GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 5, 2025

Simbarashe Chiduma
Open Arms Link
Suite 130
8161 Executive Court
Lansing, MI 48917

RE: License #: AM190409578
Investigation #: 2025A0622015
Open Arms Stoll

Dear Mr. Chiduma:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 1/20/2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Amanda Blasius, 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 #:	AM190409578
Investigation #:	2025A0622015
Complaint Receipt Date:	01/08/2025
Investigation Initiation Date:	01/10/2025
Report Due Date:	03/09/2025
Licensee Name:	Open Arms Link
Licensee Address:	Suite 130 8161 Executive Court Lansing, MI 48917
Licensee Telephone #:	(517) 253-8894
Administrator:	Simbarashe Chiduma
Licensee Designee:	Simbarashe Chiduma
Name of Facility:	Open Arms Stoll
Facility Address:	Ste 130 3285 W Stoll Rd Lansing, MI 48906
Facility Telephone #:	(517) 455-8300
Original Issuance Date:	08/25/2021
License Status:	REGULAR
Effective Date:	02/25/2024
Expiration Date:	02/24/2026
Capacity:	9
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Medication was dispensed but not logged; unknown if Resident A received prescribed medication.	Yes

III. METHODOLOGY

01/08/2025	Special Investigation Intake 2025A0622015
01/10/2025	Special Investigation Initiated - On Site
01/16/2025	Contact - Document Received
01/20/2025	Contact - Document Received
01/31/2025	Contact - Telephone call made
01/31/2025	Inspection Completed-BCAL Sub. Compliance
02/03/2025	Phone call to made to direct care worker.
02/04/2025	Phone calls made to direct care workers.
02/05/2025	Exit conference with licensee designee Simbarashe Chiduma.

ALLEGATION: Medications were dispensed but not logged; unknown if Resident A received prescribed medication.

INVESTIGATION:
On 01/08/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, a 911 medical call was made regarding Resident A and the direct care staff member onsite at Open Arms Stoll stated that Resident A was dispensed his Hydrocodone, but it was never logged into the computer. The complaint documented the direct care staff member was unaware if Resident A received his dose of Hydrocodone. Resident A also reported that he did not remember getting his recent dose of Hydrocodone.

On 01/10/2025, I completed an unannounced onsite investigation to Open Arms Stoll. During the unannounced onsite investigation, I interviewed direct care worker (DCW) Jason Zilka in person. DCW Zilka reported that he was not working during the incident but was aware that Resident A went to the hospital on 01/08/25. DCW Zilka stated that Resident A will call 911 himself when he wants pain medication and

staff state he can't have them. DCW Zilka reported that Resident A has a liver disease, prostate cancer and receives radiation for his cancer. He stated that Resident A does have a history of substance use, therefore he can only receive his Hydrocodone every six hours. DCW Zilka reported that he is aware that Resident A went to Sparrow ER on 01/08/2025 at 2:55am. DCW Zilka reported that Resident A calls 911 weekly for wanting additional pain medication. DCW Zilka confirmed that Resident A is his own guardian.

On 01/10/2025, I interviewed Resident A in person. He confirmed that he is his own guardian. Resident A stated that he is aware that he can have his Hydrocodone every six hours and on the evening of 01/07/2025, he was due for another dose. Resident A reported that he had waited the six hours and when he asked for another dose, staff refused to give it to him because it was not time. Resident A explained that then he requested to call 911 due to his pain. Resident A reported that direct care worker, Obinna Udernba assisted him with calling 911. When the ambulance arrived, Resident A reported that he wanted to be taken to the hospital due to his pain and needing medication. Resident A reported that he was at the hospital from about 12am-3am on 01/08/25. Resident A explained that the hospital gave him a pain pill and sent him home.

On 01/10/2025, I reviewed Resident A's *medication administration record*. According to the *Medication Administration Record:*

Resident A is prescribed Hydrocodone 325mg, one tablet by mouth every six hours as needed for pain.

January 7th, 2025 at 6:14am Resident A was given a pill for pain
January 7th, 2025 at 1:28pm Resident A was given a pill for pain
January 7th, 2025 at 11:13pm Resident A was not available at the home and went to the ER.
January 8th, 2025 at 2:31pm Resident A was given a pill for pain

On 01/16/2025, I received further documentation from DCW Zilka. DCW Zilka provided an *AFC Licensing Division Incident Report* (incident report) from 01/08/2025 at 12:23am. According to the incident report:

- *Explain what happened: The resident's medication was popped and not passed. Then passed at an incorrect time, so the resident could not take the medication when he requested it. When staff explained, resident requested to call 911.*

- *Action taken by staff: Staff promptly called 911 per the request of the resident. Shortly after, 10-12 minutes later paramedics arrived and took the resident to the ER.*

- *Corrective action measures taken: Redirect resident on his PRN medication schedule and notify manager to deescalate the situation.*

An emergency provider note was reviewed from Sparrow Hospital. According to the provider note:

“Chief complaint: Groin pain, (Pt presents from AFC home via EMS reporting chronic and severe groin pain, hx prostate cancer, last radiation yesterday. States home is refusing to give him additional norco. Pt reports he was given a norco 1800.Reporting pain 8/10. Denies urinary issues.)

