GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 22, 2019

Branden Acklen
4017 Morris Street
Saginaw, MI 48601

RE: License #: AF730385752
Investigation #: **2019A0576013**
Acklen AFC Home

Dear Mr. Acklen:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (810) 787-7031.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF730385752
Investigation #:	2019A0576013
Complaint Receipt Date:	12/28/2018
Investigation Initiation Date:	12/28/2018
Report Due Date:	02/26/2019
Licensee Name:	Branden Acklen
Licensee Address:	4017 Morris Street, Saginaw, MI 48601
Licensee Telephone #:	(989) 385-2140
Administrator:	N/A
Licensee Designee:	Branden Acklen
Name of Facility:	Acklen AFC Home
Facility Address:	4017 Morris Street, Saginaw, MI 48601
Facility Telephone #:	(989) 714-2247
Original Issuance Date:	09/05/2017
License **Status:**	REGULAR
Effective Date:	03/05/2018
Expiration Date:	03/04/2020
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 12/28/18, law enforcement was contacted due to Resident A escaping out of his window at 4am. When found, Resident A stated he did not want to return as they keep pouring water on his bed. Resident A's bed was found to be soaked in urine. Resident A also has bruises alleged to be from the owner.	No
Owner claimed his bedding was in the washing machine but at 4am could not show that they were actually being washed.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/28/2018	Special Investigation Intake 2019A0576013
12/28/2018	APS Referral Referral received from APS
12/28/2018	Special Investigation Initiated - Letter Sent email to Mike Nielsen, APS Investigator
12/28/2018	Contact - Document Received Received email from Mike Nielsen
01/25/2019	Inspection Completed On-site Spoke to Resident A, Resident B, Resident C, and Licensee Designee, Branden Acklen
01/25/2019	Contact - Telephone call made Left messages for Guardian 1 and Guardian 2 to return call
01/25/2019	Contact - Document Received Spoke to Guardian 1
01/29/2019	Contact - Document Received Received Health Care Appraisal
02/21/2019	Exit Conference Message left with Licensee Designee, Branden Acklen to return call regarding Exit Conference

02/22/2019	Contact - Telephone call made Unsuccessful call to Licensee Designee, Branden Acklen regarding Exit Conference

ALLEGATION:

On 12/28/18 law enforcement was contacted due to Resident A escaping out of his window at 4am. When found, Resident A stated he did not want to return as they keep pouring water on his bed. Resident A's bed was found to be soaked in urine. Resident A also has bruises alleged to be from the owner.

INVESTIGATION:

On December 28, 2018, I received this referral from Adult Protective Services (APS). On December 28, 2018, I sent an email to Mike Neilson, Saginaw County APS regarding any case updates he can provide. Mr. Neilson reported Resident A has extreme mental illness along with memory loss (dementia). Mr. Neilson reported he spoke to Resident A's guardian, Guardian 1 who reported Resident A is "more incontinent" then previously. The guardian reportedly advised Mr. Neilson that Resident A is extremely difficult to care for and finding placement has been very difficult. Mr. Neilson reported the allegations involving physical abuse were a result of Resident A crawling out the window over the last 3 weeks, causing the bruising. Guardian 1 reported he was notified by the Licensee Designee, Brandon Acklen on each occasion. Mr. Neilson reported he saw Resident A today and he was unable to be interviewed as he "lacks the comprehension to understand the situation." Mr. Neilson reported he spoke to Mr. Acklen who reported Resident A has been attempting to get of the window regularly for about 2-3 weeks. Mr. Acklen put a dresser in front of the window in attempt to deter Resident A and he still tries to get out the window.

On January 25, 2019, I completed an unannounced on-site inspection at Acklen AFC and spoke to Resident A, Resident B, Resident C, and Licensee Designee, Brandon Acklen. Resident A was somewhat difficult to comprehend as his statements were disjointed. Resident A denied having water on his bed and stated he urinated on the bed. Resident A reported he wears depends and when he urinates, he washes himself. Regarding having bruises, Resident A stated he may have fell. Resident A was asked if he was hit by anyone and he did not want to answer and began shaking his head no. The interview was concluded at this time as Resident A was unable to answer any additional questions asked of him.

