GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 3, 2020

Faith Giplaye
Human Services, Inc.
3210 Eastern Ave. S.E.
Grand Rapids, MI 49508

RE: License #: AM410394626
Investigation #: 2020A0357007
Acare Home

Dear Mrs. Giplaye:

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 contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410394626
Investigation #:	2020A0357007
Complaint Receipt Date:	12/18/2019
Investigation Initiation Date:	12/18/2019
Report Due Date:	01/17/2020
Licensee Name:	Acare Human Services, Inc.
Licensee Address:	3210 Eastern Ave. S.E. Grand Rapids, MI 49508
Licensee Telephone #:	(616) 204-4651
Administrator:	Faith Giplaye
Licensee Designee:	Faith Giplaye
Name of Facility:	Acare Home
Facility Address:	2720 44th St. SE Kentwood, MI 49512
Facility Telephone #:	(616) 204-4651
Original Issuance Date:	07/11/2018
License Status:	REGULAR
Effective Date:	09/14/2019
Expiration Date:	09/13/2021
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Men are not allowed to visit the AFC home including Resident H's husband.	Yes
Resident H's pre-diabetic diet is not being followed.	No
Before moving into the AFC home, Resident H had sporadic accidents with urination and defecating on herself. The home reported it was happening daily and her doctor was not contacted.	No
The home did not post menus for 7-10 days in advance.	Yes
Resident H was not receiving fruits, vegetables and balanced meals.	Yes
Resident H did not receive her prescribed medication for a week or more.	No

III. METHODOLOGY

12/18/2019	Special Investigation Intake 2020A0357007
12/18/2019	Contact - Telephone call made To Resident H's Legal Guardian, left a message to call me back.
12/18/2019	Contact - Telephone call made To Recipient Rights
12/18/2019	Special Investigation Initiated - Telephone To Resident H's Guardian.
12/18/2019	APS Referral
12/18/2019	Contact - Telephone call received From Resident H's Guardian.
01/21/2020	Inspection Completed On-site Unannounced Inspection Reviewed resident records.
01/21/2020	Contact - Face to Face Interviewed direct care staff, Rhonda VanDyke.
01/21/2019	Contact – Documents received Resident H's Health Care Appraisal, Assessment and an Incident and Accident Report.
01/22/2020	Contact - Face to Face, Announced Inspection. Interview with Laura Esese, the Home Manager.

01/27/2020	Contact – Document Sent Email send to Faith Giplaye and Hans Giplaye requesting documents of menus and Resident H's Medication Administration Records.
01/28/2020	Contact - Telephone call made to Hans Giplaye, the owner of the facility.
01/28/2020	Contact – Telephone call made to Laura Esese.
01/28/2020	Contact – Telephone made to Resident H's Guardian.
01/28/2020	Contact – Document received From Hans Giplaye that he would drop off the requested information by 5:00 PM.
01/29/2020	Contact -Telephone call made to Resident I's Guardian. Also. telephone to Resident I's Case Manager, Kendra Kunst.
01/29/2020	Contact- Telephone call received from Lanyea Saxton, former Direct Care Staff.
01/29/2020	Contact - Documentation Received Menus.
01/29/2020	Contact -Telephone Interview with Patti T ad Resident H's Physician's office.
01/29/2020	Contact - Telephone call to Melissa at Long Term Care Pharmacy.
01/29/2020	Contact- Documents Received Resident H's Medication Administration Records.
01/29/2020	Contact – Documents Received From Faith Giplaye, Resident H's MAR's.
01/30/2020	Contact -Telephone with Direct Care Staff Rhonda VanDyke.
01/30/2020	Contact -Telephone with former Direct Cares Staff, Laynea Sexton
02/03/2020	Contact -Interview and telephone exit conference with The Licensee Designee, Faith Giplaye.

ALLEGATION: Men are not allowed to visit the AFC home including Resident H's husband.

INVESTIGATION: On 12/18/2019, I received a complaint from BCAL Online Complaints. The allegations in part included: Resident H age (74) has dementia, TBI (Traumatic Brain Injury) and hypertension. Resident H resides in a group home and has a guardian and a husband. Resident H moved in November of 2019. The home only has female residents and for safety men are not allowed to visit the home. The group home is not allowing Resident H's husband to visit Resident H. Resident H is unable to leave the home due to her dementia.

