GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 1, 2025

Tema Pefok
Precious AFC Home, Inc.
7435 Silver leaf Lane
West Bloomfield, MI 48322

RE: License #: AS820406515
Investigation #: 2025A0992013
Plum

Dear Mrs. Pefok:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820406515
Investigation #:	2025A0992013
Complaint Receipt Date:	02/07/2025
Investigation Initiation Date:	02/10/2025
Report Due Date:	04/08/2025
Licensee Name:	Precious AFC Home, Inc.
Licensee Address:	7435 Silver leaf Lane West Bloomfield, MI 48322
Licensee Telephone #:	(248) 506-5329
Administrator:	Tema Pefok
Licensee Designee:	Tema Pefok
Name of Facility:	Plum
Facility Address:	26275 Plum Inkster, MI 48141
Facility Telephone #:	(248) 506-5329
Original Issuance Date:	05/24/2021
License Status:	REGULAR
Effective Date:	11/24/2023
Expiration Date:	11/23/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A became unresponsive in the home and was declared deceased on 2/4/2025. There are concerns Resident A was not provided adequate supervision.	Yes

III. METHODOLOGY

02/07/2025	Special Investigation Intake 2025A0992013
02/10/2025	Special Investigation Initiated - On Site Direct care staff, Anani Migan, Djomion Migan and Roben Tanue and Resident B.
02/10/2025	Contact - Telephone call made Licensee designee, Tema Pefok
02/11/2025	Contact - Telephone call made Ms. Pefok
02/13/2025	Contact - Face to Face Home manager, Kia Fleors; direct care staff, Cromwell Zama and Etiennetabi Kingsley and Resident D.
02/13/2025	Contact - Telephone call made Resident A's guardian at the time of death, Relative A.
02/21/2025	Contact - Face to Face Direct care staff, Kingsley and Djomion Migan; and Ms. Fleors.
02/24/2025	Contact - Telephone call made Resident D's supports coordinator, Chris Riley with Community Living Services.
02/24/2025	Contact - Telephone call made Residents C and D's guardian, Paul Toroni with Faith Connections.
02/24/2025	Contact - Telephone call made Resident C's supports coordinator, Christina Hadley with Neighborhood Services, was not available. Message left.

02/24/2025	Contact - Telephone call made Resident B's supports coordinator, Eugena May with Neighborhood Services, was not available. Message left.
02/24/2025	Contact - Telephone call made Resident B's guardian, Relative B was not available. Message left.
02/24/2025	Contact - Telephone call made Resident A's supports coordinator, Myriah Graham with Goodwill.
02/24/2025	Contact - Document Sent Postmortem report requested from Wayne County Medical Examiner.
02/25/2025	Contact - Telephone call received Relative B
02/25/2025	Contact - Telephone call received Ms. May
02/26/2025	Contact - Telephone call made Ms. Hadley was not available. Message left.
02/28/2025	Contact - Face to Face Resident A’s medical records retrieved from Garden City Hospital.
03/03/2025	Contact - Telephone call made Ms. Hadley
03/12/2025	Contact - Telephone call made Ms. Pefok
03/12/2025	Contact - Document Received Staffing schedule
03/18/2025	Contact - Telephone call made Wayne County Medical Examiner
03/18/2025	Contact - Telephone call made Ms. Pefok
04/01/2025	Exit Conference Ms. Pefok

ALLEGATION: Resident A became unresponsive in the home and was declared deceased on 2/3/2025. There are concerns Resident A was not provided adequate supervision.

INVESTIGATION: On 02/10/2025, I completed an unannounced onsite inspection. At the time of arrival direct care staff Djomion Migan answered the door. As I entered the home, Djomion appeared to be the only staff present. Direct care staff, Anani Migan, and Roben Tanue later arrived at the home. Anani identified the home manager as Kia Fleors, he stated she went grocery shopping and would be back soon. Anani stated the files are kept locked up and Ms. Fleors has the key. He stated he does not have access to the resident files. The resident files were not available for review.

I contacted the licensee designee, Tema Pefok and made her aware of the investigation and the need to review Resident A's file. Ms. Pefok stated she would contact Ms. Fleors and instruct her to return to the home immediately to access the resident files.

