GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 29, 2026

Huma Shahid
Nannies Inn By Golden Grace
3050 Spring Street
West Bloomfield Twp, MI 48322

RE: License #: AS630418556
Investigation #: 2026A0605021
Nannies Inn By Golden Grace

Dear Huma Shahid:

Attached is the Special Investigation Report for the above referenced facility. 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 (248) 972-9136.

Sincerely,

Frodet Dawisha

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 W. Grand Blvd
2nd Floor Annex, Ste 2-730
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418556
Investigation #:	2026A0605021
Complaint Receipt Date:	05/12/2026
Investigation Initiation Date:	05/12/2026
Report Due Date:	07/11/2026
Licensee Name:	Nannies Inn By Golden Grace
Licensee Address:	3050 Spring Street West Bloomfield Twp, MI 48322
Licensee Telephone #:	(248) 431-8586
Administrator/Licensee Designee:	Huma Shahid
Name of Facility:	Nannies Inn By Golden Grace
Facility Address:	3050 Spring Street West Bloomfield Twp, MI 48322
Facility Telephone #:	(248) 562-7966
Original Issuance Date:	08/01/2024
License Status:	1ST PROVISIONAL
Effective Date:	05/01/2026
Expiration Date:	10/31/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED/TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was unkempt, dirty and had pressure ulcers. There is concern he was not receiving care for the pressure ulcers at the group home.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/12/2026	Special Investigation Intake 2026A0605021
05/12/2026	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
05/12/2026	Contact - Face to Face With Resident A and hospital staff at Henry Ford Hospital- West Bloomfield (HFHWB)
05/12/2026	Inspection Completed On-site Unannounced on-site investigation
05/12/2026	APS Referral Adult Protective Services (APS) referral was made
05/12/2026	Contact - Telephone call made Call with Resident A's family and with licensee designee Huma Shahid's son, Uzair Shahid
05/12/2026	Contact - Document Sent Email to licensee designee Huma Shahid
05/13/2026	Contact - Document Received Email from licensee designee Huma Shahid
05/19/2026	Contact - Telephone call received Discussed allegations with Resident A's legal guardian. Uzair Shahid left message to return his call
05/20/2026	Contact - Telephone call made Discussed allegations with Uzair Shahid

05/27/2026	Contact - Document Received Email from Resident A's HomeNP Health Solutions case manager Mariah Halbert
06/01/2026	Contact - Telephone call made Discussed allegations with DCS
06/03/2026	Contact - Telephone call received Follow-up with Resident A's legal guardian
06/08/2026	Contact - Telephone call made Left message for DCS and Hospice of MI
06/08/2026	Contact - Telephone call made Discussed allegations with APS worker Candid Jamerson
06/08/2026	Contact - Telephone call received Uzair Shahid left message
06/10/2026	Contact - Face to Face Unannounced face-to-face was made at the group home
06/10/2026	Contact - Telephone call made Follow-up call with Resident A's legal guardian
06/11/2026	Contact - Telephone call made Left message for Uzair Shahid
06/11/2026	Contact - Telephone call received Discussed allegations with Hospice of MI
06/15/2026	Contact - Telephone call made Discussed allegations with licensee designee Huma Shahid
06/16/2026	Contact - Telephone call received Follow-up with APS worker Candid Jamerson
06/22/2026	Contact – Document received Email from Hospice of MI
06/23/2026	Contact – Telephone call made To DCS Tiffany Clark
06/24/2026	Exit Conference Conducted exit conference with licensee designee Huma Shahid and her son Uzair Shahid with my findings and recommendation.

06/25/2026	Contact – Document received Email from Uzair Shahid
06/25/2026	Contact – Telephone call made HFH and HFH- home health care (HHC) was contacted and follow-up made with DCS Shanae McGhee
06/29/2026	Contact – Document sent Email to Uzair Shahid- recommendation from exit conference remains in effect

ALLEGATION:

Resident A was unkempt, dirty and had pressure ulcers. There is concern he was not receiving care for the pressure ulcers at the group home.

INVESTIGATION:

On 05/12/2026, intake #210611 was assigned alleging that Resident A presented to Henry Ford Hospital (HFH)- West Bloomfield covered in feces and had several open pressure wounds. I made a referral to Adult Protective Services (APS). The APS worker assigned was Candid Jamerson.

On 05/12/2026, I contacted the case manager, Sallie Amalfitano, with HFH regarding Resident A. Ms. Amalfitano reported that Resident A arrived in the emergency room (ER) with altered mental status, urinary tract infection (UTI) and pressure ulcers. Resident A was “covered in dry feces,” and “feces are embedding in his nails.” Resident A had been at HFH last month from 04/12/2026-04/14/2026 regarding a UTI and pressure ulcers. HFH recommended home health care (HHC) at discharge, but the licensee designee, Huma Shahid, stated that the group home would set this up themselves and did not need a referral to HHC. Resident A is currently presenting with pressure ulcers on his right arm, the right side of his back, the top of both feet, and he has severe scrotal wounds. There is concern that staff at this group home were not providing wound care when he was discharged from HFH on 04/14/2026. There is no current discharge date for Resident A.

