GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 19, 2024

Esther Mwankenja
Zanzibar Adult Foster Care, LLC
5806 Outer Drive
Bath, MI 48808

RE: License #: AS330406614
Investigation #: 2025A0466006
Zanzibar Adult Foster Care, LLC

Dear Ms. Mwankenja:

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 (517) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330406614
Investigation #:	2025A0466006
Complaint Receipt Date:	10/25/2024
Investigation Initiation Date:	10/29/2024
Report Due Date:	12/24/2024
Licensee Name:	Zanzibar Adult Foster Care, LLC
Licensee Address:	5806 Outer Drive Bath, MI 48808
Licensee Telephone #:	517-885-0716
Administrator:	Esther Mwankenja
Licensee Designee:	Esther Mwankenja
Name of Facility:	Zanzibar Adult Foster Care, LLC
Facility Address:	520 S. Holmes Street Lansing, MI 48912
Facility Telephone #:	(517) 885-0716
Original Issuance Date:	02/17/2021
License Status:	REGULAR
Effective Date:	08/17/2023
Expiration Date:	08/16/2025
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATIONS:

	Violation Established?
Resident A's medical needs are not being met.	Yes
On 9/23/2024 Resident A came to E.R covered in lice, feces and reeked of urine.	No
On 10/23/24 the AFC facility was filthy, trash everywhere and stunk like rotten meat.	Yes
The facility is understaffed.	No
Additional Findings	Yes

III. METHODOLOGY

10/25/2024	Special Investigation Intake 2025A0466006.
10/25/2024	Contact - Telephone call made to Complainant; message left.
10/29/2024	Special Investigation Initiated - On Site.
10/31/2024	Contact - Document Received from licensee Ester Mwankenja.
11/04/2024	Contact - Document Sent to licensee Ester Mwankenja.
12/10/2024	Contact- telephone call made to Guardian A1, message left.
12/10/2024	Contact- telephone call made to CMH case manager Eric Barriger, message left.
12/10/2024	Contact- telephone call made to Sparrow Hospital, Kelly Spitz, Manager.
12/10/2024	Contact- telephone call made to Dr. Jamie Arnold-CMH Physician; message left.
12/12/2024	Contact- telephone call recevied from CMH case manager Eric Barriger, interviewed.
12/12/2024	Contact- telephone call made to Ascension Pharmacy; Kayla Owen interviewed.

12/12/2024	Contact- telephone call recevied from Guardian A1 interviewed.
12/19/2024	Exit Conference with Licensee Mwankenja, message left.

*** Please note the resident in this report will be referred to as Resident A despite Renewal Licensing Study Report dated 08/15/2023 and completed by Adult Foster Care (AFC) licensing consultant Jana Lipps coding this same resident as Resident C. Also, Special investigation Report (SIR) dated 4/04/2024 and completed by AFC licensing consultant Rodney Gill coded this same resident as Resident A. Since he was coded last as Resident A, he will be coded as the same in this report.*

ALLEGATION: Resident A's medical needs are not being met.

INVESTIGATION:
Please refer to 2024A0790015 dated 04/04/2024 and 2023A1029009 dated 1/24/2023 where similar allegation were investigated with no violations established.

On 10/25/2024, Complainant reported that on 8/26/24 she spoke to Dr. Jamie Arnold community mental health (CMH) physician who stated Resident A has missed a monthly lab and not taken clozapine in six days. It was reported the pharmacy attempted to deliver Resident A's medications however no one at the AFC answered the door to accept the medications. Complainant reported that Dr. Arnold recommended a stay at Bridges Crisis Unit or hospitalization, which were refused by Resident A. Complainant reported adult foster care (AFC) staff was told to take Resident A to the emergency room (ER) however CMH called the AFC for three days with no answer. Complainant reported that on 9/4/2024 she received a message from Emily Kozan at CMH stating Sparrow would not certify Resident A for hospitalization and clozapine cannot be restarted until hospitalized.