On 12/18/2019 I conducted a telephone interview with Resident H's guardian. She said staff (unknown name) told her that Resident H's husband could not come to visit Resident H in the AFC home. She reported that Resident H cannot get out into the community due to her illness of Dementia along with a TBI. She also reported that Resident H was abusive towards her husband and it would be safer if the two were separated.

On 01/21/2020, I made an unannounced inspection to the AFC home. I met with Rhonda VanDyke, the Direct Care Staff on duty that day. I asked her about men not being able to visit the home. She stated that Ms. Esese had stated that they did not want males visiting in the AFC home because the home only provided care to females. She reported that Resident H's husband only called her once a couple of weeks ago. Her husband wanted Resident H to come over to his place, but she cannot go alone, and they did not have a safe way for her to go to visit at his place. She also reported that Ms. Esese told her to call Resident A's guardian and get permission for him to come to the home and visit Resident H. She stated that Resident H's guardian gave permission for him to come and visit her. She said that she understood that her husband did come over and had a nice visit, but she was not working at the time. She denied that she has not allowed Resident H's husband to visit her in the AFC home.

On 01/21/2019, I left a list of documents that I needed from Ms. Esese including Resident H's medication administration record (MAR) and the menus.

On 01/22/2020 I made an announced inspection to the AFC home to meet with Ms. Laura Esese. She reported that Resident H's husband did come for a visit last Friday and she supervised the visit from noon to 3:00 P.M. She reported that they could not go into Resident H's bedroom together because Resident H has a roommate. She denied that she had talked to Resident H's guardian and restricted Resident H's husband from visiting Resident H at the home. She reported that they limit one male visitor if they can because two other residents get overly excited when males are present. They have not had good experiences with males in their past and they do not respond well to men coming into the home. She said we just tell families that males should not visit for a long visit.

On 01/27/2020, I sent an email to Faith Giplaye, the Licensee Designee and to Hans Giplaye requesting copies of documents, including Resident H's MARs and the home's menus.

On 01/28/2020, I conducted a telephone interview with the owner of the home, Hans Giplaye. He stated that they do not have any policy on men not being able to visit residents. He stated he had no knowledge of Ms. Esese telling staff that males could not visit the AFC home. He stated that their current residents have children that are males and they come to visit their family member/residents. He stated that he also comes to the facility almost daily and at times he has been in the home for extended hours. He reported he has not experienced any of the female residents having any issues with him being in the home. He also stated that they do not have any written policies including their admission policy that would restrict males from visiting the AFC home.

On 01/28/2020, I received a telephone call from Resident H's guardian. She stated that Resident H is not able to go out on her own. She stated that a Direct Care Staff (name not known) told her that Ms. Esese had informed her that they may not have any male visitors in the home. The staff said they could meet in a public place. Resident H's guardian stated that Resident H cannot travel alone or be alone.

On 01/29/2020 I telephoned the guardian of Resident I. She reported that Resident I's case manager from Samairtas had made arrangements for Resident I's husband to visit her at the home and home staff told them he could visit Resident I.

On 01/29/2020, I conducted an interview with Resident I's Case Manager, Kendra Kunst. She confirmed that she had been the Case Manager for Resident I. She reported that she had set up a visit time for Resident I's husband to visit Resident I at the AFC home on 11/03/2019, and she had secured the Go-Bus, but Resident I's husband was ill that day and missed the bus. On 11/07/2019, Ms. Kunst was in the AFC home for a visit with Resident I and she had spoken to Ms. Esese and Ms. Sexton about the following weeks planned visit by Resident I's husband. She reported that Ms. Esese and Ms. Sexton told her that they did not know why Ms. VanDyke told her that he could visit Resident I. She stated that both Ms. Sexton and Ms. Esese told her he could not come to the AFC home for a visit with his wife because he was male, and they do not allow males in the home. She stated that she had to cancel the next planned visit because males were not allowed in the home. She reported that she did not schedule another visit between them because they told her males were not allowed in the home.

On 01/29/2020, I received a telephone call from the former direct Care Staff, Lanyea Sexton. Ms. Sexton acknowledged that she had told Resident H's guardian and her case manager that males cannot come into the home. She reported that Ms. Esese never told her that males were not allowed to visit in the home. She stated that Ms. Esese had asked her if males were allowed to visit in the home because Resident

H’s husband wanted to visit with Resident H and she told Ms. Esese that he could not visit.