On January 25, 2019, I spoke to Resident B in his bedroom. Resident B reported he has resided at his home since March and "loves it". Resident B denied he has a guardian. Resident B denied any concerns with his home or with Licensee Designee, Brandon Acklen. Resident B denied Mr. Acklen has ever mistreated him or has ever yelled or hit him. Resident B confirmed Mr. Acklen treats the residents of the home well when asked. Resident B denied he ever witnessed Ms. Acklen hit or yell at Resident A.

On January 25, 2019, I spoke to Resident C in his bedroom. Resident B and Resident C share a bedroom. Resident C reported he has resided at the home for 10 months and “it’s okay”. Resident C reported he has a guardian when asked. Resident C reported a concern he has is Resident A keeps asking him for cigarettes. Resident C reported the Licensee Designee, Brandon Acklen is a “decent guy” and he does not hit or yell at the residents. Resident C denied he ever witness Mr. Acklen hit or yell at Resident A. Resident C reported he has witnessed Resident A hit Mr. Acklen.

On January 25, 2019, I spoke to Licensee Designee, Brandon Acklen at Acklen AFC. Mr. Acklen denied mistreating Resident A in any manner and reported the bruises he sustained were due to Resident A going out his bedroom window. Mr. Acklen reported he contacted the police when he discovered Resident A had left the facility. Mr. Acklen reported there was a problem with Resident A’s medication and his Lithium was too high. According to Mr. Acklen, Resident A became physical with him on one occasion. Mr. Acklen reported Resident A urinates his bed daily and he has never thrown water on Resident A’s bed.

On January 25, 2019, I left a message for Resident A’s guardian, Guardian 1 and Resident B’s guardian, Guardian 2 to return my call. On January 25, 2019, I spoke to Guardian 1 who reported he is aware of the allegations involving Resident A. Guardian 1 reported the Licensee Designee, Branden Acklen told him that Resident A has been trying to get out of the window. Guardian 1 was told that Resident A fell out of the window and he bruised himself. Guardian 1 reported when Resident A fell out of the window, Mr. Acklen called within a couple hours to inform him. Guardian 1 reported Resident A has been living at the home for about 3 months and the facility is the only place that would accept Resident A. Guardian 1 reported Resident A was kicked out of the home he was previously residing due to “his mood and he could not be regulated”. Guardian 1 reported for the past year, Resident A has been in and out of the hospital for psychiatric issues and possibly dementia issues. Guardian 1 reported he believes Resident A is slowly getting better and he believes Mr. Acklen is doing a good job. Guardian 1 denied any concerns with physical abuse of Resident A and he believes the bruises he had were the result of him falling out of the window. Guardian 1 reported he visits Resident A every other Sunday and stated his mood is much better. Guardian 1 reported Resident A has made “non-rational” statements and has accused Brandon of stealing and this is not true. Guardian 1 reported Mr. Acklen is in constant communication with him regarding Resident A.

On January 29, 2019, I received health care appraisals for Resident A and Resident C. Resident A is noted to be a 70-year-old male and diagnosed with several maladies including Bipolar Disorder, COPD, Hyponatremia, Obesity and Chronic tobacco use. Resident C is noted to be a 57-year-old male and diagnosed with several maladies including Developmental Delay, Obesity, Hypothyroidism, Acute lower GI bleed, Systolic congestive heart failure, and right lower extremity cellulitis.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(1) A licensee shall not mistreat or permit the mistreatment of a resident by responsible persons or other occupants of the home. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm.
ANALYSIS:	There is not a preponderance of evidence to conclude a rule violation. It was alleged that Resident A had water thrown on his bed and being physically abused. Upon completion of investigative interviews, it was determined Resident A urinated on his bed and did not have water thrown on his bed. Additionally, Resident A received bruises from going out his bedroom in efforts to AWOL from the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Owner claimed Resident A's bedding was in the washing machine but at 4am could not show that they were actually being washed.

INVESTIGATION:

On January 25, 2019 I completed an unannounced on-site inspection at Acklen AFC Home and viewed Resident B and Resident C's bedroom. Resident B and Resident C did not have bedding that included two sheets.

APPLICABLE RULE	
R 400.1434	**Linens.**
	(1) A licensee shall provide bedding which includes 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread. Bed linens shall be changed at least weekly or more often if soiled.