On 10/29/2024, I conducted an unannounced investigation and I interviewed licensee designee Ester Mwankenja who reported that Resident A was not at the facility because he has been hospitalized since 9/22/2024. Licensee designee Mwankenja denied that Resident A missed any medical appointments rather she reported that Resident A refuses to go to those medical appointments or lab work. Licensee designee Mwankenja denied that Resident A missed six days of clozapine and denied that medications are not being delivered because no direct care staff member answers the door to accept the medications. Licensee designee Mwankenja reported that all resident medications are filled though Ascension Pharmacy which is the pharmacy that works with CMH. Licensee designee Mwankenja denied that CMH called her for three days without anyone answering the phone. Licensee designee Mwankenja reported that she has taken Resident A to the ER as directed and that is why he is hospitalized now. Licensee designee Mwankenja reported that I could not review Resident A's record as the file cabinet where resident records are stores was locked and she lost the key for that cabinet this morning. Licensee designee Mwankenja reported that she was having a locksmith come out so that a

replacement key could be made. Licensee designee Mwankenja reported that she had the key to one of the drawers where the medications were stored. I reviewed Resident A's medications which documented the following:

- Dispensed on 8/26/2024, ordered by Dr. J. Arnold, "Lorazepam, 1MG tablet, take 1 tablet by mouth twice daily as needed prior to procedures, appointments or anxiety." There were bubble cards of this medication, one had 4 pills left and the second package contained 30 pills.
- Another bubble pack was reviewed, that was dispensed on 09/05/2024 and dated 9/16-9/22, and contained multiple medications for morning, evening and bedtime. I noted that these medications had not been administered as prescribed and there was no written explanation why they were not administered. There was not a medication administration record (MAR) available for review as licensee designee Mwankenja reported that was kept in the locked file cabinet that she lost the key to this morning. None of these bubble packs contained a prescription for clozapine.
- Additional bubble packs that were reviewed were dated 9/23-9/29 and dispensed 9/05/2024, 10/14-10/20 dispensed 10/04/2024,10/21-10/27 dispensed 10/04/2024, 10/28-11/03 dispensed 10/04/2024.

On 10/31/2024, licensee designee Mwankenja emailed the following several documents which I reviewed. I determined that Resident A's August 2024 and September 2024 MARs documented Resident A was prescribed clozapine 100 MG tablet to be taken by mouth every morning and at bedtime. Resident A's August 2024 and September 2024 MARs documented that Resident A was administered the clozapine twice daily as directed. I reviewed Resident A's September 2024 MAR and clozapine was signed as administered twice daily on 9/01, 9/02 and 9/03. Resident A's September 2024 MAR documented the clozapine was discontinued from 09/04 through the remainder of the month. This was demonstrated by a straight line from 9/04 crossing out the rest of the month for both morning and bedtime with "D/C". At the time of the unannounced investigation the medication available in the facility could not be reviewed and compared against the MAR as the medications were locked and licensee designee Mwankenja could not locate the key. The medications that licensee designee Mwankenja did have access to were reviewed and at the time clozapine was not provided for my review. Resident A's October 2024 MAR did not document that clozapine was prescribed and it was omitted from the MAR.

I also reviewed a Prescription Cancellation Information document dated on 9/03/2024 which stated Dr. J Arnold discontinued "Clozapine 200 MG Tablet" for Resident A. I also reviewed documents from Sparrow Health which confirmed Resident A had "CBC with Platelet and differential" on 9/22/2024, 8/30/2024, 8/22/2024, 7/15/2024, 6/16/2024, 05/22/2024, 04/29/2024, 04/18/2024, 03/24/2024.

On 12/10/2024, I interviewed Guardian A1 who reported (date unknown) that she spoke to Dr. Arnold CMH physician who stated Resident A has missed monthly lab work (date unknown) and not taken clozapine in six days (date unknown). Guardian A1 stated clozapine was missed because the pharmacy attempted to deliver the

medications to the AFC but no one was home to accept the medications (date unknown). Guardian A1 reported that having Resident A's monthly lab work completed was the responsibility of licensee designee Mwankenja. Guardian A1 reported that neither licensee designee Mwankenja nor any other staff member from the facility ever contacted her to report that the monthly lab was not done or that Resident A refused a monthly lab. Guardian A1 reported Resident A was hospitalized around 9/22/2024 and that he would not be returning to this facility. Guardian A1 reported that she has experienced coming to the facility and no one answered the door on more than one occasion (dates unknown). Guardian A1 also reported experienced calling the facility with no one answering the phone even when she would call at different times throughout the day.