On 05/12/2026, I made a face-to-face visit with the case manager, Sallie Amalfitano, and Resident A’s registered nurse (RN), Karley, at HFH. The RN reported that Resident A had wounds, “the size of golf balls” on his left heels which is an indication that he was not “moved,” while lying in bed. There is also a pressure wound on the right side of the back where the back and buttocks meet that is 13 centimeters in length by six centimeters in width with Eschar tissue. There is a dime size wound on his right shoulder and a quarter size wound on his right side in the ribcage area. There is significant scabbing along the right side of his ribcage and there is skin breakdown in

his scrotum area that was also covered in dry feces when he arrived in the ER. Resident A was also found to be dehydrated. The RN stated that the ER doctor documented this as “neglect,” due to the condition Resident A presented in the ER. Resident A has been at HFH regarding a UTI in 12/2025 and currently. He was also in the hospital from 04/12/2026-04/14/2026 and at that time, “multiple abrasions,” were documented. He is non-ambulatory and requires at least two people to transfer him and provide care to him. He was in restraints when he arrived, but since then the restraints have been removed. At first, Resident A was difficult to provide care to but now he has been compliant.

On 05/12/2026, I interviewed Resident A in his hospital room at HFH. He was lying in bed watching TV. I observed significant bruises on both of his arms and there was feces embedded in his nails on both hands. Resident A stated he likes it at the group home, but that staff are 50/50 regarding him liking staff and staff doing what they are supposed to do. He then stated, “they are tear jerkers,” referring to staff but was unable to provide further information. Resident A had difficulty answering questions, so I ended the interview.

On 05/12/2026, I conducted an unannounced on-site investigation. Present were live-in direct care staff (DCS), Erin Rusell, Resident D, and Resident E. Resident C was not present, as he was at dialysis. I interviewed Erin regarding the allegations. Erin has been working for this corporation for one month. She completed all her training requirements and stated she was “live-in staff.” She works daily from 7AM-7PM. Resident A went to the hospital on 05/04/2026 because Erin discovered wounds on his buttocks near his back while changing his brief. Erin stated, “this was the first time I saw this wound, so I called the home manager (HM) Uzair Shahid, the licensee designee’s Huma Shahid’s son.” Erin advised Uzair of the open wound, and he advised her to call an ambulance, which she did. The ambulance arrived and transported Resident A to the hospital. Resident A was resistant to care by staff. He was combative and would not allow staff to change his brief. She stated, “it took two staff to change him because he keeps fighting us.” Erin heard two months ago that staff were assisting him in the toilet, but now he wears briefs. He was standing up and allowing her to change his brief, but then it became difficult for him to stand. This occurred after his discharge from HFH on 04/14/2026. He returned from the hospital with a UTI, completed all his medications and was more combative and resistant to help. Erin reported these concerns to the HM, but nothing was done. Resident A continued to resist care and would not want her to reposition him. Erin does not know anything about HHC because there was no one coming out to the home to provide wound care. She stated, “I never knew he had any wounds. I never provided wound care to him.” Prior to this hospitalization, she stated that she had only changed his brief “once before.” It was unclear who was assisting Resident A with his hygiene needs. Erin stated when Resident A was sent to the hospital on 05/04/2026 he did not have a bowel movement (BM), and she does not know why he was covered in feces.

I interviewed Resident E in her bedroom. Resident E stated, “it is alright,” when asked how she likes living at this group home. Resident E ambulates on her own without

assistance. She does not know who Resident A is but stated that “staff are alright.” She was unable to provide further information.

I interviewed Resident D in his bedroom. Resident D uses a wheelchair to ambulate. He is dependent on staff for all his care. He can assist staff with transfers and stated that staff are “Ok.” Resident A was his roommate who is in the hospital, but he was unable to provide any further information.

On 05/12/2026, I contacted Resident A’s family (Family A) on the telephone regarding the allegations. Family A visited with Resident A about three-four times during Resident A’s admission into this group home. The last visit was about a week and a half prior to his current admission into HFH. Family A spoke with Resident A’s legal guardian who advised Family A that Resident A had “pressure sores,” due to “Resident A not being changed.” Resident A was aggressive, not accepting care from staff which included being changed and refused to eat. Family A stated, “ever since I began visiting Resident A, he was unable to walk and always sitting in his wheelchair.” On the last visit, Resident A was lying in bed and was sleeping/resting. Resident A opened his eyes, and recognized Family A but then went back to sleep. Family A did not get an opportunity to observe Resident A’s condition. Family A stated that Resident A’s sister passed away in 12/2025 who was Resident A’s legal guardian. During 12/2025, Resident A required “some type of assistance,” regarding his care from staff. When he visited Resident A, he was there for about half an hour. Resident A would propel himself in the wheelchair using his hands and his feet. He was unaware of the condition Resident A was found in when admitted into the hospital.

