GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 31, 2023

Debra Krajewski
SouthWest AFC, L.L.C.
#296
6026 Kalamazoo Ave., SE
Kentwood, MI 49508

RE: License #: AM410285333
Investigation #: 2024A0583001
SouthWest AFC

Dear Ms. Krajewski:

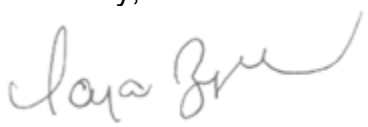
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AM410285333
Investigation #:	2024A0583001
Complaint Receipt Date:	10/06/2023
Investigation Initiation Date:	10/06/2023
Report Due Date:	11/05/2023
Licensee Name:	SouthWest AFC, L.L.C.
Licensee Address:	#296, 6026 Kalamazoo Ave., SE Kentwood, MI 49508
Licensee Telephone #:	(616) 698-6681
Administrator:	Debra Krajewski
Licensee Designee:	Debra Krajewski
Name of Facility:	SouthWest AFC
Facility Address:	212 56th St. SW Wyoming, MI 49548
Facility Telephone #:	(616) 534-5870
Original Issuance Date:	05/01/2007
License Status:	REGULAR
Effective Date:	10/18/2023
Expiration Date:	10/17/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
On 09/22/2023 Resident A did not receive her mail from facility staff.	No
Facility staff verbally mistreat residents.	Yes
On 09/29/2023 facility staff did not provide residents with breakfast.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/06/2023	Special Investigation Intake 2024A0583001
10/06/2023	APS Referral
10/06/2023	Special Investigation Initiated - Letter
10/09/2023	Inspection Completed On-site
10/10/2023	Contact - Telephone call made Resident A
10/31/2023	Exit Conference Licensee Designee Debra Krajewski

ALLEGATION: On 09/22/2023 Resident A did not receive her mail from facility staff.

INVESTIGATION: On 10/06/2023 complaint allegations were received from the BCAL Online Reporting system. The allegations stated that on 9/22/2023 Resident A saw that she received mail as it was sitting on a desk and Resident A asked staff Charlene Thompson and staff Julie Moore Glentz where the mail was and they said they didn't know where it was.

On 10/06/2023 I emailed the complaint allegations to Adult Protective Services Centralized Intake.

On 10/09/2023 I conducted an unannounced onsite investigation at the facility and privately interviewed staff Charlene Thompson, staff Julie Moore Glentz, Resident B, Residence C, and Resident D.

Staff Charlene Thompson stated Resident A typically retrieves the mail from the mailbox and gives it to staff Joyce Smith who goes through the mail and then gives

the mail to each resident. Ms. Thompson stated Resident A recently asked Ms. Thompson for her mail that Resident A stated had been placed on the facility's kitchen desk. Ms. Thompson stated she asked Ms. Smith for Resident A's mail but Ms. Smith stated she had "no idea" where Resident A's mail had gone. Ms. Thompson stated that she had no other knowledge regarding Resident A's missing mail.

Staff Julie Glentz Moore stated she did not know where Resident A's missing mail went and had no details to offer regarding the incident.

Resident B, Resident C and Resident D each stated that they did not know where Resident A's missing mail went and had no knowledge of the incident. Each resident stated that they receive their mail without issue.

On 10/10/2023 I interviewed Resident A via telephone. Resident A stated that on 09/22/2023 she observed her mail located on the facility's kitchen desk. Resident A stated that later that day she asked staff Julie Moore Glentz and Charlene Thompson if she could have her mail, but the mail was gone by that time from the desk. Resident A stated Ms. Moore Glentz and Ms. Thompson both stated they did not know where Resident A's mail had gone. Resident A stated she never received her mail.

On 10/10/2023 I emailed the complaint to Briana Fowler of Ottawa County Community Mental Health Recipient Rights.

On 10/272023 I interviewed staff Joyce Smith via telephone. Ms. Smith stated that typically Ms. Smith will request for one of the residents to go to the mailbox, retrieve the mail, and then Ms. Smith provides the mail to each resident that same day. Ms. Smith stated that she was unaware of Resident A not receiving her mail on 09/22/2023 and has no details regarding the incident.

On 10/31/2023 I completed an Exit Conference with Licensee Designee Debra Krajewski via telephone. Ms. Krajewski stated she agreed that no licensing violation occurred with respect to R 400.14304 (1).

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: **(d) The right to write, send, and receive uncensored and unopened mail at his or her own expense.**

	(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	Resident A stated that on 09/22/2023 she did not receive her mail. Resident B, Resident C and Resident D each stated that they did not know where Resident A's missing mail went. Staff Charlene Thompson, Julie Moore Glentz, and Joyce Smith each reported that they do not know where Resident A's missing mail went. A preponderance of evidence was not discovered during the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff verbally mistreat residents.

INVESTIGATION: On 10/06/2023 complaint allegations were received from the BCAL Online Reporting system. The allegations stated staff Joyce Smith verbally mistreats residents. More specifically, it was alleged that Ms. Smith "yelled" at Resident A on 09/28/2023 because Resident A's bedroom was messy. In addition, Ms. Smith also yelled at other residents on 09/29/2023 because residents were not getting ready early enough before a LARA renewal inspection.

