GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 8, 2020

Debra Krajewski
DeepWood AFC, LLC
1767 DeepWood Dr. SW
Wyoming, MI 49519

RE: License #: AS410284040
Investigation #: 2020A0583045
DeepWoods AFC

Dear Ms. Krajewski:

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) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410284040
Investigation #:	2020A0583045
Complaint Receipt Date:	09/30/2020
Investigation Initiation Date:	09/30/2020
Report Due Date:	10/30/2020
Licensee Name:	DeepWood AFC, LLC
Licensee Address:	1767 DeepWood Dr. SW Wyoming, MI 49519
Licensee Telephone #:	(616) 318-1961
Administrator:	Debra Krajewski
Licensee Designee:	Debra Krajewski
Name of Facility:	DeepWoods AFC
Facility Address:	1767 DeepWood Drive, SW Wyoming, MI 49519-6556
Facility Telephone #:	(616) 531-1023
Original Issuance Date:	08/16/2006
License Status:	REGULAR
Effective Date:	02/16/2019
Expiration Date:	02/15/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B are not being administered their medications as prescribed.	Yes
The facility is unclean and unkept.	No
The facility lacks an adequate food supply.	No

III. METHODOLOGY

09/30/2020	Special Investigation Intake 2020A0583045
09/30/2020	Special Investigation Initiated - Telephone Staff Diamond Mensah
10/01/2020	Onsite Inspection Staff Terry Krajewski, Resident A, Resident B
10/01/2020	Contact – Face to Face Licensee Designee Debra Krajewski
10/02/2020	Contact – Document Sent Licensee Designee Debra Krajewski
10/02/2020	Contact – Telephone Staff Terry Krajewski
10/06/2020	Contact – Face to Face Licensee Designee Debra Krajewski
10/07/2020	Exit Conference Licensee Designee Debra Krajewski

ALLEGATION: Resident A and Resident B are not being administered their medications as prescribed.

INVESTIGATION: On 09/30/2020 I interviewed staff Diamond Mensah via telephone. Ms. Mensah stated she no longer works at the facility. Ms. Mensah stated she worked at the facility the weekend of 08/15/2020 and while working located a large volume of Resident A and Resident B's untaken medications located in their respective bedrooms. Ms. Mensah stated she alerted Licensee Designee Debra Krajewski on 08/16/2020 of the situation via text messages which contained photographs of the located medications. Ms. Mensah stated staff Courtney Hubert

and Ryan Jones were live-in facility staff in charge of administering Resident's medications at the time the medications were located by Ms. Mensah. Ms. Mensah stated Ms. Hubert and Mr. Jones would have been in charge of administering Resident A and Resident B's medications a that time.

Ms. Mensah emailed screenshots of text messages she reported were sent to Licensee Debra Krajewski on 08/16/2020. I observed the text messages contained a photograph of two containers filled with untaken medications Ms. Mensah identified as belonging to Resident A and Resident B.

On 10/01/2020 I completed an unannounced on-site inspection at the facility and privately interviewed staff Terry Krajewski, Resident A and Resident B.

Staff Terry Krajewski stated he moved into the facility as shortly after Labor Day 2020. Mr. Krajewski stated staff Ryan Jones and Courtney Hubert resided at the facility until Mr. Krajewski moved into the facility. Mr. Krajewski stated Resident B is prescribed Melatonin daily in the evenings. Mr. Krajewski stated Resident B has a habit of not wanting to take his Melatonin when administered. Mr. Krajewski stated Resident B will often take his Melatonin from Mr. Krajewski and place it in his shirt pocket without ingesting the medication. Mr. Krajewski stated he feels his "hands are tied" because Resident B refuses to ingest his Melatonin. Mr. Krajewski stated he administers all other residents' medications as prescribed and has no other issues with other residents not ingesting their medications. Mr. Krajewski stated he has no information regarding Resident A and Resident B's medications being found in their bedrooms in August 2020.

While onsite I observed Resident B's Medication Administration Record indicates he is prescribed daily Melatonin.

Resident A stated Mr. Krajewski administers his medications as prescribed. Resident A stated staff Courtney Hubert and Ryan Jones did not observe him ingest his medications and therefore Resident A would intermittently not ingest his medications and place them on his dresser for keeping.

Resident B stated he is prescribed Melatonin daily. Resident B stated Mr. Krajewski does not regularly view him ingest his Melatonin in the evenings. Resident B stated Mr. Krajewski often tells Resident B to "get" the Melatonin "out of my site" therefore Resident B places his Melatonin in his shirt pocket and later transfers the medication to his bedroom for keeping. Resident B stated Mr. Krajewski is aware Resident B places his Melatonin in his shirt pocket and does not ingest the medication. Resident B stated he had multiple Melatonin tablets in his bedroom right now. Resident B stated staff Courtney Hubert and Ryan Jones did not observe Resident B ingest his medication as well.

I observed nine tablets of Melatonin located in Resident B's bedroom on the table next to his bed.

On 10/01/2020 I interviewed Licensee Designee Debra Krajewski face-to-face. Ms. Krajewski stated she didn't remember receiving text messages from staff Diamond Mensah on 08/16/2020 with photographs of un-taken resident medications. Ms. Krajewski stated staff Courtney Hubert and Ryan Jones informed Ms. Krajewski that Resident B has a history of refusing to take his medications and placing them in his shirt pocket. Ms. Krajewski stated she informed Resident B's guardian of the issue.

On 10/02/2020 I interviewed staff Terry Krajewski via telephone. Mr. Krajewski stated he confiscated Resident B's untaken Melatonin located inside of Resident B's bedroom. Mr. Krajewski stated he plans to contact Resident B's physician and request changing Resident B's Melatonin from a daily medication to a PRN medication.