12/12/2024, I contacted Ascension Pharmacy and spoke with pharmacist Kayla Owen who reported that the last time Resident A's clozapine medication was filled was on 07/08/2024 with a 28-day supply. Pharmacist Owen reported that on 08/22/2024, her system noted that Resident A had been out of clozapine for 3 days and did not have updated labs allowing for the medication to be refilled. Pharmacist Owen reported she contacted the prescribing physician, Dr. Arnold who stated that Resident A needed to have lab work done (CBC with Platelet and differential) and if that was completed, Dr. Arnold would probably have to lower the dosage since days of the clozapine were missed. Pharmacist Owen reported that this is the only pharmacy that fills CMH prescriptions and that Dr. Arnold would not have called this prescription into any other pharmacy. Pharmacist Owen reported that there is no record that Resident A's clozapine has been filled since 07/08/2024. Pharmacist Owen reported that Dr. Arnold recommended Resident A stay at the Bridges Crisis Unit so that this matter could be sorted out. Pharmacist Owen reported that Resident A's MAR documents that it is the responsibility of a caretakers at the AFC to provide the pharmacy with documentation of Resident A's monthly lab work once it is completed. Pharmacist Owen reported that working with this facility has been a struggle. Pharmacist Owen reported drivers report it is difficult to contact licensee designee Mwankenja by phone which is not a typical problem with AFC facilities. Pharmacist Owen reported drivers make several attempts to deliver medications but cannot because no direct care staff member answers the door. Pharmacist Owen reported drivers even contact licensee designee Mwankenja directly to schedule a day/time to drop off the medications and still there have been times when no one answers the door.

I interviewed Michael Horvath, who is a driver for Ascension Pharmacy, and he reported that he is familiar with Zanzibar Adult Foster Care and licensee designee Mwankenja. Driver Horvath reported much frustration working with this facility as direct care staff or licensee designee Mwankenja are difficult to get a hold of via phone and do not always answer the door to receive medications being delivered to the facility. Driver Horvath reported that even when a scheduled a day and time have been confirmed with licensee designee Mwankenja to drop medications off, there is not always someone there to accept it. Driver Horvath reported being

frustrated as at times because he believes that there are people in the facility yet they do not answer the door.

Resident A's case manager Eric Barriger with CMH of Clinton, Eaton and Ingham (CEI) County reported that Resident A has a history of refusing lab work and medical intervention. Case manager Barriger confirmed experiencing it difficult to contact licensee designee Mwankenja. Case manager Barriger the experiences described by pharmacy personnel. Case manager Barriger reported that he has also experienced this and therefore he has to schedule his monthly meeting in advance with licensee designee Mwankenja because if he does not, he many come to the facility and no one answers the door. Case manager Barriger reported that he is aware that Resident A is no longer prescribed clozapine but the specifics about how that transpired would need to be sought from the physician and or the pharmacy. Case manager Barriger reported that Resident A was hospitalized around 9/22/2024 and he will not be returning to this facility as another living arrangement was made prior to his hospital discharge.

As of the completion of this report Resident A's physician Dr. J. Arnold did not return my phone call as requested to provide information about this allegation.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Licensee designee Mwankenja provided Sparrow Health documentation confirming Resident A completed required bloodwork, "CBC with Platelet and differential", on 9/22/2024, 8/30/2024, 8/22/2024, 7/15/2024, 6/16/2024, 05/22/2024, 04/29/2024, 04/18/2024, 03/24/2024. This bloodwork is required to refill the clozapine medication. Based on this information therefore there was insufficient evidence found indicating Resident A has not been getting his blood drawn monthly. Additionally, case manager Barringer was unaware and had no knowledge of Resident A failing to get his blood drawn monthly.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions. **(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.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Pharmacist Owen reported that the last time Resident A's clozapine medication was filled was on 07/08/2024 with a 28-day supply. Pharmacist Owen reported that on 08/22/2024, her system noted that Resident A had been out of clozapine for three days and the medication has not been filled since. Resident A's August 2024 and September 2024 MARs documented that Resident A was prescribed "clozapine 100 MG tablet to be taken by mouth every morning and at bedtime." The August 2024 and September 2024 MARs documented via staff initials that Resident A was administered clozapine twice daily and was initialed by a staff member every day in August 2024 and on 9/01/2024, 9/02/2024 and 9/03/2024, however based on the information provided by Ascension Pharmacy, clozapine could not have been on-site and available for administration for that duration of time since the prescription was last filled on 07/08/2024 with only a 28 day supply. Therefore a violation has been established as Resident A's clozapine medication was not administered as prescribed since 8/19/2024, even though direct care staff had initialed the medication as administered, and the physician discontinue order was not issued until 09/03/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 9/23/2024 Resident A came to ER covered in lice, feces and reeked of urine.