On 10/09/2023 I conducted an unannounced onsite investigation at the facility and privately interviewed staff Charlene Thompson, staff Julie Moore Glentz, Resident B, Residence C, and Resident D.

Staff Charlene Thompson stated staff Joyce Smith is "very boisterous" and "loud". Ms. Thompson stated Ms. Smith informs residents that their bedrooms are unkept with statements like, "you can't live like this" and, "I'm not picking that up". Ms. Thompson was asked if Ms. Smith's verbal treatment of residents was inappropriate and Ms. Thompson stated, "sometimes and sometimes not". Ms. Thompson stated Ms. Smith's treatment of residents' is "strict" and "excessive". Ms. Thompson stated she has observed Ms. Smith to tell residents to "get up and do it yourself" and "you're too slow". Ms. Thompson stated she has never observed Ms. Smith curse at residents or call them inappropriate names.

Staff Julie Moore Glentz stated that she has never observed Ms. Smith verbally mistreat residents.

Resident B denied she is verbally mistreated by Ms. Smith.

Resident C stated Ms. Smith is “hard” on residents and “gets angry” with residents when they do not clean their bedrooms. Resident C stated she has not observed Ms. Smith curse at residents.

Resident D stated she was hesitant to answer questions relating to Ms. Smith’s treatment of residents. Resident D stated Ms. Smith is “not nice” and Resident D is “afraid” of Ms. Smith.

On 10/10/2023 I interviewed Resident A via telephone. Resident A stated that on 09/29/2023 staff Joyce Smith “yelled” at Resident A to “clean your room” because “it is really messy and we have an inspection”. Resident A stated Ms. Smith’s voice tone was loud. Resident A stated that Ms. Smith often yells directions towards residents with a loud voice tone but has not called Resident A derogatory names.

On 10/27/2023 I interviewed staff Joyce Smith via telephone. Ms. Smith stated she has never yelled at any resident and characterized the allegations of verbal mistreatment as “false”. Ms. Smith stated that she has never yelled at Resident A but stated Resident A struggles with keeping her room clean. Ms. Smith stated she often verbally directs Resident A to clean her bedroom and Resident A does not like being directed to do so.

On 10/31/2023 I completed an Exit Conference with Licensee Designee Debra Krajewski via telephone. Ms. Krajewski stated that staff Joyce Smith is “loud” regarding her voice level, but she is “not abusive” towards residents. Ms. Krajewski stated she disagrees with the Special Investigation findings and that she feels the allegations were made in retaliation. Ms. Krajewski stated that she will submit an acceptable Corrective Action Plan.

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:	Staff Joyce Smith stated she has never yelled at any resident and charactered the allegations of verbal mistreatment as “false”. Staff Charlene Thompson stated staff Joyce Smith tells residents that their bedrooms are unkept with statements like “you can’t live like this” and “I’m not picking that up”.

	Ms. Thompson stated Ms. Smith's treatment of residents' is "strict and excessive". Ms. Thompson stated she has observed Ms. Smith tell residents to "get up and do it yourself" and "you're too slow". Resident C stated Ms. Smith is hard on residents and "gets angry" with residents when they do not clean their bedrooms. Resident C stated she has not observed Ms. Smith curse at residents. Resident D stated she was hesitant to answer questions relating to Ms. Smith's treatment of residents. Resident D stated Ms. Smith is "not nice" and Resident D is "afraid" of Ms. Smith. Resident A stated that on approximately 09/29/2023 Ms. Smith "yelled" at Resident A to "clean your room" because "it is really messy and we have an inspection". Resident A stated Ms. Smith's voice tone was "loud". Resident A stated that Ms. Smith often "yells" directions towards residents with a loud voice tone but has not called Resident A derogatory names. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Staff Joyce Smith does not treat facility residents with respect when she "yells" at them.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 09/29/2023 facility staff did not provide residents with breakfast.

INVESTIGATION: On 10/06/2023 complaint allegations were received from the BCAL Online Reporting system. The allegations stated that on 09/29/2023 staff Joyce Smith told residents they were not allowed to have breakfast due to the scheduled morning LARA renewal inspection.

On 10/09/2023 I conducted an unannounced onsite investigation at the facility and privately interviewed staff Charlene Thompson and staff Julie Moore Glentz.

Staff Charlene Thompson and Julie Moore Glentz both stated that they did not work on the morning of 09/29/2023 and had no knowledge of the alleged incident.

On 10/23/2023 I interviewed Resident A via telephone. Resident A stated that on the morning of 09/29/2023 the facility hosted a licensing renewal inspection. Resident A stated staff Joyce Smith informed Resident A that she woke up too late

to eat breakfast and subsequently wouldn't allow Resident A to have breakfast that morning. Resident A stated Ms. Smith often tells residents that they cannot eat breakfast if they get up too late.