On 05/12/2026, I interviewed the licensee designee’s son, Uzair Shahid, who oversees the home, regarding the allegations. Resident A began declining after his sister, who was Resident A’s legal guardian, passed away in 12/2025. Resident A was combative, refusing to be changed by staff. Resident A did not want to take his medications or eat. He has been at HFH a few times because of a UTI. Uzair stated, “there were no pressure sores until recently.” He was unable to provide a timeframe when the pressure sores showed up and stated that after his discharge from HFH on 04/14/2026, medication was given for the UTI, which Resident A finished, but it did not clear up the UTI. On 05/04/2026, DCS Erin Russell discovered the pressure wound on Resident A’s buttocks and contacted Uzair. He directed her to call an ambulance, which she did. After his discharge from HFH on 04/14/2026, a referral was sent to Universal HHC, but they did not accept his insurance. No other referrals were made to HHC. Therefore, the pressure wounds were not cared for by staff. On 04/22/2026, HomeNP came out to see Resident A and ordered bloodwork, but because Resident A was “combative,” the doctor was unable to complete an assessment. The doctor ordered UTI medications due to symptoms Resident A was having. Uzair stated that he would send me staff documentation logs, a body skin assessment and HFH discharge papers. He was unable to answer questions regarding the pressure sores and whether staff were providing wound care.

On 05/14/2026, I received an email from Uzair Shahid with the staff schedule for 04/2026-05/2026. The staff schedule did not have the names of the staff, just their first initials, did not have the hours worked on all the days on either 04/2026-05/2026, and did not have job titles. I also received the incident reports (IR) dated 05/04/2026 completed by DCS Erin Russell. The IR stated, “refusing to be changed for hours, being combative and hitting staff while trying to complete hygiene care and brief changes. Refusing to eat meals, has a bleeding bed sore. EMS came and transported Resident A to the hospital where he was admitted.” An IR dated 04/20/2026 regarding a routine brief change, noted that Resident A was resistant to care and verbally and physical refused assistance. Two persons assist utilized, attempted to proceed with hygiene care ensuring safety, cleaned “affected areas,” care was fully completed after delayed and refused for hours. IR dated 04/11/2026 regarding Resident A refusing to be changed, he was in a lot of pain and could not move, EMS contacted and he was taken to the hospital. IR dated 04/08/2026, staff Erin Russell tried to change Resident A’s brief, but he could not stand. EMS was contacted and assisted Erin with getting Resident A up and into his chair. Guardian and owner of facility were notified.

I reviewed Resident A’s personal care documentation by staff from 03/2026-05/04/2026. According to documentation on 04/11/2026, Erin Russell wrote, “slept entire shift. Changed before lunch, took meds, skipped breakfast, changed before dinner. He is very sensitive down there and barely wants staff to touch him. Good mood overall.” However, according to the IR dated 04/11/2026, written by Erin Russell at 7:10AM, Resident A needed to be changed, and Resident A was unable to stand due to being in lots of pain, two DCS try to change him, but he did not allow them, could not stand so EMS was called and transported to the hospital. The documentation and IR contradict each other. Throughout the month of 04/2026, documentation by several staff members stated that “Resident A was resistant to brief changes, staff requiring assistance from other staff to provide care to Resident A, and Resident A combative and violent towards staff.”

I reviewed Resident A’s assessment plan completed on 04/29/2026. The assessment plan stated that Resident A is a “one person assist” with his care; however, according to the personal care documentation, Resident A required two DCS to provide care on several occasions. On 04/08/2026, the IR stated that Erin Russell needed EMS to assist her in transferring Resident A to his chair.

On 05/19/2026, I received a return call from Resident A’s legal guardian. The legal guardian is Resident A’s nephew. The legal guardian was informed that Resident A was admitted into HFH for “change in his mental state, being combative, and refusing to eat.” He was also informed that Resident A had a UTI, wounds on his buttocks, and was dehydrated. Staff were unable to provide care to Resident A because Resident A was “violent, towards them.” Resident A is being discharged back to the group home from HFH with hospice services. The legal guardian has spoken with Uzair Shahid regarding hospice and staff providing care to Resident A. I advised the legal guardian that I will follow up with Uzair.

