GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 16, 2021

Tanisha Johnson
Victory AFC INC
14 Victory Court
Saginaw, MI 48602

RE: License #: AS730362423
Investigation #: 2021A0576030
Victory AFC INC

Dear Ms. Johnson:

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.
- 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. 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 (517) 284-9730.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730362423
Investigation #:	2021A0576030
Complaint Receipt Date:	05/21/2021
Investigation Initiation Date:	05/21/2021
Report Due Date:	07/20/2021
Licensee Name:	Victory AFC INC
Licensee Address:	14 Victory Court, Saginaw, MI 48602
Licensee Telephone #:	(989) 971-9333
Administrator:	Tanisha Johnson
Licensee Designee:	Tanisha Johnson
Name of Facility:	Victory AFC INC
Facility Address:	2525 Mackinaw Street, Saginaw, MI 48602
Facility Telephone #:	(989) 971-9333
Original Issuance Date:	05/05/2015
License Status:	REGULAR
Effective Date:	11/05/2019
Expiration Date:	11/04/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has a brace on his leg. His leg was observed to be beet red with active drainage seeping through his skin. His right shoe was taken off and it contained about an inch of fluid. His foot was 3x the normal size. He had maggots on the inside of his saturated sock. His shoe would have had to remain on for weeks for him to have maggots. The brace must have been left on for an extended amount of time. Concern for neglect and lack of proper care.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/21/2021	Special Investigation Intake 2021A0576030
05/21/2021	APS Referral Intake received from Adult Protective Services (APS)
05/21/2021	Special Investigation Initiated - Telephone Left message for Complainant to return call
05/21/2021	Contact - Telephone call received Message received from Complainant
06/10/2021	Inspection Completed On-site Spoke to Staff, Bernice Phillips, Resident B, and Resident C
06/14/2021	Contact - Document Received Reviewed Resident A documents
07/02/2021	Contact - Telephone call made Spoke to Complainant
07/02/2021	Contact - Telephone call made Spoke to Dorothy Moore, PACE Nurse
07/02/2021	Contact - Document Received Reviewed Progress Note regarding Resident A
07/13/2021	Contact - Telephone call made

	Spoke to Guardian A
07/16/2021	Exit Conference Exit Conference conducted with Licensee Designee, Tanisha Johnson

ALLEGATION:

Resident A has a brace on his leg. His leg was observed to be beet red with active drainage seeping through his skin. His right shoe was taken off and it contained about an inch of fluid. His foot was 3x the normal size. He had maggots on the inside of his saturated sock. His shoe would have had to remain on for weeks for him to have maggots. The brace must have been left on for an extended amount of time. Concern for neglect and lack of proper care.

INVESTIGATION:

On May 21, 2021, I received this intake from Adult Protective Services (APS). The intake was rejected for APS investigation.

On May 21, 2021, I left a message for the Complainant to return my call. On May 21, 2021, Complainant left a message returning my call. On July 2, 2021, I interviewed the Complainant who advised Resident A is currently residing at a home for the aged and doing well. Complainant advised when the allegations occurred, Resident A went to the doctor for a catheter change, which he requires every month. Complainant advised this is when the wound to Resident A was discovered. Complainant advised Resident A's right leg was infected and there were maggots found in between Resident A's toes. Resident A was sent to the hospital and spent 4-5 days there. Resident A required IV antibiotics and was diagnosed with cellulitis. Complaint advised Resident A utilizes a brace on his right leg due to being impaired from a stroke. Resident A requires a wheelchair, cannot walk, and is impaired from the waist down. According to Complainant, Resident A requires staff to bathe and dress him.

On June 10, 2021, I completed an unannounced on-site inspection at Victory AFC and interviewed Staff, Bernice Phillips, Resident B and Resident C. Ms. Phillips reported Resident A no longer resides at the home and she did not know where he currently resides. Resident A had lived in the home since at least 2017. Ms. Phillips stated there are currently 2 residents who live in the home. Regarding the allegations, Ms. Phillips reported Resident A had a wound on his toe and she did not know about the wound. Ms. Phillips stated she did not know how Resident A got the wound or when. Resident A went to the doctor for a routine monthly appointment and staff at the doctor's office discovered the wound. The staff at the doctor's office said "the wound was bad" so Resident A was immediately sent to the hospital. Resident A was admitted to the

hospital however Ms. Phillips did not know for how long and he has since been discharged.

