GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 7, 2025

Vivian Ngwa
Emerald Care LLC
25465 Wykeshire Rd
Farmington Hills, MI 48336

RE: License #: AS820415081
Investigation #: 2025A0121031
Grand

Dear Ms. Ngwa:

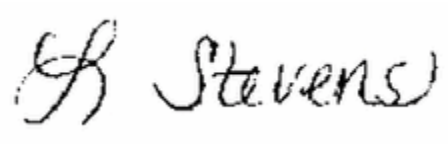
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0439.

Sincerely,



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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820415081
Investigation #:	2025A0121031
Complaint Receipt Date:	05/13/2025
Investigation Initiation Date:	05/14/2025
Report Due Date:	07/12/2025
Licensee Name:	Emerald Care LLC
Licensee Address:	25465 Wykeshire Rd Farmington Hills, MI 48336
Licensee Telephone #:	(248) 861-8365
Administrator:	Vivian Ngwa
Licensee Designee:	Vivian Ngwa
Name of Facility:	Grand
Facility Address:	3000 West Grand Street Detroit, MI 48238
Facility Telephone #:	(313) 305-4456
Original Issuance Date:	06/20/2023
License Status:	REGULAR
Effective Date:	12/20/2023
Expiration Date:	12/19/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Medication is not documented properly.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/13/2025	Special Investigation Intake 2025A0121031
05/13/2025	Referral - Recipient Rights Received
05/13/2025	APS Referral Made by Recipient Rights
05/14/2025	Special Investigation Initiated - Telephone Call Domonique Moore, Recipient Rights
07/01/2025	Contact - Document Received Received this investigation from consultant Kara Robinson
07/03/2025	Inspection Completed On-site Face to face with Resident A, B and staff Frances Ngang
07/03/2025	Inspection Completed-BCAL Sub. Compliance
07/03/2025	Exit Conference Telephone exit conference with licensee designee, Vivian Ngwa

ALLEGATION: Medication is not documented properly.

INVESTIGATION: On 07/03/2025, I completed an unannounced onsite inspection. I reviewed medication and medication logs. Both Resident A and Resident B are new admissions to the facility. Resident A was admitted on 07/01/2025 and Resident B was admitted on 07/02/2025. Neither resident had a completed medication log

sheet. When asked, they indicated they received their medication. I interviewed the staff, Frances Ngang. He indicated he administered the medication but had not completed the logs. In addition to these logs, I reviewed the medication log for Resident C. Resident C was discharged from the facility. I observed his old medication log to not have initials to verify administration on April 3, 2025, April 4, 2025, April 17, 2025, and April 18, 2025. I informed Mr. Ngang medication logs should be initialed at the time of administration. He stated that it was normally his practice to initial during administration, but he hadn't this time.

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:	I completed an unannounced onsite inspection. I observed Resident A and B to have blank medication log sheets. The medication log did not have initials to verify administration of medication. Resident A was admitted to the facility on 07/01/2025 and Resident B was admitted 07/02/2025. Both residents are prescribed morning and bedtime medication. I also reviewed the medication log of Resident C, a discharged resident. His medication log did not have initials to verify administration on April 3, 2025, April 4, 2025, April 17, 2025, and April 18, 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 07/03/2025, I completed an unannounced onsite inspection. At the time of my arrival the facility was without staffing. The home is a two-family

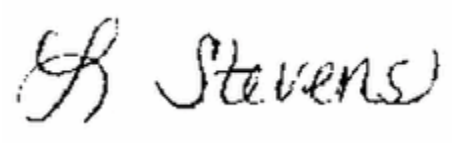
flat and both units are separate licensed adult-foster care facilities. I observed an unidentified male in the lower unit; I identified myself and asked if he was staff for the upstairs facility. He stated he was not staff. While speaking with him Resident B came on the porch. I asked if there were staff upstairs and he stated no. I called the licensee designee, Vivian Ngwa, and informed her of the situation. Within five minutes, Frances Ngang arrived. I arrived at the facility at 12:18 p.m. and Mr. Ngang arrived at 12:35 p.m. Mr. Ngang stated he is facility staff and indicated the man in the lower unit was also staff. I informed him, he told me he wasn't staff, and that unit is a separate licensed area and cannot be combined with this upper unit. Furthermore, I informed him the residents were not made aware he was staff because the Resident indicated no staff were available. Therefore, no staff were available for the upstairs unit in which I was investigating.

I completed a telephone exit conference with licensee designee, Vivian Ngwa. She was informed this complaint will be substantiated. Ms. Ngwa had no comment regarding the medication logs not being initialed as administered. However, she indicated Mr. Ngang was staff for the upstairs licensed area and left the facility.

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:	At the time of my unannounced onsite inspection residents were at the facility with no staff supervision. I arrived at the facility at 12:18 p.m. and staff arrived at 12:35 p.m. The facility did not have the required staff to resident ratio. Resident B indicated no staff were inside of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



07/07/2025

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LaKeitha Stevens Date
Licensing Consultant

Approved By:

07/07/2025

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Ardra Hunter Date
Area Manager