I interviewed Anani Migan regarding the allegation. Anani stated on 2/03/2025, he worked along with Cromwell Zama and Roben Tanue. Anani stated his shift started at 4:00 p.m. but he arrived early. Anani stated he was assigned as Resident A's 1:1 staff. Anani stated Resident A is non-verbal, but able to make noise and gestures to communicate. Anani stated he asked Resident A how he was doing, and he gestured he was fine. Anani stated he prepared dinner, and Resident A was eating slowly which was not normal for him. Anani stated he asked Resident A what's wrong and he said, "chocho," which meant he wanted some water. Anani stated he gave Resident A some water, Resident A took two more bites of his dinner and vomited. Anani stated he called Kia Fleors, but she did not answer. Anani stated he bathed Resident A and got him all cleaned up. Anani stated Resident A walked into the living room and sat in the chair. Anani stated he took Resident A's soiled clothes to the basement and gave them to Roben, who was washing clothes. Anani stated he was in the basement for less than a minute. Anani stated he handed Roben Resident A's clothes and immediately went back upstairs. Anani stated when he came back upstairs Resident A was not moving and was unresponsive. Anani stated he called Kia, Cromwell and 911. Anani stated he moved Resident A to the floor and started cardiopulmonary resuscitation (CPR) while on the phone with 911. Anani stated Cromwell had gone to the other home and was not present at the time. Anani stated Residents B, C and D were in the home at the time the incident occurred.

I interviewed Roben Tanue. He confirmed he was on shift on 2/03/2025, and that his shift started at 4:00 p.m. He stated when he arrived Residents A, B, C and D were in the living room. He stated Anani prepared dinner, and the residents were eating. Roben stated Resident A vomited. Roben stated Anani took Resident A to the bathroom and cleaned him up. Roben stated he mopped up the vomit. He stated after Resident A got cleaned up, he sat in the living room. Roben stated he went to the basement to pour out the mop water. Roben stated while in the basement, Anani

yelled for him. He stated when he got upstairs Resident A was in the chair shaking. Roben stated Anani called 911 and performed CPR. He stated the emergency medical service (EMS) arrived and Resident A was transported to the hospital. Roben stated he was shocked because Resident A appeared fine. He stated he seemed healthy and didn't have any medical issues.

I observed Resident B sitting in the living room. He appeared to be clean and adequately dressed. Resident B is non-verbal and unable to be interviewed.

Kia did not return while I was onsite. I made follow-up contact with Ms. Pefok and made her aware that I intended to return to review the resident files.

On 02/11/2025, I contacted Ms. Pefok and interviewed her regarding the allegation. Ms. Pefok stated she was not in the home when the incident occurred. She stated she received a call from Anani, and he made her aware of what happened. Ms. Pefok provided statements consistent with the statements Anani provided to me during my face-to-face interview with him on 02/10/2025. Ms. Pefok stated Anani denied Resident A demonstrated any signs of illness other than vomiting. Ms. Pefok stated Kia worked that day as well, from 8:00 a.m. to 4:00 p.m. and she did not report any abnormal behavior from Resident A. Ms. Pefok identified Resident A's guardian as Relative A and his supports coordinator as Myriah Graham with Goodwill.

On 02/13/2025, I completed an onsite inspection and interviewed Kia, Cromwell Zama; direct care staff, Etiennetabi Kingsley; and Resident D regarding the allegation. Kia stated on 2/03/2025, she worked from 8:00 a.m. to 4:00 p.m., along with Etiennetabi Kingsley and Djomion. She stated she was not on shift when the incident occurred. Kia stated during her shift, she was assigned as Resident A's 1:1 and he appeared fine. Kia stated Resident A did not demonstrate any signs of illness and carried on as normal. Kia stated all residents were present during her shift, including Residents B, C and D. Kia stated all residents are non-verbal except Resident D.

I interviewed Cromwell. Cromwell confirmed he worked on 02/03/2025 from 8:00 a.m. to 4:00 p.m.; he stated he stayed over a little later that day. He stated during his shift Resident A did not show any signs of illness. Cromwell stated Resident A is non-verbal, but he used gestures to communicate. Cromwell stated it was a normal day, and Resident A did not appear ill until he vomited. Cromwell stated when Resident A vomited, he went to the store to get some cleaning supplies, so that staff could clean up. He stated while he was gone, he received a call from Anani stating Resident A was unresponsive. Cromwell stated he immediately returned to the home and EMS was there. Cromwell stated EMS transported Resident A to the hospital and he followed them.

I interviewed Etiennetabi Kingsley. He confirmed he worked on 02/03/2025 from 8:00 a.m. to 4:00 p.m. He stated during his shift Resident A appeared fine.

Etiennetabi stated Resident A had breakfast, he was dressed and did not show any signs of distress.

Cromwell awakened Resident D, and he agreed to be interviewed. I attempted to interview Resident D. Resident D did not maintain focus and started to mumble; his speech was unintelligible. Resident D did not address the allegation. He did not appear competent to be interviewed.