On 05/20/2026, I received a return call from Uzair Shahid. Resident A was discharged from the hospital back to this group home and is currently receiving services including wound care through Hospice of MI.

On 05/27/2026, I received an email from Mariah Halbert with HomeNP regarding Resident A. The email stated the following: “I wanted to give a little background as well. From our team's perspective, the wound was not reported to us prior to 05/04/2026. During our communications with the facility between 04/30/2026 and 05/04/2026, the primary concerns relayed to us were rapid cognitive decline, aggression/combative behaviors, refusal of care, refusal to get out of bed, and difficulty obtaining labs or providing hygiene care due to resistance. In response to those concerns, we discussed adding nursing support, attempted to obtain lab work, coordinated vascular follow-up appointments/imaging, and initiated low-dose risperidone to help reduce aggressive behaviors interfering with care. The facility also reported concern that he may be exceeding their scope of care due to his decline. On 05/04/2026, the facility notified us that EMS was called because the patient had refused eating, changing, and movement for most of the day, and they then reported a bedsore/wound. That was the first time our team was made aware of a wound concern. Once hospitalized, records documented the wound's findings. At the time of prior evaluations, Katherine Holyfield (nurse practitioner- NP) could only assess conditions that were visible/reported and tolerated by the patient, as the patient had ongoing resistance to care and examinations. Additionally, during the NP’s visit on 05/14/2026, the caregiver reported there were no wounds needing to be addressed/reported at that time. The patient also declined a full body assessment during the visit. Ongoing refusal of care continued to be a barrier, as the patient remained resistant to hygiene care, brief changes, repositioning, and assessments, often becoming agitated during these attempts. Due to continued agitation and behavioral concerns interfering with care delivery, risperidone was subsequently increased to three times daily in an effort to improve cooperation with necessary care and reduce distress/aggressive behaviors.”

On 06/01/2026, I interviewed DCS Shanae McGhee regarding the allegations. She has worked for this corporation since 02/2026. She works four days a week, two days a week from 7AM-7PM and two days a week from 7PM-7AM. Shanae stated, “one day I worked, Resident A didn’t have the wound and the next time I worked, he had the wound on his butt and testicles.” She worked on 05/01/2026, which is when she observed the wounds. She stated, “there was a little rash, so I put cream like I’m supposed to.” She did not see breakage of skin, but did see red marks on his arms, back, and legs. Resident A is wheelchair bound, but he was walking before. He has been complaining about his knees hurting. He stopped walking and began using the wheelchair. Sometimes he would allow Shanae to provide care for him, but other times he refused. One time, she started her shift from 7PM-7AM and found feces in Resident A’s brief when he did not have a BM. The feces was because the previous staff (name unknown) did not wipe Resident A after he had a BM during their shift. Prior to 05/01/2026, she had not provided any wound care to Resident A because she states, “he refused care.” She stated she did not see HHC at this home providing wound care to Resident A.

On 06/01/2026 and 06/08/2026, I attempted to interview DCS Angel Evans regarding the allegations, but the recording stated that “this person is not accepting calls.”

On 06/03/2026, I received a call from Resident A’s legal guardian. The legal guardian stated that Hospice of MI, registered nurse (RN) Wendy is providing wound care to Resident A at the group home. The group home has ordered a new bed and a better wheelchair for Resident A. The legal guardian receives a telephone call from the RN and the medical doctor each time they visit Resident A at this group home with an update. Resident A is eating and his mood has leveled out. He is stable and non-violent and accepts care from Hospice of MI. The legal guardian believes that the staff at the group home lack the ability to deal with residents who are resistant to care and get them to cooperate. I advised him that I will follow up with Hospice of MI.

On 06/10/2026, I conducted an unannounced face-to-face visit at the group home to ensure that Resident A was receiving the care he required from staff. I was greeted by DCS Bathandwa Williams-Zondo who goes by “B.” B stated that Resident A was moved from this group home yesterday, 06/09/2026, to another facility. Hospice of MI RN Wendy came out yesterday while B was at the group home advising her that there should be two DCS on shift because Resident A required two staff members to provide care, specifically to treat Resident A’s wounds and to reposition him. However, B was working by herself. B began working at this home a week ago. She was working at this corporation’s other group home before coming here. She works Tuesdays from 7AM-7PM and Fridays-Wednesdays from 7AM-7PM. When she first met Resident A, she observed bruises on both hands and the right side of his body, plus she observed four different wounds on his body. She observed two wounds on the right side of his back, and two wounds on his buttocks. The RN told B that “staff were not repositioning Resident A, nor were they providing wound care.” B stated that other staff told her that “Resident A was combative,” but B stated that, “staff never gave (Resident A) his PRN meds that they were supposed to give whenever he’s combative.” B stated, “I assisted the aide twice with wound care and when I did, I observed the wounds leaking.” I requested to observe Resident A’s medications and medication logs, but B stated that Hospice of MI took Resident A’s medications and that Uzair had the medication logs.

