GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2025

Huma Shahid
Golden Grace LLC
6449 Rutledge Park Dr.
West Bloomfield, MI 48322

RE: License #: AS630417897
Investigation #: 2025A0991007
Golden Grace, LLC

Dear Huma Shahid:

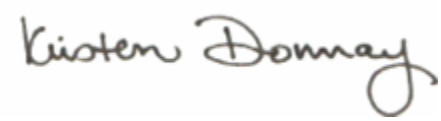
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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 #:	AS630417897
Investigation #:	2025A0991007
Complaint Receipt Date:	12/09/2024
Investigation Initiation Date:	12/09/2024
Report Due Date:	02/07/2025
Licensee Name:	Golden Grace LLC
Licensee Address:	3840 Manchester Ct. Bloomfield Hills, MI 48302
Licensee Telephone #:	(248) 431-8588
Licensee Designee:	Huma Shahid
Name of Facility:	Golden Grace, LLC
Facility Address:	6449 Rutledge Park Dr. West Bloomfield, MI 48322
Facility Telephone #:	(248) 431-8588
Original Issuance Date:	02/06/2024
License Status:	REGULAR
Effective Date:	08/06/2024
Expiration Date:	08/05/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff are not changing the residents' briefs throughout the night. Direct care worker, Peggy, sleeps during the midnight shift.	Yes
The owners buy expired food and serve it to the residents.	No
Additional Findings	Yes

III. METHODOLOGY

12/09/2024	Special Investigation Intake 2025A0991007
12/09/2024	APS Referral Received from Adult Protective Services (APS) - denied for investigation
12/09/2024	Special Investigation Initiated - Telephone Call to complainant - left message
12/11/2024	Inspection Completed On-site Unannounced onsite inspection - interviewed licensee designee and residents
12/12/2024	Contact - Telephone call received Interviewed complainant
12/19/2024	Contact - Telephone call made Left message for hospice provider
01/06/2025	Contact - Telephone call made Call to direct care worker, Peggy Tate - voicemail not set up
01/28/2025	Contact - Telephone call made Interviewed licensee designee, Huma Shahid
01/29/2025	Contact - Telephone call made Call to hospice provider for Resident E
01/29/2025	Contact - Telephone call made Call to Resident B's hospice nurse

01/29/2025	Contact - Telephone call made Interviewed direct care worker, Peggy Tate
02/03/2025	Exit Conference Via telephone with licensee designee, Huma Shahid

ALLEGATION:

Staff are not changing the residents' briefs throughout the night. Direct care worker, Peggy, sleeps during the midnight shift.

INVESTIGATION:

On 12/09/24, I received a complaint from Adult Protective Services (APS), alleging that the residents' briefs are not being changed throughout the night. A live-in caregiver, Peggy, sleeps during the midnight shift and does not change the residents. The complaint also alleged that the owners purchase expired food and remove the expiration dates of the food. They instruct staff to give the expired food to the residents. It is unknown if any residents have become sick from eating expired food. The complaint was denied for investigation by APS.

On 12/11/24, I conducted an unannounced onsite inspection at Golden Grace. I interviewed the licensee designee, Huma Shahid. Ms. Shahid stated that they recently fired a staff person, and she felt that they were making complaints in retaliation. She stated that a complaint was made against her other licensed home as well. Ms. Shahid stated that she did not have any concerns about residents not being changed in a timely manner. She stated that they have cameras throughout the home, so they can check to make sure staff are doing what they are supposed to be doing. Ms. Shahid stated that the residents also have call buttons, so they can alert staff if they need assistance. There are currently six residents in the home. Resident A wears briefs and does not go to the toilet. She has a call button and is able to alert staff in the night if she needs to be changed. Resident B wears briefs and does not go to the toilet. She has a call button and can tell staff if she needs to be changed. Resident C can go to the toilet. She lets staff know when she needs to go to the bathroom, and staff provide her with assistance. Resident C has a call button, but she does not use it. Resident D is bedbound and is receiving hospice services. Resident D had a wound when she first moved into the home, but it has completely healed. Resident D has a catheter and wears briefs. Staff check her regularly to make sure the catheter is not leaking. Resident E is receiving hospice services. He wears briefs and does not have any wounds. Resident E recently began using "DriQ" technology to monitor his briefs for wetness. DriQ is a sticker tag that is placed on the outside of the brief. It monitors for moisture and connects to a hub, which alerts staff when moisture is detected. If the brief is not changed within six minutes, it sends an alert to the owners of the home. Ms. Shahid stated that Resident F is also utilizing the DriQ technology. He recently returned from the hospital and wears

briefs. He is not able to tell staff when he needs to be changed. Ms. Shahid stated that none of the residents have any bed sores, wounds, or issues from not being changed. None of the family members have complained about the care the residents are receiving.