I obtained a copy of Resident A's individual plan of services (IPOS), effective 1/01/2025 through 12/31/2025. Resident A's IPOS reads as follows,
• "Will continue to receive 1:1 staff to assist and monitor with food seeking behaviors, pica-like behaviors, and picking with his hands which cause sores daily through PCP period ending in 12/31/2025."
• "Staff will monitor (Resident A) regarding pica-like behaviors. The staff will ensure that (Resident A) is not eating any thing that is inedible. Staff will continue to redirect (Resident A) when he participates in this behavior via verbal prompts like no, this is not good to eat, no this is for wiping only and etc."
• "Staff will teach (Resident A) how to identify what is edible and inedible such as this is a banana, or this is a napkin, etc."
• "Staff will monitor (Resident A) when around others with food and/or beverages to make sure (Resident A) will not grab food from other as he is food motivated. Staff will redirect consumer when he attempts to grab food and beverages from others via verbal cues."
• "Staff will continue to cut up (Resident A's) food to ensure no choking hazard due to only having 4 teeth." "Staff will monitor that (Resident A) is eating an appropriate pace to avoid a choking hazard."

On 02/13/2025, I contacted Resident A's guardian, Relative A and interviewed her regarding the allegation. Relative A stated there are a lot of concerns regarding the circumstances that lead to Resident A's demise. Relative A stated outside of Resident A being non-verbal, he was otherwise healthy. She stated he did not have any known health issues; he did not have high blood pressure, etc. She stated it does not make sense to her at all. She stated the lack of empathy Kia expressed was disheartening. She stated she received a call from Kia stating Resident A was vomiting and was transported to the hospital by EMS. Relative A stated there was no sense of seriousness. She stated she contacted the hospital, and they made her aware that Resident A came in through emergency as a code blue and he expired. Relative A stated she spoke with the physician, and he stated Resident A aspirated. Relative A stated according to Anani he gave Resident A a shower after he vomited, got him dressed and Resident A sat in the living room. She stated Anani went to the basement and when he returned Resident A was unresponsive. She stated according to the emergency room medical report; Resident A was found face down when EMS arrived. She stated how can you perform CPR on a person that is face down. Relative A stated she believed Resident A choked while Anani was in the basement and fell on the floor, which is why he was found faced down. Relative A confirmed Resident A required 1:1 staffing and should never have been left alone.

On 02/21/2025, I completed an unannounced onsite inspection and made face-to-face with Etiennetabi, and Djomion; Ms. Fleors arrived shortly after. I requested to review Residents B, C and D's IPOS.

I obtained a copy of Resident B's IPOS, effective 10/22/2024 through 10/21/2025. Throughout Resident B's IPOS it reads as follows,
• "CLS (Community Living Services) will provide 2:1 staffing within arm's length for (Resident B)."
2:1 staffing within arm's length is mentioned seven times within Resident B's IPOS.

Resident C's IPOS, effective 2/29/2024 through 2/23/2025. Throughout Resident C's IPOS it reads as follows,
• "2:1 staff ratio during waking hours and 1:1 staffing at night.
2:1 staffing within arm's length is mentioned nine times within Resident B's IPOS.

Resident D's IPOS, effective 4/25/2024 through 3/19/2025. Throughout Resident D's IPOS it reads as follows,
• "Awake hours: I am receiving 1:1 staffing ratio due to gait issues, predatory sexual behavior, and property destruction. As described by staff (Resident D) is always seeking ways to take advantage of a vulnerable housemate, so he will try to sneak into his bedroom and inappropriately touch him if within close proximity."
• "The psychologist has recommended a 1:1 to help with predatory behaviors towards the housemates and certain staff."

On 02/24/2025, I contacted Resident D's supports coordinator, Chris Riley with Community Living Services to confirm Resident D's staffing needs. Mr. Riley stated Resident D requires 1:1 staffing in the home and community.

On 02/24/2025, I contacted Residents C and D's guardian, Paul Toroni with Faith Connections to confirm their staffing needs. Mr. Toroni was uncertain of their staffing needs. He suggested I contact Resident C and D's supports coordinator to confirm their needs.

On 02/24/2025, I contacted Resident A's supports coordinator, Myriah Graham with Goodwill regarding the allegation. Myriah confirmed the allegation and stated she was previously made aware by Kia. She stated she received a copy of the incident report, and it was vague. She stated she called Kia and was made aware of Resident A's demise. As far as medical history, Myriah stated Resident A had some hypertension issues, but she is uncertain if he was actually diagnosed with hypertension or not. Myriah stated she last visited Resident A in 1/2025 and did not have any concerns.

On 02/24/2025, I submitted a request to Wayne County Medical Examiner for a copy of the postmortem report.

On 02/25/2025, I contacted Resident B's guardian. Relative B stated she is actively involved with Resident B services and denied having any concerns regarding the quality of care provided. She stated to her knowledge Resident B requires and receives 1:1 staffing. Relative B stated every time she visits there are at least two staff in the home.