According to Ms. Phillips, Resident A could not walk and utilized a wheelchair. Resident A required a brace on his leg when he was awake, and she did not know why. According to Ms. Phillips, Resident A's brace was taken off every night and staff would assist him with taking off the brace. Ms. Phillips stated Resident A could put on his own shoes and his shoes had straps that he could fasten. Ms. Phillips reported Resident A wore his shoes when he was awake and would take them off at night. Ms. Phillips denied Resident A slept with his shoes or brace on. Ms. Phillips stated Resident A can put his socks on and staff, including Ms. Phillips assisted him with this task. Resident A takes a shower twice per week, usually during the "night shift," and staff assist Resident A with showering. Ms. Phillips reported she leaves her shift at 7pm and Resident A would be in bed by this time.

Ms. Phillips reported she was working the day Resident A went to the doctor and she began her shift at 7am. According to Ms. Phillips, Resident A's appointment was at 1:30pm and she did not know about the appointment. Staff from the doctor's office transports Resident A to his appointment and "they just showed up". Ms. Phillips reported she told Resident A to get ready and she assisted him with getting his shirt and shorts on. Resident A had his socks on and one shoe on and she gave him the other shoe to put on. Ms. Phillips did not see Resident A's sock wet or saturated or that his leg or foot to be swollen. Ms. Phillips did not see or smell anything out of the ordinary regarding Resident A. Ms. Phillips denied seeing the wound or any injury to Resident A's foot. Ms. Phillips denied smelling any odor coming from Resident A or his foot nor did she see maggots on his foot. According to Ms. Phillips, Resident A did not say anything to her to indicate he was in pain. Ms. Phillips stated Resident A cannot talk however he can moan and point to something if it was bothering him or if he needed something.

On June 10, 2021, I interviewed Resident B who reported he has resided at his home for 2 years. Resident B stated his home okay when asked and staff take care of him. Resident B denied any concerns and stated he was "fine".

On June 10, 2021, I interviewed Resident C who reported he has lived at his home for 2 years. Resident C discussed dinner and a movie he just saw. Resident C stated his home is alright and staff treat him well. Resident C denied any current concerns.

On June 14, 2021, I reviewed Resident A's AFC Assessment Plan which revealed Resident A is 75 years old and requires assistance with toileting, bathing, grooming, dressing, and personal hygiene. The assessment plan indicates Resident A cannot walk and nods his head and gives hand cues to communicate.

On July 2, 2021, I interviewed Dorothy Moore, Nurse from PACE where Resident A attends for medical care. According to Ms. Moore, Resident A is nonverbal due to a stroke and comes into the office every month for a catheter change. Ms. Moore advised

Resident A was never on time for his medical appointments. On the day of the allegations, Resident A came in, pointed to his right leg and was moaning. Resident A's temperature was also elevated. Resident A was taken to a room and Ms. Moore took his brace and shoe off and saw an "inch of fluid" at the bottom of the shoe and it was "sopping wet". Ms. Moore rolled Resident A's sock down, which was completely wet and saw maggots on the inside of Resident A's sock. There were maggots crawling around and going into Resident A's skin. Resident A's leg was draining fluid and there were 2 open sores on is foot and in between his toes. Ms. Moore stated Resident A's leg was very swollen and smelled. The decision was made to send Resident A to the hospital and an ambulance was called. According to Ms. Moore, Resident A was in the hospital for 5 days; May 20, 2021, through May 25, 2021. Ms. Moore advised she just saw Resident A "five minutes ago" and he is doing well, and his leg has since healed.