INVESTIGATION:
On 10/25/2024, Complainant reported that on 9/23/2024 she received call from Pilar Monta at Sparrow Hospital ER that Resident A came to ER covered in lice and reeked of urine and feces.

On 10/29/2024, I conducted an unannounced investigation and I interviewed licensee designee Mwankenja who denied that Resident A went to the hospital with lice in his hair and smelled of urine and feces. Licensee designee Mwankenja reported that Resident A is able to meet his personal hygiene needs independently which includes showering daily. Licensee designee Mwankenja reported that most of time Resident A showers on his own but occasionally requires verbal prompting. Licensee designee Mwankenja reported that Resident B is the only resident currently living in the facility.

At the time of the unannounced investigation, I was not able to review Resident A's resident record as licensee Mwankenja had locked the cabinet that contained the record and lost the key. Resident A was hospitalized at the time of the unannounced investigation and therefore could not be interviewed

I interviewed Resident B who reported that he is independent and able to meet his personal care needs himself. Resident B reported that he does shower regularly but could not report the last time he showered but stated it was "recently." I observed Resident B in clean clothing and although I did not notice any foul odor it may have been because Resident B was smoking a cigarette during the entire interview. I observed Resident B's hair to be greasy and disheveled. Resident B denied that he had a foul odor, that he lice or maggots in his hair. Resident B reported that he was only resident living in the facility as Resident A was hospitalized.

On 10/31/2024, licensee designee Mwankenja emailed a copy of Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* (assessment plan). It could not be determined when this documented was completed nor if it was written in collaboration with the CMH case manager and/or Guardian A1 as the last page of the document that contains the date completed and signature page was not provided. The assessment plan documented that Resident A requires prompts to bathe, for grooming, to wear clean clothing and for personal hygiene. Licensee designee Mwankenja did not provide any shower records.

On 12/10/2024, I interviewed Guardian A1 who reported that on date unknown Sparrow Hospital called concerned as Resident A presented to the ER with lice and maggots in his hair and smelled of urine and feces. Guardian A1 reported that she did not have any documentation of Resident A's condition from the hospital. Guardian A1 confirmed Resident A is able to care for his personal hygiene needs independently including showering daily.

On 12/10/2024, I contacted Sparrow Hospital and attempted to interview Pilar Monta. I spoke with manager Kelly Spitz who reported that she would review Resident A's medical file and speak to the team that interacted with Resident A, including Pilar Monta, when these allegations were made and contact me back.

On 12/11/2024, licensee designee Mwankenja denied that Resident A was taken to the hospital with maggots in his hair.

On 12/12/2024, I interviewed case manager Barriger who reported that Resident A has an issue with urinating and defecating in his room so even though he showers daily he may smell of urine and/or feces. Case manager Barriger reported Resident A can meet his activities of daily living independently including showering daily. Case manager Barriger reported that Resident A does not like to have visitors at his home and they noticed that his urinating and defecating in his bedroom occurred more when he was aware that visitors were coming over. Case manager Barringer stated they were working with Resident A on this. Case manager Barriger reported that Sparrow Hospital did contact him about Resident A having "bugs" and he wasn't sure if that meant lice or maggots, but he reported that Resident A refuses haircuts. Due to Resident A's psychological conditions case manager Barriger reported that Resident A was likely to smell of urine and feces when he presented for hospitalization as Resident A has a lot of anxiety about any medical intervention.