I observed Resident C, Resident D, Resident E, and Resident F in their bedrooms. They all stated they are doing “ok,” and reported no concerns.

On 06/11/2026, I received a return call from Hospice of MI, RN Wendy, regarding Resident A. Hospice of MI is providing wound care to Resident A twice weekly and an aide comes out to the home three times a week. This was increased because of the concerns the RN observed when she was at the group home on 06/01/2026. On this day, the RN was at the group home and greeted DCS Tiffany (she did not know the last name) who advised the RN that she had only been working for this corporation for two days. Tiffany was working alone and did not know anything about Resident A’s care. She did not have basic information about Resident A, which concerned the RN. Also, the RN advised Tiffany that Resident A requires two staff members to provide wound

care, due to Resident A being a large individual with dementia. Tiffany offered to call the HM, which she had his number but did not know his name. The Hospice of MI aide came out to the home on 06/03/2026 and 06/04/2026, to provide care to Resident A, but the aide had difficulty getting the group home staff to assist her with Resident A. On 06/05/2026, two Hospice of MI aides had to come to the group home to provide care for Resident A, because they could not get help from the staff at this group home. The RN had serious concerns regarding Resident A not receiving the care he needed at this group home when Hospice of MI was not at the home, because there was only one staff member. In addition, staff were not providing wound care per hospice's plan of care. Therefore, the RN discussed her concerns with the Hospice of MI care team who also shared the same concerns. Resident A's legal guardian was contacted with these concerns. The RN advised the legal guardian that Resident A required a higher level of care that this group home cannot provide and that it would be safer for Resident A to move. The legal guardian agreed, so Resident A was moved to an appropriate placement. The RN stated that no one from this group home advised the RN that staff could not provide the higher level of care Resident A needed as she had observed.

On 06/16/2026, I received a telephone call from APS worker, Candid Jamerson. Ms. Jamerson is substantiating her case for neglect against Nannies Inn by Golden Grace.

On 06/22/2026, I received an email from Hospice of MI with Resident A's plan of care completed on 05/31/2026 with detailed instructions provided to this group home on how to care for Resident A's wounds. The wound care would begin on 06/01/2026, completed twice weekly or more often as needed if soiled or dislodged.

On 06/25/2026, I received an email from Uzair Shahid with documentation and clarification regarding the allegations pertaining to Resident A and DCS Tiffany Clark. He stated that Resident A was extremely combative and aggressive. He refused care, refused to allow staff to change him, and was physically aggressive towards staff and nurses. There were no instructions provided after Resident A was discharged from HFH back to this group home on 05/13/2026 regarding wound care. On 05/14/2026, Resident A was seen by HomeNP, Katherine Holyfield, who did not provide any wound care instructions. During all of this, Resident A's nephew was seeking guardianship. Resident A started hospice on 05/31/2026, with Hospice of MI, but the orders and instructions changed on different dates including 06/01/2026, 06/03/2026, and 06/05/2026. The plan of care regarding wound care was not provided until after Resident A moved out on 06/09/2026. Uzair stated that when the group home requested the plan of care, only verbal/written instructions were given by Hospice of MI RN Wendy. I reviewed the documents provided by Uzair, specifically HFH discharge paperwork dated 05/13/2026. The paperwork stated, "wounds multiple," but there were no instructions other than medication changes. Uzair stated, "because there were no new wound care instructions from the hospital discharge paperwork or from the HomeMD visit note, there was nothing specific for us to adjust or change regarding wound care at that time."

On 06/25/2026, I contacted case manager Sallie Amalfitano regarding the 05/13/2026 discharge paperwork. Ms. Amalfitano stated that an ambulance transported Resident A back to this group home with an envelope that included discharge instructions. Ms. Amalfitano pulled up the discharge paperwork that was sent with Resident A that stated, “Henry Ford Home Health Care (HFHHC),” was referred and set up for wound care after discharge. Ms. Amalfitano stated that whenever a patient is presented with wounds, HFH always makes a referral for wound care and documents wound care instructions on all discharge paperwork. She recommended that I call HFHHC to confirm that services were provided to Resident A at this group home. She stated that she would email me the discharge paperwork that was sent to the group home with Resident A to reflect wound care instructions.

On 06/25/2026, I contacted HFHHC and spoke with a representative who confirmed that wound care was provided to Resident A at this group home (address verified) after discharge on 05/13/2026 from HFH.