Medical Decision Making: Patient had completed his radiation treatments for prostate yesterday. The area was examined and there are no open wounds, no warmth. Patient was given a Norco and discharged to self.”

On 01/20/2025, I received an email from DCW Jason Zilka, which stated the following: “After looking into this situation it was evident that there was some miscommunication during the evening of January 7/8 regarding [Resident A].” DCW Jason Zilka attached a corrective action plan to his email.

On 01/31/2025, I attempted to call DCW Casey Lake, who worked on 01/07/2025 from 2:46pm-11:14pm. A voicemail was left for DCW Lake. A text message was received from DCW Lake and stated the following: “I am not sure what your special investigation is about, but I no longer work there, and I do not wish to speak about this place, thanks.” On 02/03/2025 I interviewed DCW Jason Zilka via phone. DCW Zilka confirmed that DCW Casey Lake was let go from Open Arms Stoll on 01/31/2025.

On 02/04/2025, I interviewed DCW Obinna Udernba via phone. He confirmed that he worked the 3rd shift on 01/7/25 into 01/08/2025. He stated that he arrived at the home at 11pm and completed his medication count. At that time, he found the count to be off and he asked DCW Casey Lake if the count was off when he arrived at 3pm. DCW Lake reported to DCW Udernba that the count was correct when he arrived at 3pm. DCW Udernba stated that Resident A came to him and asked for his Hydrocodone around 11pm. DCW Udernba stated that he checked the medication administration record and found that the medication was prepped, but was administered, according to the medication administration record. DCW Udernba stated that within the bubble pack, the Hydrocodone medication was also popped. DCW Udernba reported that he asked DCW Casey if the Hydrocodone medication was administered to Resident A and he was told yes. DCW Udernba reported that the medication administration record would not allow him to administer additional Hydrocodone. Therefore, DCW Udernba explained this to Resident A that he could not have another dose of Hydrocodone. DCW Udernba reported that Resident A requested to call 911 and he assisted Resident A with making the phone call. DCW Udernba stated that he could not recall the time that the ambulance arrived, nor the time when he returned from the hospital. DCW Udernba stated that EMS took Resident A to the hospital due to his pain and needing additional pain medication and the AFC home not being able to administer an additional pill. DCW Udernba reported that he did communicate with the manager of the home via phone, Jason Zilka.

On 02/04/2025, I interviewed direct care worker, Marquitta Warren. She reported that she is no longer employed at Open Arms Stoll. She confirmed that she worked second shift on 01/07/25 with DCW Casey Lake. She stated that DCW Casey Lake took a resident somewhere and she was left at the home to prepare dinner and care for the residents. DCW Warren stated that it was 8pm, so she stopped to prepare to pass medications. DCW Warren reported that she was not assigned to medications, and she had to log into the system under DCW Casey Lake. DCW Warren stated that she popped the Hydrocodone medication but forgot to log it into the medication administration record. DCW Warren reported that Resident A did take the Hydrocodone and that she was sorry about the documentation error, as it cause additional problems for Resident A.

There was one previous special investigation for Open Arms Stoll in 2022 which also included a medication error.

1. Special Investigation Report #2022A0790006 dated March 30, 2022, documented the facility did not have Resident A's medication administration records for November 2021 or December 2021 available for review. It is required for the facility to maintain at least a copy of resident medication administration records even if requested by law enforcement.

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:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(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:	Based on interviews with direct care workers and reviewing the medication administration record for Resident A it was determined that direct care workers did not properly log the administration of Resident A's hydrocodone medication on 01/07/25 in the evening. The time the Hydrocodone was administered and the initials of the person who administered the medication were missing from Resident A's medication administration log. The documentation error completed by DCW Warren and DCW Lake caused confusion in determining when Resident A was due for his next Hydrocodone medication which resulted in Resident A calling 911 and going to the hospital.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR # 2022A0790006 DATED MARCH 30, 2022, CAP COMPLETED FOR INVESTIGATION].**

IV. RECOMMENDATION

An acceptable corrective action plan has been received, therefore; I recommend no change in the license status.

02/05/2025

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Amanda Blasius Date
Licensing Consultant

Approved By:

02/05/2025

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Dawn N. Timm Date
Area Manager