On 02/03/2020, I conducted a telephone interview with Faith Giplaye. She stated that the residents have a right to have visitors including their husbands and they cannot prohibit men from visiting. She was reportedly not aware that staff had told individuals that men could not visit the home.

On 02/03/2020 I conducted an interview with the Licensee Designee, Faith Giplaye. She agreed with my findings.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.**
ANALYSIS:	Direct Care Staff, Rhonda VanDyke stated that Ms. Esese had told her that they did not want males to visit because the home cares only for females. She denied telling Resident H’s husband that he could not visit Resident H and reported that her husband had recently visited the home. Hans Giplaye stated that they do not have any policies that restrict male visitors in the AFC home, including their admission policy. Ms. Esese and Ms. VanDyke both stated that Resident H’s husband recently visited the home with no issues. Ms. Esese denied telling Resident H’s guardian that Resident H’s husband could not visit her in the AFC home. Resident H’s guardian stated she was told by an unnamed direct care staff that males are not allowed to visit in the AFC home.

	The Case Manager for Resident I stated that she was informed by a former direct care worker of the home and Ms. Esese on 11/07/2019 that Resident I's husband was not allowed to visit his wife because males cannot visit the home. She canceled the planned future visits. Former Direct Care Staff, Lanyea Sexton acknowledged that she had told Resident H's guardian and case manager that Resident H's husband could not visit the home because he was male. There is a preponderance of evidence to indicate that the former staff of the facility did not allow male residents to receive visitors in the AFC home on 11/07/2019.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident H's pre-diabetic diet is not being followed.

INVESTIGATION: On 12/18/2019, I received a complaint from BCAL Online Complaints alleging that Resident H, is pre-diabetic and there have been several times where she has been observed eating pizza for lunch.

On 12/18/2019 I conducted a telephone interview with Resident H's guardian. She reported that Resident H is pre-diabetic and her diet is not regular. She reported that she was at the home on 12/17/2019 and observed that pizza was served with no fruits or vegetables. She reported she had been to the home another time (no date provided) and again she did not see fruits and vegetables served. Resident H's guardian reported that Ms. Esese had requested that Resident H's History and Physical (H&P) be sent to her at the home. She stated that she had the H&P faxed to the home, but the fax machine was not working at the time. She reported that she provided Resident H's physician's name and telephone number and she had communicated to the home that they could call and obtain the necessary documents.

On 01/21/2020 I made an unannounced inspection to the home. I conducted an interview with Direct Care Staff, Rhonda VanDyke. I asked her for Resident H's file so I could review her documents. She provided a copy of Resident H's Health Care Appraisal. The form was completed and signed by Ms. Esese, RN, BSN. This document was not dated. The diagnosis was recorded as "Dementia." The section # 14, "Special Dietary Instructions and Recommended Caloric Intake" Ms. Esese had written diet as "Regular." I reviewed Resident H's Assessment Plan completed by Ms. Esesd dated 11/07/2019 and signed by Resident H's guardian on12/16/2019. Under the section of Health Care Assessment, the Special Diet was checked with a "No." Ms. VanDyke stated that she was not aware that Resident H was a pre-diabetic.

On 01/22/2020, I was in the home for an announced inspection and I conducted an interview with Ms. Esese. She explained that Resident H's guardian did not supply her History and Physical, so she had no knowledge of a special diet for Resident H. Ms. Esese reported that she had no physician's prescribed order for a pre-diabetic diet. She also said that she had contacted Resident H's physician many times with no return telephone calls.

On 02/03/2020 I spoke with the Licensee Designee, Faith Giplaye. She stated that she did not have any knowledge that Resident H had any special diet.

On 02/03/2020, I conducted a telephone Exit Conference with the Licensee Designee, Faith Giplaye, and she agreed with my findings.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Resident H's pre-diabetic is not provided and there are no fruits and vegetables. Resident H's Health Care Appraisal completed by Ms. Esese R.N. recorded a "regular" diet. Resident H's Assessment Plan completed by Ms. Esese and signed by Resident H's guardian recorded under the section of Health Care Assessment, the Special Diet was checked with a "No." Ms. Esese stated that she did not have any prescribed diet from Resident A's physician. There was no evidence found that Resident H was prescribed a prediabetic diet by a physician.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Before moving in the home Resident H had sporadic accidents where she urinated and defecated on herself. The home reported it is happening daily and her doctor has not been contacted.