On 06/25/2026, I followed up with DCS Shanae McGhee regarding these allegations. Shanae told Uzair that Resident A needed two DCS to provide care because, “it’s too much.” Shanae stated after Resident A was discharged from HFH on 05/13/2026, she worked from 05/14/2026-05/16/2026 and during this time she never provided wound care. Shanae stated that Resident A’s wounds were closed; however, she then went on vacation from 05/20/2026-05/26/2026. When she returned on 05/27/2026, she was informed by DCS “B,” that his wounds were open. After Hospice of MI became involved in Resident A’s wound care, Shanae was only doing wound care on Resident A after he had a bowel movement, because DCS “B,” told Shanae that “hospice nurse will complete all wound care.”

On 06/25/2026, I received an email from Uzair Shahid stating that Resident A’s wounds were cared for by DCS from 05/16/2026-06/01/2026; however, there was resistance from Resident A regarding receiving wound care from staff. On 05/21/2026, A nurse came and completed the wound change with DCS Erin Russell; therefore, it appears that Resident A was receiving wound care from HFHHC when Uzair stated that there were no discharge instructions from HFH. Uzair also stated, “Resident A was frequently combative, aggressive, and refusing care during this time. This included refusing changes from soiled briefs, which made wound care more difficult due to the location of the wound on his bottom/pressure area. Despite Resident A’s refusals and combative behavior, the documentation shows that staff and nurses made repeated attempts to provide care, attend to the wound, and complete wound changes when possible. The wound was changed multiple times during this period, and when Resident A refused or became combative, those difficulties were also reflected in the notes.”

On 06/29/2026, I emailed Uzair Shahid advising him that my recommendation based on my findings after reviewing the documents remains revocation of the license.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Based on my investigation and information gathered, there was insufficient staff to meet the needs of Resident A in accordance with his individual plan of service. Resident A began hospice services on 05/31/2026 with Hospice of MI. On 06/01/2026, RN Wendy with Hospice of MI advised staff that Resident A is currently a two person assist with repositioning and wound care; however, from 06/01/2026-06/09/2026, there was only one DCS working per shift. RN Wendy had to have two hospice aides at the home on 06/04/2026 and 06/05/2026, due to staff not assisting with Resident A's wounds and care. Due to these concerns, Resident A was moved out of this group home on 06/09/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on my investigation and information gathered, the licensee designee, Huma Shahid, did not provide supervision, protection, and personal care according to Resident A's needs and hospice care plan. Resident A was discharged back to the group home from HFH on 05/13/2026, with multiple wounds. According to Uzair Shahid, no instructions were provided by HFH nor HomeNP on 05/14/2026. Hospice of MI provided the group home with the plan of care after Resident A was discharged from the home on 06/09/2026. Therefore, there were no updates or addendums added to Resident A's assessment plan to reflect wound care after his discharge from HFH on 05/13/2026.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR: 2026A090991013 dated 04/16/2026, CAP dated 04/30/2026**

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing**
	(2) A licensee shall ensure the resident receives or has access to all of the following: **(c) Assistance with resident hygiene as needed.**
ANALYSIS:	On 05/12/2026, I interviewed HFH staff who reported that Resident A presented to the ER covered in feces, including under his fingernails. The ER doctor documented that "(Resident A) was neglected," at this group home. I reviewed pictures at HFH taken by hospital staff of Resident A's scrotum, which was covered with dry feces. DCS reported through their interviews and documentation that Resident A was resistant to care; therefore, care was not provided including assistance with his hygiene due to his resistance.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR: 2026A0611008 dated 02/12/2026, CAP dated 02/20/2026**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: **(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.**
ANALYSIS:	Based on my investigation and information gathered, Nannies Inn at Golden Grace did not have the amount of personal care, supervision, and protection required by Resident A available at this group home, as the group home was understaffed. Resident A presented to HFH dehydrated with several pressure sores and a UTI. The pressure sores were not being cared for by DCS at