Ms. Shahid stated that they have a live-in caregiver, Peggy Tate. Ms. Tate lives in the upstairs area of the home. She works the midnight shift and is expected to be downstairs throughout her shift. Ms. Shahid did not have any concerns about Ms. Tate sleeping while on shift. She stated that staff do not wake up the residents to change them if they are peacefully sleeping. Staff respond if a resident uses their call button or if the DriQ alarm sounds. The residents are typically changed and go to bed around 7:00pm.

On 12/11/24, I interviewed Resident A. Resident A stated that she moved into the home in September. She stated that it has been great living in the home. Everyone is nice, friendly, and caring. She stated that she wears briefs and needs to be changed. Staff are good about changing her. She is never left wet or soiled for a long period of time. She stated that she could not recall if staff come into her room to change her at night. She stated that she would rather not be bothered or woken up at night if it is not necessary. Resident A stated that she has a call button, so she can alert staff if she needs help. She doesn't use it unless it is necessary. Staff respond when she presses the call button. She stated that she does not have any sores or wounds. Staff are available 24 hours a day.

On 12/11/24, I interviewed Resident C. Resident C stated that she is doing fine, but she wants to return to her home in West Bloomfield. She stated that she does not go to the bathroom on herself. Staff help her go to the toilet.

I observed the other residents in the home, but they were unable to participate in an interview due to limited verbal and cognitive abilities. The residents appeared to be clean and had good hygiene. I did not observe any odors in the home.

On 12/12/24, I interviewed the complainant via telephone. The complainant stated that she knows staff who worked in the home, and she has concerns about the care the residents are receiving. She stated that she never worked in the home, but she did visit the home. The complainant stated that Peggy works the midnight shift and is not able to change the residents, so the residents do not get changed throughout the night. Peggy also sleeps throughout the night. The owners told Peggy that it was okay to sleep at night. The complainant stated that Resident E is often soaked head to toe in urine and his room smells very bad in the morning.

On 01/29/25, I interviewed the administrator from the hospice provider for Resident E. The hospice administrator stated that the nurses who visit Resident E have reported concerns about him being wet and not being changed regularly. Resident E developed a wound on his coccyx, which was not there upon his admission to the home. The hospice administrator stated that the wound could have been caused by Resident E not

being changed often enough. She stated that the visiting nurses have reported that a new caregiver started working in the home within the last two weeks, and care is getting better since the new worker started. They stated that Resident E was not being changed regularly prior to the new caregiver starting. The hospice administrator stated that hospice also bumped up Resident E's services, so they could monitor Resident E and his care more closely. She stated that Tuesday is the only day hospice is not in the home now. The hospice administrator stated that she would expect Resident E to be changed throughout the night if he was wet or soiled, especially due to the wound, which is a stage three wound on his buttocks.

On 01/29/25, I interviewed Resident B's hospice nurse. The hospice nurse stated that she recently changed companies and has not been to the home in about a month. She stated that she never had any concerns when she was at the home. The home looked clean and smelled okay. She stated that she typically went to the home in the morning, after the morning shift change, so Resident B was always changed and clean. Resident B did not have any wounds or skin breakdowns, and the hospice nurse did not have any concerns about Resident B not being changed regularly. She stated that there was no indication that Resident B was left for long periods of time in a soiled brief. Resident B's hospice nurse stated that Resident B sometimes complained that staff did not come help her in a timely manner, but Resident B "complained about everything under the sun."

On 01/29/25, I interviewed direct care worker, Peggy Tate. Ms. Tate stated that she began working in the home at the end of June and lived in the upstairs area of the home. She stated that she stopped working in the home a few weeks ago, because she received a letter stating that she was ineligible to work in the home after being fingerprinted. Ms. Tate stated that she worked the night shift in the home. She stated that she did sleep throughout her shift. She typically stayed up until 10:00pm, then she would "take a nap". She stated that she set an alarm for 11:00pm, 2:00am, and 5:00am, at which time she would get up and check on the residents. She stated that she would check if the residents needed to be repositioned or changed. Ms. Tate stated that she always changed the residents, and they were never left in soiled briefs for an extended period of time. She stated that Resident E did develop a wound on his bottom, but it was being treated and was in the process of healing. Ms. Tate stated that she cared about all of the residents in the home and took great care of them.

