

STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING

In the matter of

License #: AS630311899
SIR #: 2015A0603001
Troy Hills

Imran Khan
Pioneer Rehabilitation Specialists, Inc.

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ORDER OF SUMMARY SUSPENSION
AND NOTICE OF INTENT TO REVOKE LICENSE

The Michigan Department of Human Services, by Jerry Hendrick, Director, Adult Foster Care Division, Bureau of Children and Adult Licensing, Orders the Summary Suspension and provides notice of the intent to revoke the license of Licensee, Pioneer Rehabilitation Specialists, Inc., to operate an adult foster care small group home pursuant to the authority of the Adult Foster Care Facility Licensing Act, 1979 PA 218, as amended, MCL 400.701 et seq., for the following reasons:

1. On or about August 9, 2011, Licensee was issued a license to operate an adult foster care small group home with a licensed capacity of 6 at 6372 Tutbury Ln., Troy, MI 48098.
2. On October 1, 2014, Licensing Consultant Stephanie Williams received the following complaint allegations: Licensee Designee Imran Khan and Administrator Zubair Ahmed were no longer operating Troy Hills, there is not enough appropriate food in the home to make full meals for the residents and medication errors have occurred without any consequences.

3. On October 2, 2014, Ms. Williams received an email from Mr. Ahmed. In this email Mr. Ahmed confirmed that Troy Hills had been sold to JSN Services, Inc. The sale of Troy Hills by Mr. Ahmed and Mr. Khan was never reported to the Bureau of Children and Adult Licensing (BCAL), nor did they report to the BCAL that they were no longer involved in the day-to-day operations and care of the residents of Troy Hills. JSN Services, Inc. submitted an application for an adult foster care small group home license on April 2, 2014, but an application incomplete letter was forwarded to JSN Services, Inc. on April 18, 2014, by the BCAL. As of this date their license to operate an adult foster care small group home has not been issued.
4. On October 2, 2014, Ms. Williams received email correspondence from Ms. Tomic. In this email Ms. Tomic confirmed that she purchased Troy Hills from Mr. Ahmed and Mr. Khan on February 19, 2014.
5. On October 2, 2014, Ms. Williams interviewed the complainant by telephone. During this conversation the complainant stated the following:
 - a. Tijana Tomic is the owner of Troy Hills but Ms. Tomic only comes to the home a couple of times during the week;
 - b. The medication cabinet in the home is never locked and is always kept open;
 - c. Residents do not always get their medications as prescribed and there are numerous medications that do not have prescriptions;
 - d. There are medications for deceased residents that are still being kept in the home;

- e. Residents were being "tied down" with "belts;"
 - i. Resident C is made to sleep in a recliner or couch during the night and a belt is used to keep her from moving out of the chair;
 - ii. Resident E is kept in her wheelchair "all the time" with a belt;
 - f. Resident F died on September 6, 2014, but no incident report was completed to document the death;
 - g. Complainant has been working at Troy Hills for the last three to four weeks but she has not completed a background check, including fingerprints, but Ms. Tomic has not provided her with the information to complete the required background check.
6. On October 2, 2014, Ms. Williams made an unannounced onsite investigation of Troy Hills. When she arrived John Nikolich, Staff Member Olta Cumani, Resident A, Resident B, Resident C, Resident D and Resident E were present. Ms. Williams conducted her investigation and identified the following licensing rule violations:
- a. Mr. Nikolich identified himself as the president of JSN Services, Inc. and he confirmed that he assisted his daughter, Tijana Tomic, with the purchase of Troy Hills from Mr. Ahmed and Mr. Khan;
 - b. Mr. Nikolich further stated that he and his wife were assisting Ms. Tomic with operating Troy Hills;

- c. Ms. Cumani has been working at Troy Hills for approximately three months but has not completed the necessary employee background checks;
- d. Ms. Williams observed the following medication errors:
 - i. Resident B was not prescribed stool softener but was receiving Resident A's prescribed stool softener, per the medication log, "every other day at 9:00 p.m.;"
 - ii. Resident C was given Cranberry Supplement and Digestive Probiotic/50 vegetable capsules daily but Ms. Cumani could not locate a prescription for these supplemental medications;
 - iii. Resident D's dosage of Zoloft 100 mg, two tablets once daily, was not initialed for the 12:00 p.m. dosage on October 2, 2014;
 - iv. The label for Resident E's Lorazepam medication stated to discard after September 25, 2014, but Resident E was administered the Lorazepam on September 30, 2014, and again on October 1, 2014;
 - v. Resident F's nasal solution medication was in the refrigerator door in the butter section with several bottles of nail polish;
 - vi. Ms. Williams observed Ms. Cumani leave the medication cabinet unlocked after she had finished administering medications to the residents;
- e. Ms. Williams observed Resident C, Resident D and Resident E eating lunch which consisted of turkey patties, mixed vegetables, salad and

flour tortillas. When Ms. Williams reviewed the October menu it stated that for lunch residents would be served a ham sandwich, soup, vegetable salad and 8 ounces of juice/water. The changes to the lunch menu were not posted, as required.