	the group home. The DCS I interviewed stated they did not know Resident A had pressure sores. Resident A was discharged from HFH on 05/13/2026 back to this group home, with wound care provided by Hospice of MI. Hospice of MI reported to staff that Resident A was a two-person assist as of 06/01/2026 for all his care; however, there was only one DCS working per shift. Staff were not caring for Resident A's wounds, so due to concerns that the group home could not meet Resident A's needs, he was moved out of the home on 06/09/2026. The amount of care/supervision required by Resident A, including the requirement of a two-person assist, was not added/updated nor specified in Resident A's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: **(b) The services, skills, and physical accommodations required by the resident that are available at the facility.**
ANALYSIS:	Based on my investigation and information gathered, Nannies Inn at Golden Grace did not have DCS that had the skills needed to provide wound care to Resident A. Hospice of MI, provided this group home with instructions on how to care for Resident A's wounds, but according to the RN and DCS Bathandwa Williams-Zondo (who goes by B), staff were not repositioning Resident A nor were they changing Resident A's wounds. B stated that she observed the wounds "leaking," due to staff not changing the dressing on the wounds. In addition, the DCS at this group home, Tiffany Clark, was left unsupervised, providing care to these residents without any proper training. Because of these concerns, Hospice of MI removed Resident A from the group home. Resident A's assessment plan was not updated with Hospice of MI plan of care that stated right edge of sacrum stage 2: cleanse with wound cleanser, pat dry, apply barrier cream to surrounding skin, cover with adhesive dressing. RN and/or staff to change weekly or as needed if soiled or dislodged.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based on my investigation and information gathered, DCS did not follow the instructions and recommendations of Resident A's Hospice of MI plan of care dated 05/31/2026 regarding wound care. According to the care plan, Resident A's wound dressings needed to be replaced twice weekly or more often if soiled or dislodged. DCS Bathandwa Williams-Zondo observed the wound leaking when she was assisting the hospice aid with Resident A's wound care. Due to these concerns, Resident A was moved from this group home by Hospice of MI.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/11/2026, I interviewed Hospice of MI, RN Wendy who stated that when she was at this group home on 06/01/2026, DCS Tiffany Clark who informed Wendy that she had only been working for two days was working alone during her shift. Wendy stated that, "Tiffany did not have basic information regarding Resident A," when Wendy was asking her questions pertaining to Resident A's wounds and care. Wendy requested to call Tiffany's boss and Tiffany stated, "I have his number, but I don't know his name."

On 06/15/2026, I interviewed licensee designee Huma Shahid via telephone regarding Tiffany. Mrs. Shahid stated that Tiffany's last name is Clark. She was hired at the end of 05/2026 for about six-to-seven days at this group home, but then quit because she got pregnant. Tiffany did not complete her fingerprints, nor did she complete any of her training, but was working alone sometimes according to Mrs. Shahid. Mrs. Shahid stated other times, "I would or Uzair worked with Tiffany," but then stated, "but sometimes she was by herself." Mrs. Shahid gave Tiffany everything she had to complete but she never returned it, so she quit.

On 06/23/2026 I attempted to contact DCS Tiffany Clark, but her number is not in service.

On 06/24/2026, I received a call from Uzair Shahid. He stated that he has documentation showing compliance with all the rules pertaining to Resident A and Tiffany Clark. Uzair stated that on 06/01/2026, he was at the group home in the garage working and his mother, Ms. Shahid, was also present as was DCS Shanae McGhee. I advised Uzair that according to Hospice of MI RN Wendy, Tiffany was alone on 06/01/2026 when she was at the group home. Uzair said, “that’s not correct,” even though Ms. Shahid confirmed that Tiffany was alone for a short period of time. I advised Uzair to provide documentation he has no later than end of business day 06/25/2026, which he acknowledged. I received Ms. Clark’s communicable disease screening certificate dated 05/20/2026 and conditional employment policy signed and dated by Tiffany on 05/20/2026. No additional documentation or verification of training was received. I reviewed the workforce background check system under Nannies Inn by Golden Grace and Tiffany Clark was not fingerprinted.

During the investigation, I requested and received a copy of the staff schedule for 04/2026-05/2026 from Uzair Shahid. The staff schedule did not have the names of the staff, just their first initials. It did not have the hours worked on all the days on either 04/2026-05/2026, and did not have job titles.

On 06/24/2026, I conducted the exit conference via telephone with licensee designee, Huma Shahid, with my findings and recommendations. Ms. Shahid stated that Resident A was combative towards staff and refused to allow staff to change him so on 05/04/2026, after it was becoming extremely difficult to provide care, Resident A was sent to the hospital. Ms. Shahid stated that Resident A’s issues occurred after his sister passed away and because his nephew was seeking guardianship, they could not discharge Resident A even though they were unable to provide care due to him being non-compliant. Ms. Shahid stated, “we were helping the nephew out by keeping Resident A until the nephew got guardianship. We told the nephew, “We’re having a hard time taking care of him.” Ms. Shahid never issued a 30-day discharge. Ms. Shahid stated that after Resident A was discharged initially from HFH on 04/12/2026, he did not have any bedsores, and she does not know how his bedsores got to the point they did on 05/04/2026. I advised Ms. Shahid that I observed pictures of Resident A’s bedsores at HFH and according to the pictures, the wounds did not appear to be addressed by the group home staff. Ms. Shahid stated that Resident A refused care and was combative. She stated, “staff couldn’t handle him.” I asked Ms. Shahid why she allowed Resident A to be discharged back to the group home on 05/31/2026 if staff were unable to provide him with care due to him being combative. She stated, “the family said to take care of him, so we did.” Ms. Shahid stated that on 06/01/2026, DCS Tiffany Clark was left alone by Ms. Shahid when Hospice of MI was at the home because Ms. Shahid had to go to her other group home. Prior to that, Tiffany was always with either Ms. Shahid or her son, Uzair.

