shift and the one responsible for administering the am medication.

On 11/15/2024, I completed a telephone interview the administrator, Sheila Hawkins. According to Mrs. Hawkins, Ms. Ohia refused to administer one medication to Resident A because it did not look like the picture. According to Mrs. Hawkins, she contacted the pharmacist and was told it was the same pill but a different manufacturer. Mrs. Hawkins stated staff Ms. Ohia continued refusal to administer even after being told the pill was the same. Mrs. Hawkins stated she was advised by the Office of Recipient Rights to write-up Ms. Ohia. According to Mrs. Hawkins, Ms. Ohia refused to accept the write-up and quit. Mrs. Hawkins stated Resident A went several days without her medication because Ms. Ohia refused to administer.

On 11/21/2024, I reviewed the medication log for Resident A. Resident A did not receive her B Complex Vitamin on 10/1/2024, 10/5/2024, 10/6/2024 and 10/7/2024.

On 12/5/2024, I completed a telephone interview with Resident A. Resident A stated she did not recall getting her medication. She stated she receives her pills daily.

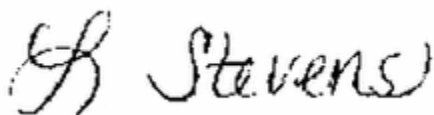
On 12/5/2024, I completed a telephone interview with Guardian A. She stated there has been no previous history regarding Resident A not receiving her medication. She stated this appears to be an isolated incident and she has not complaints regarding the facility.

On 12/5/2024, I completed an exit conference with licensee designee Betty Mackie. I reviewed the complaint with her. I informed Ms. Mackie I understood the hesitation of staff Ms. Ohia initially and the reason she did not administer the medication. However, I do not understand why it remained a continued refusal after it was cleared by the pharmacist. In addition, why did the facility not ensure Resident A received her medication and why did another entity have the instruct the administrator to write-up the staff. I informed Ms. Mackie; this complaint will be substantiated, and I am requesting a corrective action plan. Ms. Mackie stated she agreed with the findings.

APPLICABLE RULE	
R 400.14312	Resident medications.
	<p>(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:</p> <p>(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.</p>
ANALYSIS:	<p>Staff Pennie Ohia refused to administer Resident A medication because it did not match the pill package. Once the pill was deemed to be the same medication but a different manufacturer, Ms. Ohia continued refusal this modifying Resident A's medication without physician instructions.</p> <p>Resident A went four days without receiving her vitamin B-Complex medication.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend this complaint is closed and the status of the license remain unchanged.



12/9/2024

LaKeitha Stevens

Date

Licensing Consultant

Approved By:

A handwritten signature in black ink, appearing to read "A. Hunter", is written over a light blue rectangular background.

12/11/2024

Ardra Hunter
Area Manager

Date