GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2023

James Saintz
Agnus Dei AFC Home Inc.
1307 42nd St.
Allegan, MI 49010

RE: License #: AS800287287
Investigation #: 2023A1031026
Agnus Dei AFC Home Inc.

Dear Mr. Saintz:

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.

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,
Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800287287
Investigation #:	2023A1031026
Complaint Receipt Date:	03/29/2023
Investigation Initiation Date:	03/30/2023
Report Due Date:	05/28/2023
Licensee Name:	Agnus Dei AFC Home Inc.
Licensee Address:	1307 42nd St. Allegan, MI 49010
Licensee Telephone #:	(269) 686-8212
Administrator/ Licensee Designee:	James Saintz
Name of Facility:	Agnus Dei AFC Home Inc.
Facility Address:	37139 County Road 390 Gobles, MI 49055
Facility Telephone #:	(269) 521-6041
Original Issuance Date:	01/29/2007
License Status:	REGULAR
Effective Date:	10/02/2022
Expiration Date:	10/01/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's special diet was not followed.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/29/2023	Special Investigation Intake 2023A1031026
03/30/2023	Contact - Documents Received.
03/30/2023	Special Investigation Initiated - Telephone Interview with ORR Officer Candice Kinzler.
04/10/2023	Inspection Completed On-site
04/10/2023	Contact - Face to Face Interviews completed with Judith Olexa and Amanda Hensley.
04/11/2023	Contact - Telephone Interview completed with Cody Harsh.
04/11/2023	Inspection Completed-BCAL Sub. Compliance
04/11/2023	Contact – Documents Reviewed.
04/13/2023	Exit Conference held with Licensee Designee James Saintz.

ALLEGATION:

Resident A's special diet was not followed.

INVESTIGATION:

On 3/30/23, I received an incident report that was dated 3/28/23 completed by direct care worker (DCW) Cody Harsh. The incident report documents Resident A "wanted cookie milk" and there was no milk in the home. Staff gave Resident A a piece of a cookie and choked. Staff called 911 and Resident A was transported to the hospital.

Corrective measures noted on the report is to make sure food is pureed before given to Resident A.

On 3/30/23, I completed a telephone interview with Van Buren Office of Recipient Rights Director Candice Kinzler. Ms. Kinzler reported Resident A has a special diet that requires her food to be pureed due to a history of choking.

On 4/10/23, Ms. Kinzler and I interviewed the home manager Judith Olexa in the home. Ms. Olexa reported she was not working when Resident A choked. Ms. Olexa reported she was informed by staff that Resident A choked on a cookie that was given to her. Ms. Olexa reported Resident A has a special diet which requires that he food be pureed or "softened". Ms. Olexa reported the staff involved in the choking incident was Cody Harsh. Ms. Olexa verified that Ms. Harsh has completed all necessary training pertaining to Resident A's diet plan. Ms. Olexa reported she had a conversation with Ms. Harsh regarding the importance of following the diet plans to prevent incidents like this from occurring.

On 4/10/23, Ms. Kinzler and I interviewed DCW Amanda Hensley. Ms. Hensley reported she was the home manager at the time the incident occurred but was not present in the home. Ms. Hensley reported she received a telephone call from Ms. Harsh stating Resident A choked on a cookie she provided to Resident A. Ms. Harsh informed her that she was choking, and she called 911 after she attempted to complete the Heimlich Maneuver. Ms. Hensley reported Resident A has a specialized diet that requires all her food to be pureed.

On 4/10/23, I observed notes on the refrigerator outlining Resident A's specialized diet. The notes indicated Resident A is to have purees, nectar thick liquids, and pills are to be crushed.

On 4/11/23, I interviewed Ms. Harsh via telephone. Ms. Harsh reported Resident A wanted "cookie milk". Ms. Harsh explained Resident A likes to have cookie crumbles mixed with her milk. Ms. Harsh indicated there was no milk in the home so she gave Resident A "cookie halves". Ms. Harsh instructed Resident A to suck on the cookies and Ms. Harsh closely observed Resident A while she was eating the cookie. Ms. Harsh then observed Resident A start coughing and realized she was choking. Ms. Harsh reported she completed a back thrust on Resident A in attempts to dislodge the cookie. Ms. Harsh reported she then completed the Heimlich Maneuver which dislodged the cookie. Ms. Harsh contacted 911 and Resident A was taken to the hospital to ensure nothing else was lodged in Resident A's throat. Ms. Harsh reported she did receive training pertaining to Resident A's diet plan and was aware that all her food is to be pureed. Ms. Harsh reported she made a mistake and did not intentionally try to harm Resident A.

On 4/11/23, I reviewed Resident A's *Van Buren County Mental Health – Health Care Assessment.* The assessment indicated that Resident A has a "special – soft mechanical" diet. The assessment also indicates that Resident A continues a

mechanical soft diet with thickened liquids due to macroglossia and being edentulous.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(b) Special diets.**
ANALYSIS:	Ms. Harsh admitted to not pureeing Resident A's food and providing her with pieces of a cookie. Ms. Harsh did not follow Resident A's specialized diet which required all food to be pureed which resulted in Resident A choking and going to the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 4/10/23, Ms. Kinzler and I completed an onsite inspection. The home was observed to have multiple portable space heaters located in the living room and dining room.

APPLICABLE RULE	
R 400.14510	**Heating equipment generally.**
	(5) Portable heating units shall not be permitted.
ANALYSIS:	The home was observed to have multiple portable space heaters located in the living room and dining room.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference Special Investigation Report #2022A1031002 dated 4/15/22 Corrective Action Plan dated 5/6/22]**

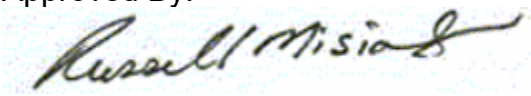
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

4/11/23

Kristy Duda Date
Licensing Consultant

Approved By:



4/11/23

Russell B. Misiak Date
Area Manager