On 06/25/2026, I received an email from Uzair Shahid regarding Tiffany Clark. He stated that Tiffany never worked alone at this group home and that on 06/01/2026, Uzair stated he was present in the garage when hospice RN Wendy was at the home as was his mother Mrs. Shahid, even though Mrs. Shahid told me she left Tiffany alone on

06/01/2026, for “a bit,” because “she went to her other group home.” Uzair also stated that DCS Shanae McGhee was present on 06/01/2026, but in the room with another resident, when RN Wendy was at the home. Uzair stated that Tiffany was provided with all the documents needed for fingerprinting and training, but she never completed it, so she was never hired and never worked alone.

On 06/25/2026, I followed up with DCS Shanae McGhee regarding Tiffany Clark. Tiffany denied working on 06/01/2026 with Tiffany Clark. She stated that she left her shift at 7AM that day and does not recall Uzair Shahid or Huma Shahid at the home either. Shanae also stated that when she began her shift on 06/03/2026 at 7PM, Tiffany was working alone that day without Uzair or Mrs. Shahid or any other trained staff. She stated, “I remember this day because when I came in I asked Tiffany how her shift went and that’s when Tiffany told me that the hospice RN was there and helped Tiffany with Resident A.” Shanae stated, “Tiffany said, I’m glad the RN was there because it is difficult to care for Resident A by yourself.” Shanae stated, “I’m upset that you were told I was with Tiffany when I wasn’t.”

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 my investigation and information gathered, DCS Tiffany Clark did not have her criminal history check completed when she was working unsupervised on 06/01/2026, providing care to Resident A, Resident B, Resident C, Resident D, and Resident E. Licensee designee Huma Shahid stated that she and Uzair Shahid would work with Tiffany sometimes and other times, Tiffany worked alone.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR: 2026A090991013 dated 04/16/2026, CAP dated 04/30/2026**

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation and information gathered, DCS Tiffany Clark did not possess all the qualifications needed before working independently. She did not complete her criminal history check, signed medical statement by a licensed physician nor her required training to determine if she could meet the physical, emotional, intellectual, and social needs of each resident. According to Hospice of MI, RN Wendy, Tiffany did not know the “basics of Resident A’s needs,” on 06/01/2026 when she was working alone during her shift.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases including recognizing signs of illness.** **(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.** **(i) Nutrition and special diets.**
ANALYSIS:	Based on my investigation and information gathered, DCS Tiffany Clark was not trained nor was she competent in all the following areas before performing assigned tasks independently. She did not complete her reporting requirements, first aid, cardiopulmonary resuscitation, personal care, supervision, and protection, resident rights, safety and fire prevention, prevention and containment of communicable diseases, food safety and nutrition and special diets training. According to licensee designee, Huma Shahid, “Tiffany was given everything, but she never returned anything.”
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR: 2026A090991013 dated 04/16/2026, CAP dated 04/30/2026** **Renewal LSR dated 01/29/2025, CAP dated 03/17/2025**

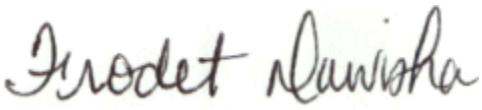
APPLICABLE RULE	
R 400.631	**Health screenings.**
	(2) A licensee shall have on file a statement signed by a licensed physician or physician's designee attesting to the

	physical health of the licensee, staff, and members of the household. Statements for the licensee and Uzai must be signed no more than 6 months before the issuance of a temporary license and at any other time requested by the department. Statements for staff and members of the household must be obtained within 30 days of employment start date, assumption of duties, or occupancy in the facility.
ANALYSIS:	Based on my investigation and information gathered, DCS Tiffany Clark did not have a statement signed by her licensed physician or physician's designee attesting to her physical health when she was providing care to Resident A, Resident C, Resident D, Resident E and Resident F.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.639	**Staff records.**
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: **(a) Names of staff on duty.** **(b) Job titles.** **(c) Hours or shifts worked.**
ANALYSIS:	I reviewed April 2026 and May 2026 staff schedules to determine who worked during these months; however, the staff schedule did not include the full names of DCS on duty, just the first initial of their first name. It did not include their job titles or the hours or shifts worked. Therefore, I was unable to determine who worked what shift during April and May 2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the license currently being on a provisional license and the intervening quality of care violations, I recommend revocation of the license.



06/29/2026

Frodet Dawisha Date
Licensing Consultant

Approved By:

WOC Area Manager for 06/29/2026

Denise Y. Nunn Date
Area Manager