On 02/25/2025, I contacted Resident B's supports coordinator, Eugena May with Neighborhood Services. Ms. May stated she was assigned as Resident B's support coordinator, but the case was recently reassigned to Jennifer Williams. Ms. May stated no changes have been made to Resident B's IPOS and he does require 2:1 staffing within arm's length. She stated when visiting with Resident B there were at least two staff on shift.

On 02/28/2025, I obtained a copy of Resident A's medical records. The medical record reads as follows, "Patient (Resident A) arrives to ED (emergency department) for cardiac arrest. Per Inkster EMS, patient (Resident A) is a resident of a group home and during shift change rounds patient (Resident A) was found down by group home staff with potential aspiration and unknown downtime. Patient (Resident A) arrives with active CPR performed by Inkster."

"Patient (Resident A) is a 49-year-old gentleman with past medical history of autism and hypertension who was brought in by EMS due to cardiac arrest. Patient (Resident A) lives in a group home, per EMS group home personnel step out to do laundry when they came back patient (Resident A) was face down and blue. Upon EMS arrival patient (Resident A) was Lue, did not have any pulses, EMS initiated CPR intubated patient (Resident A) and brought patient (Resident A) here the total CPR done by EMS was 10 minutes."

On 03/03/2025, I contacted Resident C's supports coordinator, Christina Hadley with Neighborhood Services to confirm Resident C's staffing needs. Ms. Hadley stated Resident C requires 2:1 staffing at all times during awake hours and 1:1 during sleep hours.

On 03/12/2025, I contacted Ms. Pefok and requested a copy of the home staffing schedule for 1/01/20025 to 2/28/2025.

On 03/12/2025, I received and reviewed the home staffing schedule from 1/01/20025 through 2/28/2025. According to the staffing schedules, there are three shifts: 8:00 a.m. to 4:00 p.m.; 4:00 p.m. to 12:00 a.m.; and 12:00 a.m. to 8:00 a.m. There are three staff scheduled per shift.

On 03/18/2025, I contacted the Wayne County Medical Examiner regarding the postmortem report request. The report is pending.

On 03/18/2025, I contacted Ms. Pefok regarding the findings. I explained that upon review of Residents A's IPOS, he requires 1:1 staffing at all times. I acknowledged

that Anani was assigned as Resident A's 1:1 on 2/03/2025, and he left Resident A in the living room unsupervised while he went to the basement. I made Ms. Pefok aware that I reviewed Residents B-D's IPOS, along with the staffing schedule, and there is insufficient staffing during all shifts. Ms. Pefok explained that at one point there were five direct care staff on shift, along with the residents and it was too chaotic. She stated the resident's behaviors were heighten. Ms. Pefok stated instead of having five staff plus four residents, she decided to decrease the staff but hire more experienced staff. She stated the more experienced staff were able to redirect the residents as needed and their behaviors decreased. I explained that based on Residents A-D's IPOS, there should have always been six staff on duty. I informed her that Resident A required 1:1 staffing; Resident B requires 2:1 staffing; Resident C requires 2:1 staffing and Resident D requires 1:1 staffing.

On 04/01/2025, On 12/11/2017, I completed an exit conference with Ms. Pefok and made her aware of my findings. I also made Ms. Pefok aware that she will receive a copy of the special investigation report. Ms. Pefok was very apologetic and stated she has been operating in good standing for many years, and this was an isolated incident. She stated she had good intentions by decreasing the staff and hiring more experienced staff, thinking they would be better suited to handle the residents' behaviors that they were exhibiting at that time. She stated the residents' behaviors have since decreased and they are thriving. Ms. Pefok requested the department take her history in consideration when considering the next course of action.

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 upon my investigation, which consisted of multiple interviews with licensee designee, direct care staff, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that direct care staff did not provide Resident A with supervision and protection as specified in his IPOS on 2/03/2025 for his protection and safety. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	During my investigation, which consisted of multiple interviews with licensee designee, direct care staff, and a review of pertinent documentation relevant to this investigation, including Residents A-D's IPOS and the staffing schedule. According to Residents A-D's IPOS, Resident A required 1:1 staffing; Resident B requires 2:1 staffing; Resident C requires 2:1 staffing and Resident D requires 1:1 staffing. Based on the resident needs there should always be six staff per shift. According to the home staffing schedule from 1/01/20025 through 2/28/2025. There are three shifts, and each shift contains three direct care staff. Based on my findings there is sufficient evidence that the licensee did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents to provide the services specified in the resident's resident care agreement and assessment plan. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend revocation of the license.

04/30/2025

_____

Denasha Walker Date
Licensing Consultant

Approved By:

05/01/2025

_____

Ardra Hunter Date
Area Manager