GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 27, 2024

April Anders
Golden Heart Home Services, LLC
264 Homestead Lane
Saginaw, MI 48601

RE: License #: AS730415996
Investigation #: 2024A0871004
Golden Heart Care Home LLC

Dear April Anders:

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 (517) 643-7960.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730415996
Investigation #:	2024A0871004
Complaint Receipt Date:	02/09/2024
Investigation Initiation Date:	02/14/2024
Report Due Date:	04/09/2024
Licensee Name:	Golden Heart Home Services, LLC
Licensee Address:	264 Homestead Lane Saginaw, MI 48601
Licensee Telephone #:	(336) 870-0267
Administrator:	April Anders
Licensee Designee:	April Anders
Name of Facility:	Golden Heart Care Home LLC
Facility Address:	264 Homestead Lane Saginaw, MI 48601
Facility Telephone #:	(989) 321-2626
Original Issuance Date:	06/13/2023
License **Status:**	REGULAR
Effective Date:	12/13/2023
Expiration Date:	12/12/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There is concern that residents are not given proper supervision and care. Licensee April Anders demands that residents are prescribed Xanax.	No
Residents were served pork and beans for four days in a row.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/09/2024	Special Investigation Intake 2024A0871004
02/14/2024	Special Investigation Initiated - On Site Interviewed Residents A-C
02/14/2024	Contact - Telephone call made Telephone call to Case Manager Stewart Fielding
02/14/2024	Inspection Completed On-site Interviewed Residents A, B, and C
02/14/2024	Contact - Telephone call made Telephone Call to Resident A's Case Manager Stewart Fielding
02/15/2024	Contact - Telephone call made Telephone call to TTI Supports Worker Lisa Randall
03/05/2024	Inspection Completed On-site Interviewed Residents B and D
03/05/2024	Contact - Telephone call made Telephone call to Certified Medical Assistant Julia Rogalski
03/18/2024	APS Referral From Saginaw County MDHHS
03/18/2024	Inspection Completed On-site Interviewed Resident D
03/19/2024	Contact - Telephone call made Telephone call to Physician Assistant Gage Paget

03/25/2024	Inspection Completed On-site Interviewed Staff Todd Wilford and Resident B
03/25/2024	Inspection Completed-BCAL Sub. Compliance
03/27/2024	Exit Conference Telephone Exit Conference with Licensee April Anders

ALLEGATION:
There is concern that residents are not given proper supervision and care. Licensee April Anders demands that residents are prescribed Xanax.

INVESTIGATION:
On February 16, 2024, I conducted an unannounced onsite investigation and interviewed Resident B. Resident B said she was prescribed Xanax and the pharmacist stopped it. Resident B indicated she no longer is taking Xanax.

On March 5, 2024, I conducted an unannounced onsite investigation and interviewed Staff Letia Johnson and she stated Resident B did have a prescription for Xanax, but it has been discontinued.

On March 18, 2024, I telephoned Physician Assistant Gage Paget. PA Paget indicated she knows Resident B and Licensee April Anders told her that Resident B "was pacing back and forth." PA Paget did order Xanax for her, and it has since been discontinued.

On March 5, 2024, I asked Staff Johnson to see Resident B's *Medication Administration Record* for February 2024. I observed that the following medications were prescribed to Resident B:

Alprazolam: 3 times per day; Trazodone: Nightly; Oxynorm: Daily and Zoloft: Daily.

I observed that the not initial Alprazolam was initialed as given three times daily but was given in the morning and evening. All medications were not initialed as given on February 18,19, 25th, 28th and 29th.

I asked Staff Johnson why the medications were not initialed as given and she stated that Resident B "did receive her medications."

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 S333.1101 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 she did have Xanax prescribed to her but no longer takes Xanax. Staff Letia Johnson stated Resident B was prescribed Xanax, but it has been discontinued. Physician Assistant Gage Paget stated she prescribed Xanax to Resident B because Licensee April Anders said Resident B was pacing back and forth and she is aware of the behaviors of Resident B. The Xanax has since been discontinued. There is insufficient evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Residents were served pork and beans for four days in a row.

INVESTIGATION:
On February 14, 2024, at the unannounced onsite investigation, Residents B and C were eating lunch. They both were eating a bowl of soup. Resident B was interviewed and said is getting good food. Residents C also said she gets enough food and likes living in the facility. I attempted to interview Resident A, but she would not provide any information.

On February 16, 2024, I conducted an unannounced onsite investigation and interviewed Resident D. Resident D stated she “gets good food and a variety of food.” Resident D indicated she has never had the same meals for four days in a row.