On 10/07/2020 I completed an Exit Conference with Licensee Designee Debra Krajewski via telephone. I informed Ms. Krajewski of the investigative findings and she stated she would complete an acceptable Corrective Action Plan.

APPLICABLE RULE	
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.
ANALYSIS:	Resident B stated he is prescribed Melatonin daily. Resident B stated Mr. Krajewski does not regularly observe him ingest his Melatonin in the evenings and therefore Resident B places his Melatonin in his shirt pocket and later transfers the medication to his bedroom for keeping. Resident B stated Mr. Krajewski is aware Resident B places his Melatonin in his shirt pocket and does not ingest the medication. Resident B stated he had multiple Melatonin tablets in his bedroom right now. Resident B stated staff Courtney Hubert and Ryan Jones also did not observe Resident B ingest his medication. I observed nine tablets of Melatonin located in Resident B's bedroom on his tablet next to his bed.

	Resident A stated Staff Courtney Hubert and Staff Ryan Jones did not observe him ingest his medications and therefore Resident A would intermittently not ingest his medications and place them on his dresser. There is a preponderance of evidence to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility is unclean and unkept.

INVESTIGATION: On 09/30/2020 I interviewed staff Diamond Mensah via telephone. Ms. Mensah stated she worked at the facility the weekend of 08/15/2020 and observed the facility to be unclean and unkept. Ms. Mensah stated she observed residents' bedding to be unwashed, facility floors to be upswept, and the facility to be overall unclean. Ms. Mensah stated she alerted Licensee Designee Debra Krajewski on 08/16/2020 of the situation via text messages. Ms. Mensah stated staff Courtney Hubert and Staff Ryan Jones were live-in facility staff and in charge of cleaning the facility at that time. Ms. Mensah stated she cleaned the facility herself the weekend of 08/15/2020.

On 10/01/2020 I completed an unannounced on-site inspection at the facility. I privately interviewed Staff Terry Krajewski, Resident A and Resident B.

Staff Terry Krajewski stated he moved into the facility as staff shortly after Labor Day 2020. Mr. Krajewski stated staff Ryan Jones and Courtney Hubert resided at the facility until he moved in. Mr. Krajewski stated the facility is clean and well kept. He stated he did not observe the facility to be unclean when he moved into the facility.

I observed the facility to be clean and appropriately kept. I observed residents' bedding as clean, floors swept, and with no safety concerns noted.

Resident A and Resident B both stated the facility is clean and well-kept. Resident A and Resident B both stated August 2020 the facility was clean and sanitary.

On 10/01/2020 I interviewed Licensee Designee Debra Krajewski face-to-face. Ms. Krajewski stated the facility has always been clean and appropriate. She denied the facility was unclean August 2020.

On 10/07/2020 I completed an Exit Conference with Licensee Designee Debra Krajewski via telephone. I informed Ms. Krajewski of the investigative findings.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	I observed the facility to be clean and appropriately kept. I observed residents' bedding as clean, floors swept, and with no safety concerns noted. Resident A and Resident B both stated the facility is clean and well-kept. Resident A and Resident B both stated that inAugust 2020 the facility was clean and sanitary. There is not a preponderance of evidence to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility lacks an adequate food supply.

INVESTIGATION: On 09/30/2020 I interviewed staff Diamond Mensah via telephone. Ms. Mensah stated she worked at the facility the weekend of 08/15/2020 and viewed the facility lacked an adequate volume of food. Ms. Mensah stated the posted menu could not be followed due to the lack of food contained at the facility. Ms. Mensah stated she alerted Licensee Designee Debra Krajewski on 08/16/2020 of the situation via text messages. Ms. Mensah stated staff Courtney Hubert and Ryan Jones were live-in facility staff and in charge of maintaining the facility at that time. Ms. Mensah stated Ms. Krajewski arraigned for the attainment of food later that weekend.

On 10/01/2020 I completed an unannounced on-site inspection at the facility. I privately interviewed staff Terry Krajewski, Resident A and Resident B.

Staff Terry Krajewski stated he moved into the facility as staff shortly after Labor Day 2020. Mr. Krajewski stated staff Ryan Jones and Courtney Hubert resided at the facility Mr. Krajewski moved into the facility. Mr. Krajewski stated when he moved into the facility, he never observed a lack of food. Mr. Krajewski stated facility staff follow posted menus and document substitutions as needed. Mr. Krajewski stated facility staff provide residents with three nutritious meals daily. Mr. Krajewski stated the facility has adequate food.

Resident A and Resident B both stated staff follow the posted menus and there is an adequate amount of food in the home. Resident A and Resident B both stated

August 2020 the facility contained an adequate volume of food and menus were followed by staff.

I observed a plentiful amount of food in the facility cupboards and refrigerators. I also observed the posted menus appear adequate.

On 10/01/2020 I interviewed Licensee Designee Debra Krajewski face-to-face. Ms. Krajewski stated the facility has always had an adequate volume of food and residents are always provided three nutritious meals daily. She denied the facility lacked an adequate of food August 2020.

On 10/07/2020 I completed an Exit Conference with Licensee Designee Debra Krajewski via telephone. I informed Ms. Krajewski of the investigative findings.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	I observed the facility to be have an adequate amount of food. Resident A and Resident B both stated staff follow the posted menus and there is an adequate amount of food in the home. Resident A and Resident B both stated that in August 2020 the facility contained an adequate amount of food and menus were followed by staff. There is not a preponderance of evidence to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

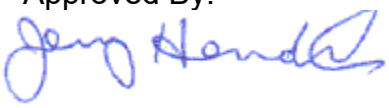
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

10/07/2020

Toya Zylstra Date
Licensing Consultant

Approved By:



10/08/2020

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Jerry Hendrick Date
Area Manager