As of the completion of this report, Kelly Spitz, manager at Sparrow Hospital never contact me back with more information about the allegations that were made.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Complainant reported that Resident A came to ER covered in lice and reeked of urine and feces. I contacted Sparrow Hospital on 12/10/2024, but manager Kelly Spitz at Sparrow Hospital did not return my phone call verifying Resident A's condition at the time of admission. Licensee designee Mwankenja, Guardian A1 and case manager Barriger all reported that Resident A can meet his personal hygiene needs independently which does include him showering daily therefore there is not enough documentation to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 10/23/24 the AFC facility was filthy, trash everywhere and stunk like rotten meat.

INVESTIGATION:
On 10/25/2024, Complainant reported that on 10/23/24 she went to the facility unannounced with CMH case worker Eric Barriger and the house was filthy, trash everywhere, stunk like rotten meat, in all areas of the facility except 1 bedroom.

On 10/29/2024, I conducted an unannounced investigation and I observed the facility to be cluttered, dirty and in disarray. When I walked into the facility by the front door was a pile of trash. The family room/living area was cluttered with blankets and possible laundry on the couches. Random items were on the tv stand such as a large jar of peanut butter and ant spray on the coffee table along with random cups and other clutter. In front of the living room window there was a pile of things such as lamps, old blinds, binders and other items in a storage tote. The kitchen was cluttered with a large garbage bag on the kitchen island with trash in it, old banana peels, teacups with trash in them, empty take-out containers, peanut butter jar and other grocery bags on the counter. The sink was full of dirty dishes and there were dirty dishes on the counter and table. By the stove there were dirty muffin pans, dishes and a dirty pan on the stove with a wooden spoon lying on the pan. By the sink were opened eggshells, a carton of eggs, seasonings, dirty dishes that were used to make eggs and dirty silverware. The kitchen table was full of dirty dishes, silverware, cups, empty Tupperware, boxes and empty food packages. The kitchen floor had tracked dirt and mud throughout.

I interviewed licensee designee Mwankenja who reported that she was in the process of remodeling, cleaning and getting rid of items which was why there were piles of trash by the front door and in front of the window. Licensee designee Mwankenja did not have any explanation for the condition of the kitchen but she reported that she would clean it today.

I interviewed Resident B about the condition of the facility. Resident B reported that he likes living there and licensee designee Mwankenja does the best she can to keep the facility in a nice condition.

I reviewed a Renewal Licensing Study Report dated 08/15/2023 and completed by Adult Foster Care (AFC) licensing consultant Jana Lipps. The report cited Rule 400.14403.(1) due to this same resident's bedroom smelling of urine and having a thick layer of dirt on the baseboards, windows coverings, and floors. This same resident's mattress was observed to be soiled with urine and not in good condition. The corrective action plan documented the room would be cleaned and the mattress replaced. Licensee designee Mwankenja submitted a corrective action plan (CAP) dated 8/15/2023 that stated: "Resident C's room was found to be unclean. Clean Resident C's room. Have a conversation with CMH case manager and Resident C to establish a plan for sanitary living conditions." Compliance to be achieved by "8/32/2023 by licensee designee Mwankenja."

Special investigation Report (SIR) dated 4/04/2024 and completed by AFC licensing consultant Rodney Gill who documented violation of Rule 400.14403(1). At the time of the Special Investigation Report there was sufficient evidence found indicating Ms. Mwankenja did not adequately maintain Resident A's bedroom in a manner which provided for Resident A's health, safety, and well-being. Ms. Mwankenja admitted there was feces all over the floor and the walls in Resident A's bedroom on 03/21/2024. She also admitted on 03/06/2024 she put a black bucket in Resident A's bedroom for him to urinate in. Licensee designee Mwankenja submitted a corrective action plan (CAP) dated 4/22/2024 that stated: "Room checks will be completed daily. Resident will be reminded to use the bathroom." Compliance to be achieved "immediately by caregiver."