INVESTIGATION: On 12/18/2019 I conducted a telephone interview with Resident H's guardian. She stated that Direct Care Staff (names unknown) had reported to

her that Resident H was incontinent all the time. She said that before Resident H moved in this was not the case. She said they requested that she purchase more adult protection for Resident H's use because they had to borrow the adult protection from another resident. She said she asked if there was a possibility if she had a bladder infection and should they report this change of incontinence to Resident H's physician. There was no response from the staff to her knowledge they did not contact her physician. She also stated that the staff told her they try to get Resident H to the restroom every two hours. She stated that it seemed to her that they were very disorganized in providing personal care to Resident H.

On 01/21/2020 I made an unannounced inspection to the home. I conducted an interview with Direct Care Staff, Rhonda VanDyke. She explained that she usually only works the weekends and she denied talking to Resident H's Guardian about Resident H's incontinence. She said it just seemed like Resident H was incontinent on a regular basis of bowel and bladder since she was admitted. Ms. VanDyke was not aware of any discussion of calling Resident H's physician for her incontinence. She said she found no symptoms or problems and it would be up the Ms. Esese, the Registered Nurse to make the decision to call Resident H's physician.

Ms. VanDyke did state that on January 5, 2020, that Resident H got up for her meds and breakfast. She said she was not looking good, her color was pale and her speech was a little slurred. She reported she immediately took her blood pressure and it was 186/86. She stated she called Dr. Bates and he recommended that Resident H be sent to the emergency room to get evaluated. She said she immediately called 911. She said she telephoned Resident H's guardian and left her a message. Ms. VanDyke reported that Resident H came back very soon from the ER and there was nothing wrong except she had bleeding hemorrhoids and there were no other concerns. Ms. VanDyke provided a copy of the Incident/Accident Report for Resident H dated 01/05/2020, which contained the same information that Ms. VanDyke had explained to me.

On 01/22/2020, I was in the home for an announced inspection and I conducted an interview with Ms. Esese. I asked her about the concern of Resident H's guardian and calling her physician for what she had reported was a change in Resident H's increased incontinence. She stated that she, Resident H's guardian, had not telephoned her. She was aware of Resident H's daily incontinence. She stated that she is a Registered Nurse and there were no symptoms reported by staff that would indicate that Resident H had a Urinary Tract Infection or a bladder infection. In her judgement she did not see the need to contact Resident H's physician for the incontinence. She did reference the incident on 01/05/2020 and stated the staff did seek immediate care by contacting Resident H's physician and following his recommendation by calling 911 and sending Resident H to the emergency room for evaluation. She reported that the Emergency Room visit indicated that Resident H had bleeding hemorrhoids and there were no other concerns. Ms. Esese stated there was no reason to contact Resident H's physician except for the change of condition of Resident H on 01/05/2020.

On 02/03/2020 I spoke by telephone with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident H was noted by staff to be incontinent of bowel and bladder which her guardian thought was occurring more frequently than before she moved into the facility. Resident H's guardian thought her physician should have been contacted. Ms. Esese (RN) stated the direct care staff had not reported any symptoms to her that would be associated with a possible Urinary Tract Infection or Bladder Infection for Resident H and there was no medical reason to contact Resident H's physician regarding her incontinence. Ms. VanDyke and Ms. Esese both stated that on 01/05/2020 Ms. VanDyke did notice a sudden change in Resident H's condition and she immediately contacted Resident H's physician and called 911 and Resident H was transported to the hospital Emergency Room for evaluation. She was found to be fine and returned to the AFC home. There is no evidence that would indicate a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The home did not post menus for 7-10 days in advance.

INVESTIGATION: On 12/18/2019, I conducted a telephone interview with Resident H's guardian. She reported that she has been in the home several times and she has not observed the required posting of the menus a week in advance.

