



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

October 2, 2023

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

RE: License #: AM120413630  
Investigation #: 2023A1032049  
Agnus Dei AFC Home Inc.

Dear James Saintz:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If 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 black ink, appearing to read "Dwight Forde".

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

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM120413630
<b>Investigation #:</b>	2023A1032049
<b>Complaint Receipt Date:</b>	08/02/2023
<b>Investigation Initiation Date:</b>	08/04/2023
<b>Report Due Date:</b>	10/01/2023
<b>Licensee Name:</b>	Agnus Dei AFC Home Inc.
<b>Licensee Address:</b>	1307 42nd St. Allegan, MI 49010
<b>Licensee Telephone #:</b>	(269) 686-8212
<b>Licensee Designee:</b>	James Saintz, Designee
<b>Name of Facility:</b>	Agnus Dei AFC Home IV
<b>Facility Address:</b>	738 E. Grant St Bronson MI 49028
<b>Facility Telephone #:</b>	(517) 858-1027
<b>Original Issuance Date:</b>	01/29/2007
<b>License Status:</b>	TEMPORARY
<b>Effective Date:</b>	05/05/2023
<b>Expiration Date:</b>	11/04/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A's medical conditions were not being properly managed by the home.	No
Additional Findings	No

**III. METHODOLOGY**

08/02/2023	Special Investigation Intake 2023A1032049
08/04/2023	Special Investigation Initiated - On Site
08/10/2023	Contact - Document Received email from Ambulatory Care Coordinator Kathleen Fish
08/14/2023	Inspection Completed On-site Interview with Resident A
08/18/2023	Contact - Document Received Incident Report received.
08/24/2023	Contact - Document Received email exchange with APS specialist Richard Jacoby
09/29/2023	Exit Conference

**ALLEGATION:**

**Resident A's medical conditions were not being properly managed by the home.**

**INVESTIGATION:**

On 8/4/23, I interviewed manager Patricia Torres in the home. Ms. Torres reported that Resident A went to the emergency room after night staff had been alerted to the fact that there were maggots in her foot. She stated that Resident A has a boot and a bandage on her left foot, and that the bandage is changed three times a week. Ms. Torres stated that as far as she was aware, the bandage was being changed on schedule. She was asked if there was a log of when employees changed the bandage, and she stated that there was no such log. She advised that she was unsure of how the maggots developed in the wound, since the bandage was being changed regularly. She advised that Resident A has a history of resisting doing her hygiene, and is regularly prompted to take showers. Ms. Torres advised that Resident A was only recently started on diabetes medication. She advised however that Resident A, being her own guardian, will typically buy candy and sodas at the nearby Dollar General Store.

I reviewed doctor's instructions for changing Resident A's bandage. According to the document, the bandage was supposed to be changed three times a week.

On 8/10/23, I interviewed Ambulatory Care Coordinator Kathleen Fish, via email. Ms. Fish advised that Resident A had attended a recent follow-up appointment that was scheduled on her behalf. Ms. Fish advised that there was a history of missed appointments for Resident A supposedly due to staffing issues that prevented transportation.

On 8/14/23, I interviewed Resident A in the home. Resident A was unsure of how maggots developed in her wound. She denied missing appointments due to lack of transportation. She acknowledged not managing her diet very well and stated that the employees do prompt her to attend to her hygiene.

I interviewed home manager Patricia Torres in the home. Ms. Torres stated that the bandage changing schedule remained the same because of insurance issues and availability of the special bandage material.

I observed the bathrooms while I was onsite. The bathrooms appeared clean.

On 8/18/23, I reviewed the incident report detailing the home's efforts have Resident A's wound treated through emergency services, once the maggots were detected.

On 8/24/23, I spoke with Adult Protective Services Specialist Richard Jacoby via email. Mr. Jacoby stated that he will be substantiating his case against Resident A, because Resident A was not properly taking care of herself, despite being prompted by employees to do so. I was advised that by doing so, APS is able to offer Resident A additional services. Mr. Jacoby and I considered that some maggots can develop in less than twenty-four hours.

<b>APPLICABLE RULE</b>	
<b>R 400.14310</b>	<b>Resident health care.</b>
	<p><b>(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></p> <p style="padding-left: 40px;"><b>(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.</b></p>
<b>ANALYSIS:</b>	Based on interviews conducted, it appears that Resident A's bandage was being changed according to the schedule. Resident A did not manage her hygiene despite being prompted by employees. Resident A also appears resistant to a diabetic diet and purchases candy and sodas on her own. There was no evidence that the home did not maintain a proper cleaning schedule that would promote a proliferation of insects.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

On 9/29/23, I conducted an exit conference with residential director Judith Olexa, in licensee designee James Saintz's absence. I shared my findings and Ms. Olexa agreed with the conclusions reached.

#### **IV. RECOMMENDATION**

I recommend no change to the status of this license.



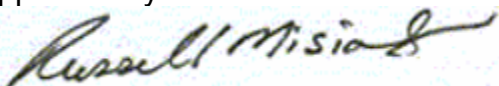
10/2/23

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Dwight Forde  
Licensing Consultant

Date

Approved By:



10/2/23

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Russell B. Misiak  
Area Manager

Date