On July 2, 2021, I reviewed a *Great Lakes Pace Progress Note* regarding Resident A. The progress note is dated for May 20, 2021, authored by Dorothy Moore, RN, and reason for visit is listed as "change suprapubic cath. monthly skin check". Under "findings" it was noted that the Victory AFC did not have Resident A ready when the transporter arrived to pick him up for his appointment. It took staff an additional hour to get Resident A ready while the transporter waited. The transporter advised the office Resident A had a slightly elevated temperature. Upon Resident A's arrival, he was noted to be wearing a shirt, basketball shorts, tall socks, right leg brace, and shoes. Resident A was repeatedly pointing to right leg and Ms. Moore looked to see what Resident A was pointing at. Ms. Moore noticed Resident A's right leg was red, swollen, and actively draining from the knee down. Resident A was taken to a clinic room for further evaluation. Ms. Moore and a CNA assisted Resident A to a clinic chair and his right shoe was removed. There was "a significant amount of fluid" inside the shoe (about an inch) and a "horrendous odor". Another nurse was called to assist, and Resident A's leg brace was removed. Multiple and scattered open areas to the skin were seen on his right shin and calf that were actively draining pus and serous fluid. Resident A's right sock was completely saturated and Resident A would grimace when his leg was touched for further evaluation. Resident A's sock was rolled down and maggots were seen crawling on the inside of the sock. Resident A's foot was noted to be twice its normal size and "active maggots seen in between all toes, behind toes, and on top of toes" and crawling in and out of his skin. Resident A could not indicate how long his foot had been in this condition. Dr. Argyle saw Resident A and determined EMS would be contacted to transport Resident A to the hospital for cellulitis of the right leg.

On July 13, 2021, I interviewed Resident A's guardian, Guardian A who reported Resident A resided at Victory AFC for a "couple years" and no incident as described in the allegations has happened before. Guardian A reported being told by medical staff that Resident A had an infection in his leg and there were maggots on his foot. Guardian A denied the facility notified him of any injury or wound to Resident A. According to Guardian A, Resident A has since recovered however there is no plan for Resident A to return to Victory AFC. Guardian A reported that although Resident A's wound/infection was not life threatening, he was sent to the hospital, provided

antibiotics, and wound treatment, and was in the hospital for several days. Guardian A reported that the AFC Staff said there was no indication of any injury to Resident A however Guardian A believes this should have been caught by AFC staff. Guardian A stated he visited Resident A at the home about a week prior to this incident and, although a short visit, Resident A seemed in good spirits and seemed healthy. Guardian A reported he was surprised by the incident and Resident A recovered very well.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A had several sores on his leg and there were maggots crawling in his sock at the site of the sores. Additionally, Resident A's leg was red, swollen, and actively draining fluid and no one from Victory AFC addressed this issue. There is a preponderance of evidence to conclude a rule violation. Resident A was taken for a routine medical appointment and medical staff immediately noticed Resident A was in pain and discovered swelling and redness to his right leg. Further evaluation by medical staff found Resident A's sock and shoe to be saturated with pus and drainage. Maggots were found in Resident A's sock, on Resident A's sores and toes, and they were crawling in his skin. Resident A was immediately sent to the hospital for the infection, which required a 5 day stay. Per Resident A's AFC Assessment Plan, staff are to assist Resident A with bathing, grooming, and hygiene. At no time were staff aware of the problem Resident A was having with his leg. The significant infection and the manner in which Resident A was found (i.e., maggots crawling in his skin) indicates his safety and personal needs were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 14, 2021, I received an email from Licensee Designee, Tanisha Johnson who advised Resident A does not have a current health care appraisal. Ms. Johnson advised Resident A's last health care appraisal was completed in 2019. Ms. Johnson provided Resident A's last health care appraisal dated for October 23, 2019.

APPLICABLE RULE	
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.
ANALYSIS:	On June 14, 2021, Licensee Designee, Tanisha Johnson advised Resident A's last health care appraisal was completed in 2019. Ms. Johnson provided Resident A's last health care appraisal, which was dated for October 23, 2019. Resident A did not have a health care appraisal completed annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On June 14, 2021, I reviewed Resident A's AFC Assessment Plan which revealed Resident A is 75 years old and requires assistance with toileting, bathing, grooming, dressing, and personal hygiene. The assessment plan indicates Resident A cannot walk and nods his head and gives hand cues to communicate. Resident A's AFC Assessment Plan was not signed by Resident A or his guardian.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On June 14, 2021, I reviewed Resident A's AFC Assessment Plan Resident A's AFC Assessment Plan was not signed by Resident A or his guardian.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 16, 2021, I completed an Exit Conference with Licensee Designee, Tanisha Johnson. I advised Ms. Johnson I would be requesting a corrective action plan with respect to the cited rule violations.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change to the license status is recommended.

7/16/2021

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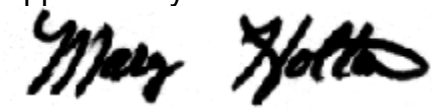
Christina Garza Date
Licensing Consultant

Approved By:



7/16/2021

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Mary E Holton Date
Area Manager