On 01/21/2020, I made an unannounced inspection to the home. I conducted an interview with Direct Care Staff, Rhonda VanDyke. I asked to see the menu for the week. She went to the other side of the kitchen and brought me a single piece of paper. It read "Becky Dorner and Associates Sunday, Week II Cycle 11GH NCSF395, Menu Substitutions-Lunch-Dinner." On the side of the form was listed Breakfast, Lunch, Dinner, HS and 4PM snack. The top of the form was divided into columns with "Regular/NAS, Mechanical Soft, Puree, Low Chol/Low Fat, Diabetic, Calorie Restricted, NCS and NCS P." The form contained a list of foods for

Breakfast, Lunch and Dinner, and then broke down what should be served for each type of special diets. I asked Ms. VanDyke if this was the menu for today and she said it was not. She said she was fixing pork tonight for dinner. I asked to see the menu for the week, and she said she did not have one. She said that Ms. Esese must have taken them, in order to work on them. She stated if the food items listed for the meals are not available, she just finds other foods to prepare and serve to the residents. I made a list of documents that I needed copied for Ms. VanDyke to give to Ms. Esese, which included weekly menus since November 2019 through the present.

On 01/22/2020, I was in the home for an announced inspection and I conducted an interview with Ms. Esese. I asked her if the menus are posted a week in advance and she said they were. She said that Ms. VanDyke must have just missed the weekly menu. I did not observe a weekly posted menu on the cabinet. She went to her office area and pulled out a file folder and showed me the menus. She said they have a four-week cycle, but I observed that none of the weekly menus had dates on them. So, I asked her how I would know what week they were on and she said it would be the menu posted for the week. She did not have the menus copied for me. I requested them from her, and she said she would have to send them to me because she had a meeting with case managers shortly. She acknowledged that the menus were not dated.

On 01/27/2020, I sent an email to Faith Giplaye and Hans Giplaye and I requested that they send me the menus, as soon as possible.

On 01/28/2020, Hans Giplaye sent me an email that stated he would drop off the information at my office on this date by 5PM.

On 01/29/2020, I telephoned Mr. Giplaye and asked for the menus. He said he was at the facility and he would fax them to me.

On 01/29/2020, I received the faxed menus. When I first saw the menus with Ms. Esese, on 01/22/2020, they did not have any dates on them. I reviewed the faxed menus and the dates had been handwritten in. One of the menus ended on Saturday 12/14/2019 and the next menu started on 12/15/2019. I observed that the date on Wednesday of that week was recorded as 12/16/2019 when it was actually 12/18/2019. I observed the rest of the week, and the three days, were not the correct dates of the month. Therefore, four days did not match the actual date of the week. It appears that someone had just written in the dates and the four days were incorrect.

On 02/03/2020, I spoke with Ms. Faith Giplaye, and she stated that if I had not observed it posted then it was not posted.

On 02/03/2020, I conducted an Exit Conference by telephone with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
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.
ANALYSIS:	Resident H's Guardian reported that she had been in the home several times and she had not seen a weekly posted menu. On 01/21/2020, I did not observe a posted weekly menu one week in advance. Direct Care Staff, Rhonda VanDyke was unable to provide the written weekly menu. Ms. Esese stated that the staff just did not know where the menus were located, so she showed me the menus which were in a file folder in a cabinet. When I observed them, they did not have any recorded dates on them. When I received the menus by fax the dates had been written in. The week of 12/15-21/2019 did not have the correct dates for four days, Wednesday through Saturday. There is a preponderance of evidence that the required written menus were not posted a week in advance. There were no changes or substitutions noted and considered as part of the original menu.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident H was not receiving fruits, vegetables and balanced meals.

INVESTIGATION: On 12/18/2019, I conducted a telephone interview with Resident H's guardian. She reported that she had been in the AFC home several times and observed pizza being served and there were no fruits or vegetables.

On 01/21/2020 I was at the home and interviewed Rhonda VanDyke. She explained that she was fixing a pork roast, mashed potatoes, gravy and green beans for dinner. She reported that she did not have a menu for that day, so she figured out what she had available to fix the dinner menu.

On 01/29/2020, I received, and reviewed the menus with a start date of 10/27/2019 through 01/18/2020. The menu for 01/21/2020, reported the dinner as Grilled

sausage & peppers on a bun, Oven Baked Fries, Broccoli, Brownies 2% milk, Coffee-tea-Sanka. There were no substitutions recorded.