- f. Ms. Williams reviewed the resident files for Resident A, Resident B, Resident C, Resident D and Resident E and observed the following:
 - i. Resident A and Resident B's Resident Care Agreements were last completed on April 23, 2013, but were not signed by the licensee designee, both Health Care Appraisals were completed on April 4, 2013, and Assessment Plans were last completed on April 23, 2013;
 - ii. Resident C's Resident Care Agreement was last completed on July 21, 2013, and the Assessment Plan was last completed on August 13, 2014, but was not signed by the licensee designee;
 - iii. Resident D's Assessment Plan and Health Care Appraisal were last completed on November 26, 2012;
 - iv. Resident E was admitted on September 29, 2014, but her Resident Care Agreement was not signed by her licensee designee/guardian and her Assessment Plan and Health Care Appraisal were not completed upon or prior to admission;
 - v. Resident A, Resident B and Resident C's resident files were observed and Ms. Williams noticed that their weight had not been recorded since July 1, 2014;

- vi. Resident A, Resident B, Resident C, Resident D and Resident E's resident files were observed and none of the residents had record of physician contacts and statements for supervising the residents' care. Ms. Cumani informed Ms. Williams that they only had staff notes detailing the residents' daily activities;
 - vii. Resident F's nasal medication was stored in the refrigerator;
 - viii. Ms. Cumani stated that residents had recently passed away but failed to identify Resident F, who passed away on September 6, 2014;
- g. Resident C and Resident E's resident files were reviewed and Ms. Williams did not find authorization for the use of a safety belt/gait belt for either resident.
7. On October 3, 2014, Ms. Williams interviewed Ms. Tomic over the telephone. During this interview Ms. Tomic stated that she was unaware that a doctor needed to provide authorization to use gait belts, safety belts and other assistive devices.
8. On October 3, 2014, Ms. Williams received an email from Erin Dittmer of the AFC/HFA Workforce Background Check Unit confirming that Ms. Cumani and another staff member, Ashley White, have not completed employee background checks.
9. On October 6, 2014, Ms. Williams reviewed the Troy Hills field file and noticed that there was no incident report regarding the death of Resident F on September 6, 2014.

COUNT I

The conduct of Licensee, as set forth in paragraphs 2 through 9 above, evidences a violation of:

R 400.14201 **Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**

(9) A licensee and the administrator shall possess all of the following qualifications:

(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.

COUNT II

The conduct of Licensee, as set forth in paragraphs 5(f), 6(f)(viii) and 9 above, evidences a violation of:

R 400.14311 **Investigation and reporting of incidents, accidents, illnesses, absences, and death.**

(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

(a) The death of a resident.

COUNT III

The conduct of Licensee, as set forth in paragraphs 5(b) and 6(d)(vi) above, evidences a violation of:

R 400.14312 Resident medications.

(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

COUNT III

The conduct of Licensee, as set forth in paragraph 6(d)(i) above, evidences a violation of:

R 400.14312 Resident medications.

(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

COUNT V

The conduct of Licensee, as set forth in paragraphs 6(f)(i), 6(f)(iii) and 6(f)(iv) above, evidences a violation of:

R 400.14301 Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.

(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

COUNT VI

The conduct of Licensee, as set forth in paragraph 6(f)(vi) above, evidences a violation of:

R 400.14316 Resident records.

(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:

(d) Health care information, including all of the following:

(iv) A record of physician contacts.

COUNT VII

The conduct of Licensee, as set forth in paragraphs 5(g), 6(c) and 8 above, evidences a violation of:

400.734(b)(2) Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.

(2) Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents after April 1, 2006 until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5). 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. Beginning April 1, 2009, an individual who is exempt under this subsection 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 (12). 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. That individual may transfer to another adult foster care facility that is under the same ownership with which he or she was employed or under contract. If that individual wishes to transfer to an adult foster care facility that is not under the same ownership, he or she may do so provided that a criminal history check is conducted by the new facility in accordance with subsection (4). 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 subsection (1)(a), he or she is no longer exempt and shall

be terminated from employment or denied employment.
(18) as used in this section:
(a) "Direct access" means access to a resident or resident's property, financial information, medical records, treatment information, or any other identifying information.

COUNT VIII

The conduct of Licensee, as set forth in paragraph 6(e) above, evidences a violation of:

R 400.14313 Resident nutrition.

(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.

DUE TO THE serious nature of the above violations and the potential risk they represents to vulnerable adults in Licensee's care, emergency action is required.

Therefore the provision of MCL 24.292 of the Administrative Procedures Act of 1969, as amended, is invoked. Licensee is hereby notified that the license to operate an adult foster care small group home is summarily suspended.

EFFECTIVE 6:00 P.M., on October 8, 2014, Licensee is ordered not to operate an adult foster care small group home at 6372 Tutbury Ln., Troy, MI 48098 or at any

other location or address. Licensee is not to receive adults for care after that time or date. Licensee is responsible for informing case managers or guardians of adults in care that the license has been suspended and that Licensee can no longer provide care.

HOWEVER, BECAUSE THE Department has summarily suspended Licensee's license, an administrative hearing will be scheduled before an Administrative Law Judge. Licensee will be notified of the hearing date.

Licensee MUST NOTIFY the Department in writing or by phone no later than 5 days before the hearing whether or not Licensee plans to attend. MCL 24.272 of the Administrative Procedures Act of 1969 permits the Department to proceed with the hearing even if Licensee does not appear. Licensee may be represented by an attorney at the hearing.

DATED: 10/7/2014



Jerry Hendrick, Director
Adult Foster Care Division
Bureau of Children and Adult Licensing

This is the last and final page of the ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT in the matter of Pioneer Rehabilitation Specialists, Inc., AS630311899, consisting of 12 pages, this page included.

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STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING

In the matter of

License #: [L-#]
SIR #: [SIR-#]

[First Name] [Last Name]

_____ /

PROOF OF SERVICE

The undersigned certifies that a copy of the Order of Summary Suspension and Notice of Intent was personally served upon the person below on:

_____ at _____ at _____
Date Time Place

Imran Khan

Bureau of Children and Adult Licensing