I reviewed a copy of the original licensing study report for Golden Grace LLC, dated 02/06/24, which states that the licensee designee indicated direct care staff will be awake during sleeping hours.

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 the needs of the residents were not attended to at all times. The live-in caregiver, Peggy Tate, stated that she worked the midnight shift and would sleep throughout her shift. Although Ms. Tate stated that she set an alarm throughout the night to check and change the residents, Resident E's hospice provider expressed concerns that he was not being changed regularly. Resident E developed a wound on his coccyx, which was not present at the time of his admission to the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The owners buy expired food and serve it to the residents.

INVESTIGATION:

The complaint also alleged that the owners purchase expired food and remove the expiration dates of the food. They instruct staff to give the expired food to the residents. It is unknown if any residents have become sick from eating expired food. On 12/11/24, I conducted an unannounced onsite inspection and interviewed the licensee designee, Huma Shahid. Ms. Shahid stated that the residents do not receive expired food. She stated that the residents get three meals a day, as well as two or three snacks per day. She stated that they purchase groceries from Aldi, and they go grocery shopping every week. She stated that food does not last long enough in the home to expire. Nobody has ever gotten sick from the food in the home. Staff are trained to check dates on all food before preparing or serving it, and they throw out any cans or food that have expired.

On 12/11/24, I interviewed Resident A. Resident A stated that the food in the home is very good. She has never noticed that the food was spoiled or expired. Resident A stated that she has never gotten sick from eating the food in the home. She stated that staff follow a menu. She could not believe that someone would complain about the home or the food. She stated that everything is good, and she did not have any complaints about the home or staff.

On 12/11/24, I interviewed Resident C. Resident C stated that the food in the home is good. She stated that she was full right now. She stated that she would not eat the food if it was bad or expired. She did not have any concerns about the food in the home.

During the onsite inspection, I observed the food in the home. There was an adequate supply of food in the home, including fruits and vegetables. I observed one canned good that expired in 2023. I did not observe any other expired food. The licensee designee, Huma Shahid, threw away the can. She stated that staff always check the dates before serving any food to the residents.

On 12/12/24, I interviewed the complainant via telephone. She stated that the owner and her husband have a friend who owns a 7-11 convenience store. They go to 7-11 and get expired food from their friend. The owners take the dates off of the food and tell staff to feed it to the residents. The complainant stated that they knew someone who used to work in the home and the caregiver stated that the food was so bad, “they would not feed it to their dog.” They complainant stated that they were not sure if the caregiver gave the food to the residents. The complainant would not disclose the name of the caregiver and stated that they no longer work in the home.

On 01/29/25, I interviewed direct care worker, Peggy Tate. Ms. Tate stated that she never observed any expired food in the home. She was not aware of staff being told to serve expired food to the residents.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that residents were being served food that was spoiled or unsafe for consumption. The licensee designee denied serving residents expired food. Resident A and Resident C did not have any complaints about the food in the home and had no knowledge of being served expired food. I observed one can in the home with an expiration date of 2023, but the licensee designee disposed of the can. She stated that staff check the dates prior to serving any food.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 12/11/24, the licensee designee's husband, Shahid Tahir, was present in the home. He had access to resident files and provided me with copies of the resident's assessment plans and records. Mr. Tahir was familiar with the residents and was knowledgeable about the needs of the residents in the home.

On 12/12/24, I interviewed the complainant via telephone. The complainant stated that the owner's husband got in trouble for Medicare fraud. She stated that staff in the home told her that he and five or six other doctors were convicted of $33 million in Medicare fraud in 2016.

I conducted an online search, and a report from the U.S. Department of Justice states that on March 15, 2016, Shahid Tahir, pleaded guilty to one count of conspiracy to commit health care fraud and wire fraud. The report noted that Shahid Tahir was the last of five defendants to plead guilty for his role in a $33 million Medicare fraud scheme involving Detroit-area home health care and hospice companies, in which he paid kickbacks, bribes, and other inducements to physicians, marketers, and patient recruiters for beneficiary referrals to companies he owned. Shahid Tahir admitted that they would then bill Medicare for home care and hospice services that were often medically unnecessary and not provided.

