



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 18, 2023

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

RE: License #: AM030393581
Investigation #: 2024A1024005
Agnus Dei AFC Home III

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 was required. On December 6, 2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

A handwritten signature in cursive script that reads "Ondrea Johnson".

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030393581
Investigation #:	2024A1024005
Complaint Receipt Date:	10/23/2023
Investigation Initiation Date:	10/25/2023
Report Due Date:	12/22/2023
Licensee Name:	Agnus Dei AFC Home Inc.
Licensee Address:	1307 42nd St. Allegan, MI 49010
Licensee Telephone #:	(269) 686-8212
Administrator:	James Saintz
Licensee Designee:	James Saintz
Name of Facility:	Agnus Dei AFC Home III
Facility Address:	3445 115th Avenue Allegan, MI 49010
Facility Telephone #:	(269) 355-1009
Original Issuance Date:	07/31/2019
License Status:	REGULAR
Effective Date:	01/31/2022
Expiration Date:	01/30/2024
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents were left unattended while staff was outside taking a break. There is concern residents are not supervised.	Yes

III. METHODOLOGY

10/23/2023	Special Investigation Intake 2024A1024005
10/25/2023	Special Investigation Initiated – Telephone with Adult Protective Service (APS) Specialist Michael McClellan
11/15/2023	Inspection Completed On-site with direct care staff member William Harsh, Margery Warnock, Residents A, B, C, D, and E
12/01/2023	Contact - Telephone call made with licensee designee James Saintz
12/04/2023	Exit Conference with licensee designee James Saintz
12/04/2023	Inspection Completed-BCAL Sub. Compliance
12/14/2023	Corrective Action Plan Requested and Due on 12/012/2023
12/06/2023	Corrective Action Plan Received
12/06/2023	Corrective Action Plan Approved
12/12/2023	APS Referral-already involved

ALLEGATION:

Residents were left unattended while staff was outside taking a break. There is concern residents are not supervised.

INVESTIGATION:

On 10/23/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online compliant system. This complaint alleged residents were left unattended while direct care staff members were outside taking a break. There is concern residents are not supervised.

On 10/25/2023, I conducted an interview with APS Specialist Michael McClellan who stated that APS came out to the home and observed residents unattended inside the

facility while two staff members were outside reportedly on their staff break. Michael McClellan stated the population served in the home is very vulnerable with mental illness and should be supervised by at least one staff member.

On 11/15/2023, I conducted an onsite investigation at the facility with direct care staff members William Harsh, Margery Warnock, and Residents A, B, C, D, and E. William Harsh stated that he has no knowledge of any resident not being supervised adequately and believes there is always sufficient staff in the home to provide the care and services to the residents.

Margery Warnock stated that residents who are able to be in the community without direct care staff supervision or who are their own guardian are able to be in the facility for a short period of time without direct care staff supervision during specific circumstances such as if staff has to go to the grocery store, take a resident to a doctor's appointment or when residents choose not to go on community outings with the group. Margery Warnock stated Residents A, B, C, and D have all been left at the facility alone without direct care staff supervision. Margery Warnock further stated there are emergency numbers and direct care staff phone numbers posted in the facility for residents in case residents needs assistance while they are at the facility alone. Margery Warnock stated this is a practice they have done for many years and there have not been any issues.

Resident A stated she is allowed to stay at the facility alone without direct care staff supervision because she is her own guardian however there is usually a staff member with her in the facility. Resident A stated she is left alone in the facility a few times a month while direct care staff members take residents on community outings, and she chooses not to go or when direct care staff members transport residents to medical/ personal appointments. Resident A stated she feels safe when she is left home alone without direct care staff supervision as she knows she can call direct care staff or emergency phone numbers if she ever needed assistance.

Resident B stated he has been left home alone or alone with other residents without direct care staff supervision on multiple occasions when direct care staff members must take other residents to appointments. Resident B stated he is not familiar with any direct care staff phone numbers however direct care staff members always return to the facility promptly therefore he has never needed any assistance while they were gone.

Resident C stated he has been left at the facility without direct care staff supervision only a couple of times since he has been living at the facility. Resident C stated there was an incident when Resident C was not feeling well therefore direct care staff members allowed him to stay back at the facility without direct care staff supervision while direct care staff members took the other residents to a holiday cookout in the community. Resident C stated direct care staff members were gone for about 4 hours and he stayed in the bed while they were gone. Resident C stated he had direct care staff phone numbers and was instructed by direct care staff members to use those phone numbers in the event he needed assistance.

Resident D and Resident E both stated that they have never been left home without direct care staff supervision and have always been able to get assistance from direct care staff members when needed.

On 12/01/2023, I conducted an interview with licensee designee James Saintz who stated that he was not aware that residents were not allowed to be unsupervised without the presence of direct care staff members at any given time while residing in an adult foster care facility and was under the impression that if residents had no legal restrictions or were able to be independent in the community, then they were able to be left alone in the facility for a short period of time without direct care staff supervision. Licensee designee James Saintz stated that he will conduct of meeting with his direct care staff members to ensure that all direct care staff members are in compliance with licensing rules and regulations as it pertains to staffing requirements and supervision in an adult foster care setting.

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members William Harsh and Margery Warnock and licensee designee James Saintz as well as Residents A, B, C, D, and E there is evidence residents were left on multiple occasion without direct care staff member supervision as required. Direct care staff member Margery Warnock stated she has left residents unsupervised in the facility while going to the grocery store or taking other residents on outings or to appointments. She further stated that Residents A, B, C, and D have all been in the facility alone without staff. Residents A, B, and C all stated that they have routinely been in the facility without direct care staff members present for varying lengths of time. Licensee designee James Saintz stated he was not aware of the staffing requirement licensing rule therefore allowed certain residents with no legal restrictions to stay in the home without direct care staff presence for short periods of time therefore the licensee has not had sufficient direct care staff on duty at all times for the supervision, personal care, and protection of the residents.
CONCLUSION:	VIOLATION ESTABLISHED

On 12/04/2023, I conducted an exit conference with licensee designee James Saintz. I informed James Saintz of my findings and allowed him an opportunity to ask questions and make comments.

On 12/06/2023, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

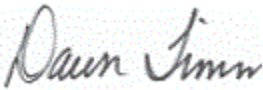
An acceptable corrective action plan was received; therefore, I recommend the current license status remain unchanged.



Ondrea Johnson
Licensing Consultant

12/12/2023
Date

Approved By:



12/18/2023

Dawn N. Timm
Area Manager

Date