On 01/30/2020, I reviewed the menus and found the lunch on five Saturdays 11/09/2019, 12/07/2019, 12/28/2019, 01/11/2020, and one in the future dated 02/01/2020, the menu recorded Taco salad and orange Sections, 2% milk, Coffee-Tea-Sanka. On Saturdays and Sundays recorded that there were no foods provided at 4:00 P.M.

On 01/30/2020, I conducted a telephone interview with Direct Care Staff, Rhonda VanDyke. I asked her if she had to serve food items that were not on the menu how she record what she served. She reported that Ms. Esese told her to scratch it out on the original menu and write in what she fixed and served. She said this did not happen very often. As I reviewed the menus there were no changes made. I asked her about the Taco Salad and Orange Sections on the Saturdays, and she did not know what orange sections were. She said she does not remember serving Taco Salad and orange sections. She said the orange sections were probably from a cup of fruit that had been sealed and was not fresh. I asked her about the times the menus recorded “Melons in season,” and she said she did not remember serving melons except maybe one or two times. I asked her about the foods served at 4:00 PM, that was recorded on the menu and she reported that she did not serve food at 4:00 PM. She said that residents could get a snack of fruit or peanut butter crackers, if they wanted it but she said dinner was served at 5:00 P.M. I asked her about the HS (night-time) food items listed on the menu and she said the residents could have a snack when they took their nighttime medications. She was not sure that the food items recorded on the menu were the ones that residents received. The menu dated 12/16/2019 recorded “Inside-out ravioli.” She said she did not know what that was. She reported that much of their fruits were from cans, like pears. Some were fresh like plumbs, apples and bananas. I asked Ms. VanDyke how she served vegetables or fruit and she explained that she just used a spoon and that there was no instrument to measure the serving sizes. She did not know if the foods were to be measured. She reported that she knew how to cook since she was 11 years old and she did not have any recipes to follow.

On 01/30/2020, I reviewed the menus and found on lunch on five Saturdays 11/09/2019, 12/07/2019, 12/28/2019, 01/11/2020, and one in the future dated 02/01/2020, the menu recorded Taco salad and orange Sections, 2% milk, Coffee-Tea-Sanka. I picked a day 11/22/2019, I was looking for fruits and vegetables. Breakfast was grapefruit juice with cereal, Lunch was Tuna salad on WW bread, pretzels, Plumbs, Dinner hotdogs, baked beans, vegetables sticks and Fruited Gelatin. Snack was P&B sandwich and HS snack was potato chips, and ice cream and beverage. They are required to serve a minimum of six servings of fruits and vegetables. This day’s menu only had grapefruit juice, a plumb and vegetable sticks and fruited gelatin, which did not meet the six required servings of fruits and vegetables and the serving sizes were not recorded. Other days did not provide the minimum of fruits and vegetables.

On 01/30/2020, I reviewed the book referenced in the Administrative Rules, 'Basic Nutrition Facts; A Nutritional Reference and Table 6.1 revised 1988. "The guide is aimed at meeting the 100% of the Recommended dietary Allowances." The first food group was Vegetable/Fruit. For ages 19-76, six servings of fruits and vegetables per day, 1 serving vegetables cooked was 1/2 cup and the same for raw. Fruits canned ½ cup, raw 1 piece, and Juice ½ cup. Bread/Cereal 5 servings per day which is one slice of bread, 1 and 1/2 to ¾ cup of cereal, 1 cup ready-to-eat cereal, ½ -3/4 cup pasta same for rice and 4-2" squares of crackers. Milk/Cheese required 2 servings per day, 1 serving is one cup milk, 1 cup yogurt, ½ serving is 1 cup cottage cheese, 1" cheese cube. 1 slice of processed cheese. Milk/Poultry/Fish and Beans. This group requires 2 and ½ servings per day. On serving is 2 ounces of meat, fish, or poultry, 1 cup of cooked dry beans or peas, ¼ cup of nuts, ½ servings ½ servings equates 1 egg, 2 tablespoons of seeds, 2 tablespoons of peanut butter or 3 ½ ounces of tofu. The last food group was Fat. This was recorded as a zero. This book stated that a menu plan is to provide each individual with the minimum recommended number of servings from each essential food group. As I reviewed the menus, they only listed the foods for Breakfast, Lunch and Dinner. There were no measurements recorded for any of the food items recorded on the menus. I have no way to determine if the residents are receiving the recommended nutritional allowances that are required by the rule.