ANALYSIS:	There is a preponderance of evidence to conclude a rule violation. It was alleged that Resident A did not have adequate bedding. On January 25, 2019 I completed an unannounced on-site inspection at Acklen AFC Home and viewed Resident B and Resident C's bedroom and beds. Resident B and Resident C did not have bedding that included two sheets.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On January 25, 2019 I requested to review resident records including health care appraisals and assessment plans and Mr. Acklen could not provide, stating they were at another location. On January 29, 2019 I received health care appraisals for Resident A and Resident C via fax.

APPLICABLE RULE	
R 400.1422	**Resident records.**
	(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.
ANALYSIS:	There is a preponderance of evidence to conclude a rule violation. On January 25, 2019 I requested to see resident records including health care appraisals and assessment plans and Mr. Acklen could not provide, stating they were at another location.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On January 25, 2019, Resident A's bedroom was viewed. Resident A's carpet was extremely dirty and soiled. Resident A's box spring was viewed to be stained and dirty. The walls and window blinds were dirty with what appeared to be a brown liquid running down the walls and blinds. Resident A's bedroom was noted to have very strong odor of urine and after some time was difficult to breath. It was noted that my nose began to burn from the strong odor of urine. Pictures were taken.

On January 25, 2019, Resident B's bedroom was noted to have an extremely strong odor of body odor. Resident B's mattress was noted to have hole/tear. Pictures were taken.

On January 25, 2019, Resident C's bedroom was noted to have an extremely strong odor of body odor as did Resident C.

On January 25, 2019, the couch in the living room was noted to be dirty without material covering one of the cushions. The foam material and padding that made up the couch cushion was noted to be completely exposed. Mr. Acklen was asked about the couch and he stated he had to remove the cover material due to a resident urinating on the cushion. Picture was taken.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(1) The premises shall be maintained in a clean and safe condition.
ANALYSIS:	There is a preponderance of evidence to conclude a rule violation. Resident bedrooms were noted to be extremely dirty and unkept. The resident bedrooms had strong odors of body odor and urine. Resident bedroom flooring/carpeting, walls, and blinds were noted to be extremely dirty and stained. The living room couch cushion was noted to have the foam padding exposed.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On January 25, 2019 Resident A's bedroom was viewed. Resident A's carpet was extremely dirty and soiled. The walls and window blinds were dirty with what appeared to be a brown liquid running down the walls and blinds. Resident A's bedroom was noted to have very strong odor of urine and after some time was difficult to breath. It was noted that my nose began to burn from the strong odor of urine. Pictures were taken.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(4) Floors, interior walls, and ceilings shall be sound, in good repair, and maintained in a clean condition.

ANALYSIS:	There is a preponderance of evidence to conclude a rule violation. Resident bedroom flooring/carpeting, walls, and blinds were noted to be extremely dirty and stained.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On January 25, 2019 I viewed Resident A's bed and box spring. The box spring was noted to be extremely dirty and stained throughout. I also viewed Resident B's bed and it was noted to be in very poor shape and had a hole in the middle of the mattress exposing the foam material. The mattress was not protected. Pictures were taken.

APPLICABLE RULE	
R 400.1433	**Bedroom furnishings.**
	(3) A licensee shall provide a resident with a bed that is not less that 36 inches wide and 72 inches long, with comfortable springs in good condition, a clean protected mattress which is not less than 5 inches thick or 4 inches thick if of synthetic construction, and with a pillow.
ANALYSIS:	There is a preponderance of evidence to conclude a rule violation. On January 25, 2019 I viewed Resident A's mattress and box spring. The box spring was noted to be extremely dirty and stained throughout. I also viewed Resident B's bed and it was noted to be in very poor shape and had a hole in the middle of the bed exposing the foam material. The mattress was not protected.
CONCLUSION:	**VIOLATION ESTABLISHED**

On February 21, 2019, I left a message with Licensee Designee, Branden Acklen to return call regarding Exit Conference.

On February 22, 2019, I attempted to contact Mr. Acklen via telephone for the purposes of conducting an Exit Conference and the call went straight to voice mail. The recording indicated the mailbox was full and I was unable to leave a message.

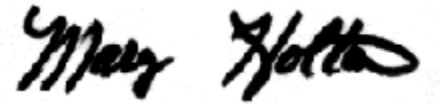
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

2/21/19

Christina Garza Date
Licensing Consultant

Approved By:



2/22/19

Mary E Holton Date
Area Manager