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	Complainant reported that on 10/23/24 she went to the facility unannounced with case manager Barriger and the house was filthy with trash everywhere. On 10/29/2024, I conducted an unannounced investigation and I observed the facility to be dirty, cluttered with trash and in disarray. Therefore a violation has been established as the housekeeping standards did not present a comfortable, clean, and orderly appearance.
CONCLUSION:	**REPEAT VIOLATIONS ESTABLISHED [SEE RENEWAL LICESING STUDY REPORT AND CORRECTIVE ACTION PLAN BOTH DATED 08/15/2023 AND SPECIAL INVESITGATION REPORT DATED 04/04/2024 AND CORRECTIVE ACTION PLAN DATED 04/22/2024.**

ALLEGATION: Facility is understaffed.

INVESTIGATION:
Please review Special Investigations # 2023A1029009 dated 1/24/2023 and 2023A1034012 dated 02/28/2023 which has addressed similar complaints however no violations have been established.

On 10/25/2024, Complainant reported that on 9/5/2024 she went to the facility and no one answered the door but she observed Resident A at the bus stop by Quality Dairy and he told her he was "going to eat!"

On 10/29/2024, I conducted an unannounced investigation and I interviewed licensee designee Mwankenja who reported that although she no longer has a live in staff member the residents are never left alone. Licensee designee Mwankenja stated there is always a direct care worker on shift 24 hours a day, seven days a week. Licensee designee Mwankenja reported that she is typically the direct care worker on duty. There was not a staff schedule posted however licensee designee Mwankenja provide me with a staff schedule *Staff Schedule* for August 2024, September 2024 and October 2024. The *Staff Schedule* provided did not document job titles, hours worked or any scheduling changes.

I interviewed Resident B who reported that there is always a direct care worker available 24 hours and day seven days a week. Resident B reported that typically licensee designee Mwankenja is the direct care worker on duty.

On 12/10/2024, I interviewed Guardian A1 who was adamant that the facility is not staffed 24 hours a day, seven days a week. Guardian A1 reported that she has called the facility for days and no one answers. Guardian A1 reported that she has called the facility at all different times throughout a day and still no one answers the telephone. Additionally, Guardian A1 reported that she has gone out to the facility more than once on various dates and no one answers the door. Guardian A1

reported that this is very odd behavior if direct care staff is actually present in the facility.

On 12/12/2024, I interviewed case manager Barriger who reported that Resident A never reported to him that the facility did not have a direct care worker 24 hours a day seven days a week. Case manager Barriger reported that it is odd that it is difficult to get a hold of licensee designee Mwankenja and that there are times when no one is at the facility as that is not typical of AFCs that provide 24 hours a day seven days a week supervision.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(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.
ANALYSIS:	Licensee designee Mwankenja, and Resident B both reported that there is always a direct care worker on shift 24 hours a day seven days a week. Guardian A1 and case manager Barriger reported that they have been to the facility when no one was home/answering the phone and or door which they described as odd. There is not enough evidence to establish a rule violation as there is no proof that the facility is not providing 24-hour staffing seven days a week therefore no violation has been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/29/2024, I conducted an unannounced investigation and licensee designee Mwankenja could not provide a *Staff Schedule*. Licensee designee Mwankenja stated it was locked in the filing cabinet and she could not locate the key. Licensee designee Mwankenja later provided a *Staff Schedule* for August 2024, September 2024 and October 2024. I noted each *Staff Schedule* provided did not document job titles, hours or shifts worked or any scheduling changes as required.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	At the time of the unannounced investigation licensee designee Esther Mwankenja could not provide a staff schedule. On 11/04/2024, licensee Mwankenja provided a *Staff Schedule* for August 2024, September 2024 and October 2024. The *Staff Schedule* provided did not document job titles, hours or shifts worked or any scheduling changes as required therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/29/2024, I conducted an unannounced investigation and at the time of the unannounced investigation Resident A's resident record was not accessible because licensee designee Mwankenja had locked the cabinet and lost the key.

On 10/29/2024, I conducted an unannounced investigation and I interviewed licensee designee Mwankenja who reported Resident A was independent and could be unsupervised in the community every day. Licensee designee Mwankenja reported that once Resident A was up, he would get ready and leave the facility for the day. Licensee designee Mwankenja reported Resident A always came back to the facility. Licensee designee Mwankenja reported Resident A was in the hospital and therefore could not be interviewed.

I interviewed Resident B who reported that Resident A was in the community every day without any direct care worker.