On 02/03/2020 I spoke by telephone with the Faith Giplaye and she stated that she knew they had menus but did not know they had to measure the foods they served.

On 02/03/2020 I conducted a telephone exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400.14313	**Resident nutrition**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix 1: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference, "Michigan Department of Public health publication no. H-808, 1/89. This publication may be obtained at cost from the Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.
ANALYSIS:	Direct Care Staff, Rhonda VanDyke acknowledged that she had no way to measure the serving sizes of any of the foods recorded on the menus.

	Upon my review of the menus for three months, I found them to be void of fresh fruits and vegetables. Both fruits and vegetables were severed in a casserole, Jell-O or in a cobbler. There were lettuce salads, applesauce, cucumbers and onion slices, raisins, dill pickles, but not a ½ cup or a full cup of vegetables. Mellon in season was recorded many times but the staff reported they only had melon once or twice. I found the menu plan to not be well balanced with all of the required food groups served. There is a preponderance of evidence that the Licensee failed to provide the Required Dietary Allowances in meals provided to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident H did not receive her prescribed medications for a week or more.

INVESTIGATION: On 12/18/2019, Resident H's guardian reported that she had made arrangements to have Resident H admitted to the Acare Adult Foster Care home. She reported that she brought Resident H and her bottles of medications to the AFC home on admission. She said the medication bottles had come from Walgreens Pharmacy. She reported that she had provided Resident H's physician's name, telephone numbers with instructions to speak with "Patty," at the physician's office, who would provide any information they needed. She said many text messages were exchanged with Ms. Esese and her. She said that Ms. Esese was provided enough information for the home staff to secure all the medical information on Resident H that they required. She said she faxed Resident H's History and Physical to the home to the fax number she had been given but she learned later that their fax machine was not working. She reported that Resident H went without her prescribed medications for at least a week. She said the home staff were not able to arrange that the scrips could be transferred from the Walgreen's Pharmacy to the Long Term Care Pharmacy, which the home used.

On 01/21/2020, I interviewed Ms. VanDyke. She reported that she administered Resident H's medications when she worked on the weekends and she signed her initials but did not remember where she had signed them. She stated that she was certain that Resident H had not missed any of her medications.

On 01/22/2020, I conducted a face-to-face interview with Ms. Esese. She reported that she never spoke directly with Resident H's guardian, but they did exchange text messages which she showed to me on her telephone. She confirmed that Resident H's guardian brought Resident H to the facility and she brought her medicine bottles. She said she had prescribed medications and several over the counter supplements. She said right after Resident H was admitted her guardian went on vacation for a

period of time and they could not reach her. She reported that Resident H's guardian did not come and sign the required paperwork for Resident H until 12/16/22019 and she was admitted on 11/07/2019. She stated that she did not receive Resident H's History and Physical, nor a list of her medications. She stated she called Resident H's physician's office at least five times with no return calls. She also stated that Resident H did not have a case manager. She reported that they were able to have the physician who services the facility accept Resident H, as a patient. I asked Ms. Esese how they recorded the administration of Resident H's medications if she was not on their computer with the Long Term Care Pharmacy who had not secured her prescribed medications. She said they did it on the computer. I asked to see and have copies provided of all of Resident H's Medication Administration Record. Ms. Esese stated that she was not able to copy them from the computer and that only the pharmacy would be able to do that. She said she would obtain copies of the MAR's and fax them to me.

On 01/29/2020 I conducted a telephone interview with the former Direct Care Staff, Lyanee Sexton. She stated that she was working when Resident H was admitted into the home. She explained that she took all the bottles of Resident H's medications and she made her own medication administration sheet. She reported that several of her medications had just been refilled from Walgreens. She stated that she and Ms. VanDyke signed their initials for each administration of Resident H's medications. She stated that she and Ms. Esese worked very hard to have the scripts transferred from the Walgreens Pharmacy to their own pharmacy, Long Term Care Pharmacy. She said it was a long process, but they were successful and then Resident H's medication administration record was on their computer. She stated that Resident H had not missed any doses of her medications.