On 10/27/2023 I interviewed staff Joyce Smith via telephone. Ms. Smith stated that on 09/29/2023 at 10:30 AM the facility hosted a LARA licensing renewal inspection. Ms. Smith stated that she could not recall what time Resident A woke up that morning or if Resident A was provided breakfast. Ms. Smith stated that breakfast is served daily at 6:00 AM and by 10:00 AM everyone needs to have had breakfast. Ms. Smith explained that "everything is done on a schedule" and if a resident is late to breakfast that resident must wait to eat until lunch which is typically served at noon. Ms. Smith stated residents are not provided any meal substitution and must wait until the next scheduled meal if they are late to a meal.

On 10/31/2023 I completed an Exit Conference with Licensee Designee Debra Krajewski via telephone. Ms. Krajewski stated that she has never observed residents not provided meals during her onsite visits. Ms. Krajewski stated that residents are never withheld meals. Ms. Krajewski stated that she disagrees with the findings of the Special Investigation. Ms. Krajewski stated that she will submit an acceptable Corrective Action Plan.

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:	Resident B, Resident C and Resident D each stated they were provided breakfast on 09/29/2023. Staff Joyce Smith stated that on 09/29/2023 at 10:30 AM the facility hosted a LARA licensing renewal inspection. Ms. Smith stated that she could not recall what time Resident A woke up that morning or if Resident A was provided breakfast. Ms. Smith stated that breakfast is served daily at 6:00 AM and by 10:00 AM everyone needs to have had breakfast. Ms. Smith explained that "everything is done on a schedule" and if a resident is late to breakfast that resident must wait to eat until lunch which is typically at noon. Ms. Smith stated residents are not provided any meal substitution and must wait until the next scheduled meal if they are late to a meal. Resident A stated that on the morning of 09/29/2023 the facility hosted a licensing renewal inspection. Resident A stated staff

	Joyce Smith informed Resident A that she woke up too late to eat breakfast and subsequently wouldn't allow Resident A to have breakfast that morning. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: On 10/09/2023, Resident E and Resident D's prescribed medications were observed to be stored in an unlocked drawer.

INVESTIGATION: While onsite, 10/09/2023, I observed two residents' medications stored in separate clear plastic drawers which were unattended and unlocked. I observed the clear plastic drawers were positioned in the communal dining room. I observed there to be one white tablet in Resident E's plastic drawer and multiple tablets in Resident D's plastic drawer. I could not identify the specific medication names of the tablets due to facility residents' medications being stored in pharmacy issued blister packages that did not contain pictures of each tablet.

Staff Charlene Thompson stated it is facility protocol to retrieve residents' medications from their original pharmacy containers and place the medications into individual clear plastic drawers which are then handed to each resident for administration. Ms. Thompson stated that this morning she placed Resident E's medications and Resident D's medications into their individual plastic drawers but forgot to administer Resident D's morning medications and observed that Resident E ingested all but one tablet which was left in the plastic drawer.

On 10/31/2023 I completed an Exit Conference with Licensee Designee Debra Krajewski via telephone. Ms. Krajewski stated she agrees that a violation occurred and will submit 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:	While at the facility on 10/09/2023, I observed two residents' medications stored in separate clear plastic drawers which were unattended and unlocked. The drawers were in the communal dining room. I observed one white tablet in Resident E's drawer and multiple tablets in Resident D's drawer. I could not identify the specific medication names of the tablets due to facility residents' medications being stored in pharmacy issued blister packages that did not contain pictures of each tablet. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Residents' medications are preset and not stored in the original pharmacy containers.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal 10/02/2023**

ADDITIONAL FINDINGS: Facility staff do not follow a posted menu and document meal substitutions.

INVESTIGATION: While onsite, 10/09/2023, I observed that there was not a menu posted at least one week in advance. Staff Charlene Thompson, Julie Moore Glentz, Resident B, Resident C and Resident D each stated that facility staff do not follow a posted menu. Staff Charlene Thompson and Julie Moore Glentz acknowledged that staff do not document meal substitutions.

On 10/31/2023 I completed an Exit Conference with Licensee Designee Debra Krajewski via telephone. Ms. Krajewski stated that all staff have been trained to post a menu in advance and follow the menu. Ms. Krajewski stated that all staff are trained to document meal substitutions. Ms. Krajewski stated that she disagrees with the special investigation's findings but will submit an acceptable Corrective Action Plan.

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:	Staff Charlene Thompson, Julie Moore Glentz, Resident B, Resident C, and Resident D each stated that facility staff do not follow a posted menu. Staff Charlene Thompson and Julie Moore Glentz stated staff do not document meal substitutions.

	A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Facility staff do not post a menu at least week in advance, do follow a posted menu, and do not document meal substitutions.
CONCLUSION:	**VIOLATION ESTABLISHED**

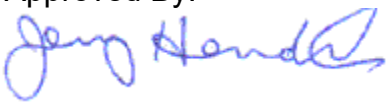
IV. RECOMMENDATION

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

10/31/2023

Toya Zylstra Date
Licensing Consultant

Approved By:



11/01/2023

Jerry Hendrick Date
Area Manager