I interviewed the licensee designee, Huma Shahid, regarding her husband's conviction. Ms. Shahid stated that this happened a long time ago. She stated that all of the residents in the home are private pay and do not receive Medicare funding. Ms. Shahid stated that her husband is not an employee at the home and has no involvement in the business. I advised Ms. Shahid that her husband was in the home at the time of my unannounced onsite inspection, and he had access to the residents and their files. She stated that he is "working as a volunteer" in the home. Ms. Shahid stated that her husband had not completed fingerprinting through the workforce background check system. She stated that she was not aware volunteers needed to be fingerprinted. Ms. Shahid then asked if the handyman needed to be fingerprinted. I advised Ms. Shahid that anyone who has regular, direct access to the residents or their files should be fingerprinted through the Michigan Workforce Background Check system.

On 01/22/25, an employee disqualification notice was received from the Michigan Workforce Background Check system for Peggy Tate at the Golden Grace, LLC home. The disqualification notice states that Peggy Tate is not eligible to work in a job that involves direct access to residents in an adult foster care facility before 11/14/26.

On 01/29/25, I interviewed direct care worker, Peggy Tate. Ms. Tate stated that she began working in the home at the end of June and lived in the upstairs area of the home. She stated that she stopped working in the home a few weeks ago, because she

received a letter stating that she was ineligible to work in the home after being fingerprinted. She stated that she got into an altercation with her sister a few years ago regarding the care of their elderly mother. Her sister called the police and then lied at the trial. Ms. Tate stated that she entered a plea and the charges were reduced to a misdemeanor. She did not realize it would go on her record or impact her employment. Ms. Tate stated that she was not fingerprinted until January 2025, but she began working and living in the home in June 2024.

I reviewed the facility information in the Bureau Information Tracking System (BITS). Peggy Tate was not listed as a member of the household and did not have an ICHAT criminal history check completed.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection

	(1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that a criminal history check was not completed for the live-in caregiver, Peggy Tate, prior to her having direct access to the residents. Ms. Tate began working and living in the home in June 2024. She did not complete fingerprinting through the Michigan Workforce Background Check System until January 2025, at which time a disqualification notice was received, indicating Ms. Tate is not eligible to work in an adult foster care facility. The licensee designee's husband, Shahid Tahir, was also working the facility in a volunteer capacity and did not have fingerprinting completed. I observed that Mr. Tahir had direct access to the residents and their files during my onsite inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	The licensee designee, Huma Shahid, did not provide written notice to the department within 5 days of a change to the household when direct care worker, Peggy Tate, moved into the home as a live-in caregiver in June 2024. Ms. Tate was not listed in the Bureau Information Tracking System (BITS) as a member of the household and did not have an ICHAT criminal history check completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Based on the information gathered through my investigation, the licensee did not ensure the suitability of the members of the household or volunteers prior to their assumption of duties. Peggy Tate began residing in the home in June 2025. She was not fingerprinted until January 2025, at which time a disqualification notice was received, indicating that she was not suitable to work in an adult foster care facility. In addition, the licensee designee's husband, Shahid Tahir, was previously convicted of conspiracy to commit health care fraud and wire fraud in 2016. Mr. Tahir was working in the home in a volunteer capacity and had direct access to the residents and their files. He did not have fingerprinting completed to show that he was suitable to work in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 12/11/24, I reviewed the assessment plans of the residents in the home. Resident B moved into the home on 11/07/24. There was no assessment plan on file for Resident B. The licensee designee, Huma Shahid, stated that Resident B moved into the home from another facility. Her son had been sick, so they were unable to obtain the required admission forms.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	During the onsite inspection, Resident B did not have an assessment plan on file that was completed at the time of admission. Resident B moved into the home on 11/07/24. There was no assessment plan completed as of 12/11/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 12/11/24, I reviewed the Resident Information and Identification Record forms for the residents in the home. Resident B moved into the home on 11/07/24. There was no Resident Information and Identification Record form on file for Resident B. The licensee designee, Huma Shahid, stated that Resident B moved into the home from another facility. Her son had been sick, so they were unable to obtain the required admission forms.

On 02/03/2025, I conducted an exit conference via telephone with the licensee designee, Huma Shahid. Ms. Shahid stated that she would submit a corrective action plan to address the violations identified during the investigation.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(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.

ANALYSIS:	During the onsite inspection on 12/11/24, Resident B did not have a Resident Information and Identification Record form on file with the required information listed above.
CONCLUSION:	**VIOLATION ESTABLISHED**

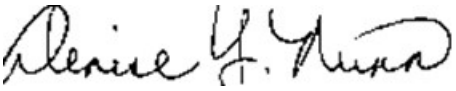
IV. RECOMMENDATION

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

02/03/2025

Kristen Donnay Date
Licensing Consultant

Approved By:



02/04/2025

Denise Y. Nunn Date
Area Manager