On 01/29/2020, I conducted a telephone interview with "Patti T" at Resident H's physician's office, Dr. Koepnick. She stated she kept documentation of all of the transactions concerning Resident H. She stated that she had worked with Resident H's guardian and she had sent out all of the documents that had been requested on the date the request came in 11/07/2019. This included the H&P and the list of Resident H's medications which she sent to Resident H's guardian because they had no information on Acare Home and no telephone number. She understood that this was an emergency admission. She reported that on 11/22/2019 at 5:00 P.M. Ms. Esese called the office and left a message that Resident H needed prescriptions because she did not have any medications. She said Ms. Esese did not leave a telephone number to call her back. She could not reach her until the following Monday 11/25/2019 after she had received a telephone call from Melissa at LTCP who provided Ms. Esese's telephone number. She stated this was the one and only time that their office had received a telephone call from Ms. Esese.

On 01/29/2020, I spoke with Melissa at LTCP. She provided the numerous steps they had to take to secure the prescriptions for Resident H's medications. She reported that the home staff called them on 11/22/2019 after they had closed (after 5:00 p.m.) and stated they were out of Resident H's medications. She stated that

Ms. Esese had called their two managers and left them voice mail messages after 5:00 P.M. She did explain that on 11/25/2019, Walgreens Pharmacy was able to transfer some of the scripts to them. They were able to complete a "Dummy Profile," for Resident H and then the staff were able to put their initials on the electronic medication system. She reported that on 01/21/2020, Mr. Giplaye had called at 6:30 P.M. asking for Resident H's medications. She was called back into work to prepare and type up the new prescriptions that had come in from Resident H's new physician, Dr. Bates on 01/23/2020. She reported that before this all happened, they were able to get Resident H's Lisinopril on 12/16/2019 because Dr. Bates had changed the 20 mg from BID to once a day. She said they also filled the Sertraline 50 mg. from the Walgreens prescription on 11/25/2019. In addition, Resident H's Xarelto 20 mg was transferred from Walgreens to them on 11/25/2019. She said all the other medications had to be created as "Dummy Scripts." She reported they eventually were able to get all of the prescriptions on their system, called "Quick Mar." She said she could send me the MARs by email with all of the staff's initials included.

On 01/29/2020, I received Resident H's MARs. I reviewed November's MAR which contained 12 medications with two medications discontinued. The staff's initials started on 11/25/2019 and were completed to the end of the month. I received and reviewed Resident H's MAR for December 2019. This document contained the staff's initials for each medication. The medication Metoprol Suc Tab 25 MG ER had no staff's initials for 12/14 at 8:00 PM and on 12/22/2019 at 8:00 PM. This document does not allow me to see the possible reason(s) that the medication was not administered. I received and reviewed Resident H's MAR for January 2020. All the dates contained the staff's initials for each medication through 01/29/2020.

On 01/29/2020 I received a faxed cover sheet from Faith Giplaye with three sets of the same handwritten MAR's. The copies did not copy the tops of the pages, but these were Resident H's medications with dates starting on 11/07/2019 through 11/24/2019 and all of the boxes were initialed by the staff. I also received Resident H's MARs that were identical to the ones I had received from the pharmacy. These documents provided evidence that from 11/07/2019 through 01/29/2020, Resident H received all of her prescribed medications proven by the staff's recorded initials.

On 02/03/2020 I conducted a telephone exit conference with the Licensee Designee, Faith Giplaye and she agreed with my findings.

APPLICABLE RULE	
R 400. 14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Direct Care Staff, Rhonda VanDyke stated that she had initialed for the administration of Resident H's medications since her

	admission to the home and she acknowledged that she did administered all of Resident H's medications. Ms. Esese stated that Resident H did not miss any of her prescribed medications since her admission to the home. There is no evidence of Resident H missing any of her prescribed medications since her admission to the home.
CONCLUSION:	VIOLAITON NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that upon receipt of an acceptable corrective action plan, the recommendation of a provisional license remain the same recommendation of Special Investigation # 2020A0357004 dated on 12/17/2019.

Arlene B. Smith 02/03/2020

Arlene B. Smith MSW Date
Licensing Consultant

Approved By:

02/03/2020

Jerry Hendrick Date
Area Manager