GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 12, 2019

Candace Yow
Holland A.F.C., LLC
806 E. Holland
Saginaw, MI 48601

RE: License #: AM730283056
Investigation #: 2019A0580011
Holland AFC

Dear Mrs. Yow:

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

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.
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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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM730283056
Investigation #:	2019A0580011
Complaint Receipt Date:	01/09/2019
Investigation Initiation Date:	01/11/2019
Report Due Date:	03/10/2019
Licensee Name:	Holland A.F.C., LLC
Licensee Address:	806 E. Holland Saginaw, MI 48601
Licensee Telephone #:	(989) 753-1101
Administrator:	Candace Yow
Licensee Designee:	Candace Yow
Name of Facility:	Holland AFC
Facility Address:	806 E. Holland Saginaw, MI 48601
Facility Telephone #:	(989) 753-1101
Original Issuance Date:	05/19/2008
License Status:	REGULAR
Effective Date:	06/08/2017
Expiration Date:	06/07/2019
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A stated that Staff Sandra Tyson has been yelling at him and telling him it is his fault he ran out of medications.	No
Resident A received a 30-day prescription supply for Zyprexa on 12/18/18 and has run out of his Zyprexa medication prior to 1/18/19.	Yes

III. METHODOLOGY

01/09/2019	Special Investigation Intake 2019A0580011
01/11/2019	Special Investigation Initiated - Telephone A telephone call was made to Mr. Tony Navarre, Recipient Rights in Saginaw Co.
01/17/2019	Inspection Completed On-site An onsite inspection was completed at Holland AFC. Contact was made with the home manager, Ms. Sandra Tyson.
01/17/2019	Contact - Face to Face A face to face contact was made with Resident A while in his room.
03/07/2019	Contact - Telephone call made A phone call was made to Mr. George Adams, assigned Hope Network case manager for Resident A.
03/07/2019	APS Referral A referral was made to APS.
03/11/2019	Contact - Telephone call made A telephone call was made to Mr. George Adams.

03/11/2019	Exit Conference An exit conference was attempted with the licensee.

ALLEGATION:

Resident A stated that Staff Sandra Tyson has been yelling at him and telling him it is his fault he ran out of medications.

INVESTIGATION:

On 01/10/19, I received a complaint via BCAL Online Complaints.

On 01/11/19, I made a phone call to the complainant. The complainant shared that while the concerns were brought to his attention, he does not have the authority to investigate the allegations. No APS referral was made.

On 01/17/19, I conducted an onsite inspection at Holland AFC located in Saginaw, MI. Contact was made with the home manager, Ms. Sandra Tyson. Ms. Tyson denies yelling and/or cursing at the residents.

On 01/17/19, I made a face-to-face contact with Resident A while in his room. Resident A shared that when he attempted to contact Hope Network regarding his prescription refill, Ms. Tyson got upset with him and began yelling and cursing.

On 01/07/19, I held a face to face interview with Resident B, while in Resident A' room. Resident A asked Resident B to confirm that Ms. Tyson yells and curses at him. Resident B indicated that while Ms. Tyson has her days where she gets frustrated with them as residents, he denies ever witnessing her directly yelling or swearing at anyone.

APPLICABLE RULE	
R 400.14308	**Resident behavior intervention prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any other person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse** **(iii) Derogatory remarks about the resident or members of his or her family** **(iv) Threats**

ANALYSIS:	It was alleged that that Staff Sandra Tyson has been yelling at him and telling him it is his fault he ran out of medications. Resident A stated that home manager, Ms. Sandra Tyson, got upset with him and began yelling and cursing because he tried to get his own prescription refilled. Resident B stated that while he has witnessed Ms. Tyson's frustration with the residents, he has never directly witnessed her swearing at any residents. Ms. Tyson denies the allegations of yelling and swearing at the residents.
CONCLUSION	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A received a 30-day prescription supply for Zyprexa on 12/18/18 and has run out of his Zyprexa medication prior to 1/18/19.

INVESTIGATION:

On 01/10/19, I received a complaint via BCAL Online Complaints.

On 01/17/19, I conducted an onsite inspection at Holland AFC located in Saginaw, MI. Contact was made with the home manager, Ms. Sandra Tyson. Upon being informed of the allegations, Ms. Tyson indicated that if she does not get a slip/form from the residents, then she does not know when they have an appointment scheduled. She cited the reason for the missed appointments as being due to the residents often telling her at the last minute. As such, she cannot always accommodate a last-minute appointment, when having to tend to the other residents.

A copy of the Assessment Plan for Resident A was obtained. It indicated that medications for Resident A would be administered by staff. A copy of the December and January med sheets for Resident A were obtained. Resident A is prescribed 10mg of Zyprexa, to be taken each day at bedtime. December med sheets indicate that Resident A was not given his Zyprexa on the night of 12/31/18. January 2019 med sheets indicate that Resident A began receiving his prescribed medication beginning 01/09/2019. Medication sheets for Resident A verify that he did not receive his Zyprexa medication from 12/31/18-01/08/19.

Ms. Tyson has no explanation as to what happened to the missing medication.

On 01/17/19, I made a face-to-face contact with Resident A while in his room. Resident A shared that he ran out of his medication, Zyprexa, shortly after Christmas. He indicated that Ms. Tyson noticed that he was out, but she did not schedule another appointment for his refill. Resident A shared that this is the 4th time that this has occurred.

On 03/07/19, I made a phone call to Mr. George Adams, assigned case manager for Resident A. Mr. Adams indicated that he was not currently in the office and would return my call later in the afternoon with the information requested.

On 03/07/19, I made a referral to APS. APS was informed of the allegations received in this complaint regarding Resident A.

On 03/11/19, I made a phone call to Mr. George Adams, assigned case manager for Resident A. Mr. Martin was able to confirm that Resident A's last prescription for Zyprexa, 10mg, had a start date of 12/18/18 and an end date of 01/18/19. Resident A receives his prescriptions for his medication via Hope Network and CHM located in Saginaw County. Mr. Adams stated that home is responsible to ensure Resident A receives his medication and refills correctly.

Mr. Adams shared that he has been the assigned case manager for Resident A since August 2017. He shared that while Resident A has shared that he has ran out of his medications in the home before, it has not occurred since he has been his assigned case manager, until now.

On 03/11/19, I held and exit conference was held with Ms. Candace Yow, licensee. Ms. Yow was informed that the licensing rule violation was established due to the resident running out of medication prior to the expiration if the prescription. Ms. Yow agreed to provide a Corrective Action Plan within 15 days.

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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(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.**
ANALYSIS:	It was alleged that Resident A ran out of his Zyprexa medication prior to the prescription expiration date. Resident A share that he received his last dosage of Zyprexa shortly after the Christmas holiday. Medication sheets for Resident A verify that he did not receive his Zyprexa medication from 12/31/18-01/08/19. It is unknown what happened to the remaining days of medication. Hope Network Case Manager, Mr. George Adams was able to verify that Resident A's prescription was written on 12/18/18, with an end date of 01/18/19. Based on the information gathered throughout the course of this investigation, there is enough evidence to support the allegations.
CONCLUSION:	**VIOLATION ESTABLISHED**

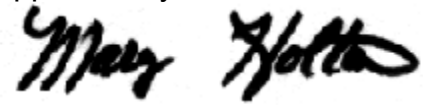
IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, I recommend no changes to the terms of the license.

March 11, 2019

Sabrina McGowan — Date
Licensing Consultant

Approved By:



March 12, 2019

Mary E Holton — Date
Area Manager