On 11/04/2024, licensee designee Mwankenja provided a written *Assessment Plan for AFC Residents (assessment plan)* however it was only three pages not the full four-page document. Since the signature page was missing, the date of the assessment was not known nor was it was documented that licensee designee Mwankenja had completed the assessment with Resident A's designated representative. Resident A's resident record documented that his admission date was 04/08/2022.

Resident A's written *Assessment Plan for AFC Residents* documented that Resident does not move independently in the community.

On 12/10/2024, I interviewed Guardian A1 who reported that on 9/5/2024 she went to the facility and no one answered the door but she observed Resident A at the bus stop by Quality Dairy and he told her he was "going to eat!" Guardian A1 did not observe any direct care staff with Resident A. Guardian A1 reported Resident A was independent in the community from the time he woke up to later in the evening when he would come back to the facility every day.

On 12/12/2024, I interviewed case manager Barriger who reported that Resident A was independent in the community every day.

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.** **(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.**

ANALYSIS:	At the time of the unannounced investigation Resident A's assessment plan was not accessible as it was locked in a cabinet that licensee designee Mwankenja did not have a key. Resident A's written *Assessment Plan for AFC Residents* documented that Resident does not move independently in the community however licensee Mwankenja, Guardian A1, case manager Barriger and Resident B all reported that Resident A was in the community independently from the moment he wakes up until later in the evening when he returns. The assessment plan provided did not contain a signature page. Consequently I could not determine when this assessment plan was completed or if Guardian A1 participated in the process.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 10/29/2024, I conducted an unannounced investigation and I did not observe a written menu. Licensee Mwankenja reported that the menu was in the locked filing cabinet to which she did not have a key.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	On 10/29/2024 at the time of the unannounced investigation a written menu was not posted as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 10/29/2024, I conducted an unannounced investigation and at the time of the unannounced investigation Resident A's resident record was not accessible because licensee designee Mwankenja had locked the cabinet and lost the key.

On 11/04/2024, licensee designee Mwankenja provided a *Resident Care Agreement* and a written *Assessment Plan for AFC Residents* however neither document contained the signature page therefore the date of the assessments was not known. Resident A's record did document that his admission date was 04/08/2022 and only one resident care agreement and assessment plan was provided so it is possible that the admission documents were never updated. Resident A's *Health Care Appraisal* was dated 09/14/2021 and that was only *Health Care Appraisal* provided.

APPLICABLE RULE	
R 400.14316	
	1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (a) Identifying information, including, at a minimum, all of the following: (i) Name. (ii) Social security number, date of birth, case number, and marital status. (iii) Former address. (iv) Name, address, and telephone number of the next of kin or the designated representative. (v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home. (vi) Name, address, and telephone number of the preferred physician and hospital. (vii) Medical insurance. (viii) Funeral provisions and preferences. (ix) Resident's religious preference information. (b) Date of admission. (c) Date of discharge and the place to which the resident was discharged. (d) Health care information, including all of the following: (i) Health care appraisals. (ii) Medication logs. (iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures. (iv) A record of physician contacts. (v) Instructions for emergency care and advanced medical directives. (e) Resident care agreement. (f) Assessment plan. (g) Weight record. (h) Incident reports and accident records. (i) Resident funds and valuables record and resident refund agreement. (j) Resident grievances and complaints. (2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.

ANALYSIS:	At the time of the unannounced investigation Resident A's entire resident record was not accessible as it was locked in a cabinet and licensee designee Mwankenja did not have a key. Additionally, when the resident care agreement and assessment plan were provided, neither contained signature pages nor were not complete documents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/29/2024, I conducted an unannounced investigation and the main large light fixture in the kitchen did not have a light bulb in it. This made the kitchen very dark as the only other light source was from the windows.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(3) All living, sleeping, hallway, storage, bathroom, and kitchen areas shall be well lighted and ventilated.
ANALYSIS:	During the unannounced onsite investigation, I found that the kitchen area was not well lit as the large kitchen light fixture did not have a lightbulb in it leaving it difficult to see in this area.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Elkins

12/19/2024

_____

Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

12/19/2024

_____

Dawn N. Timm Date
Area Manager