I asked Staff Letia Johnson to see a copy of the menu. Staff Johnson got it out of a drawer, and it was not posted. The two menus that Staff Johnson gave me were not sufficient to meet the “Basic Nutrition Facts: A Nutrition Reference,” and were not

dated. One of the menus was not completed but the completed menu did have a indicate the following:

Breakfast	Lunch	Dinner
Sunday: Pancakes Sausage, toast Eggs, grits	Peanut Butter and Jelly Sandwich	Fried Chicken String beans, Potatoes, biscuits
Monday: Oatmeal, toast Eggs, bacon	Ham & Cheese Sandwich with chips	Baked Chicken Macaroni
Tuesday: Cereal	Chicken wraps	Chicken and fries
Wednesday: Breakfast burritos	Chicken Sandwich and Fries	Spaghetti and bread
Thursday: Cereal	Grilled Cheese and soup	Goulash
Friday: Sandwiches	Soup and Crackers	Smothered chips, broccoli & potatoes
Saturday: Waffle, sausage, Grits, eggs	Pizza	Boiled chicken and rice

A list of snacks included: graham crackers, fruit, chips, pudding, cake, cookies, and fruit snacks.

The menu indicates chicken is served a lot and very few other proteins indicated.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may

	be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.
ANALYSIS:	The menu I observed does not meet the requirements of "Basic Nutrition Facts: A Nutrition Reference," which indicates there are to be six servings of vegetables/fruit, five servings of bread, cereal, two servings of milk/cheese, and 2 ½ servings of meat/poultry/fish/beans. There is substantial evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On March 5, 2024, I asked Staff Johnson to see Resident B's *Medication Administration Record* for February 2024. I observed that the following medications were prescribed to Resident B:

Alprazolam: 3 times per day; Trazodone: Nightly; Oxynorm: Daily and Zoloft: Daily.

I observed that the not initial Alprazolam was initialed as given three times daily but was given in the morning and evening. All medications were not initialed as given on February 18,19, 25th, 28th and 29th.

I asked Staff Johnson why the medications were not initialed as given and she stated that Resident B "did receive her medications."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered.

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures.
ANALYSIS:	Resident B's *Medication Administration Record* was not initialed as given on February 18, 19, 25th, 28th, and the 29th. Staff Johnson said Resident B did receive her medications, but the *Medication Administration Record* did not indicate that Resident B was administered the medications. There is sufficient evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 5, 2024, I asked Staff Letia Johnson for a copy of the menu. Staff Johnson had them in a drawer and it was not posted.

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:	On February 16, 2024, Staff Letia Johnson provided me copies of a completed menu that was kept in a drawer, and another menu that was not complete. The menu was not posted nor was a menu complete for the following week. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On February 14, 2024, I observed that Resident A did not have a door for her bedroom and a curtain was hanging. Adult Protective Service Worker Roshell Watley-Thomas also observed the curtain on March 18, 2024. On March 25, 2024, I did notice that a bedroom door had been installed.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, nonlocking-against-egress hardware.
ANALYSIS:	On February 14, 2024, I observed a curtain that was used as a bedroom door. The facility had a door installed that was noticed on an onsite visit on March 25, 2025. This violation has been corrected.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 25, 2024, I interviewed Resident C in her bedroom. I asked Resident C if she had a chair and she replied "no." Staff Todd Wilford brought a chair in from the dining room area for me.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(1) The bedroom furnishings in each bedroom shall include all of the following: **(d) At least 1 chair.**
ANALYSIS:	There was not a chair in Resident C's bedroom. Staff Todd Wilford provided a chair for me from the dining room. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 25, 2024, I observed a dead bolt lock on the front door that is used for the residents.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	There is a dead bolt lock on the front door that is used by residents as a means of egress. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On February 14, 2024, at the unannounced onsite investigation, Resident A stated that she cannot walk and only uses a wheelchair.

On February 16, 2024, I telephone Resident A's Case Manager Stewart Fielding. Manager Fielding indicated that this "might not have a been a good placement for [Resident A]" and he is looking for a new placement for her. Manager Fielding indicated that a specialized placement would be most appropriate "and it is a struggle to find one for her." Manager Fielding stated that Resident A does not walk and only uses a wheelchair.

The facility has one ramp going out of the front door and that is the only ramp the facility has.

The Original Licensing Study Report written by Licensing Consultant Kent Gieselman indicates 'wheelchair users will not be accepted."

APPLICABLE **RULE**	
R 400.14509	**Means of egress; wheelchairs.**
	(1) Small group homes that accommodate residents who regularly require wheelchairs shall be equipped with ramps that are located at 2 approved means of egress from the first floor.

ANALYSIS:	Resident A does not ambulate and only uses a wheelchair. Case Manager Stewart Fielding stated that Resident A only uses a wheelchair. This home does not have 2 means of egress, as required for a resident with a wheelchair. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On March 27, 2024, I conducted a telephone exit conference with Licensee April Anders of the several rule violations. Licensee Anders stated she has given the residents 30-day discharge notices, and she is going to close her business. Licensee Anders stated the house is for sale and a closing date is set for May 2, 2024. I told Licensee Anders that a corrective action plan is still required.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care license remain unchanged (capacity 1-6). Indicate on the corrective action plan, the date you would like to have your license closed.

03/27/2024

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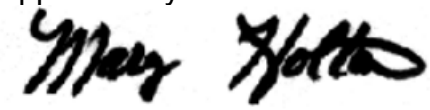
Kathryn A. Huber Date
Licensing Consultant

Approved By:



03/27/2024

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Mary E. Holton Date
Area Manager