GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 24, 2023

Vicky Cates
McAnally AFC Facility, Inc.
3960 Sharp Road
Adrian, MI 49221

RE: License #: AM460008927
Investigation #: 2023A1032042
McAnallys AFC Facility

Dear Vicky Cates:

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,

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

| **License #:** | AM460008927 |
| --- | --- |
| | |
| **Investigation #:** | 2023A1032042 |
| | |
| **Complaint Receipt Date:** | 06/26/2023 |
| | |
| **Investigation Initiation Date:** | 06/27/2023 |
| | |
| **Report Due Date:** | 08/25/2023 |
| | |
| **Licensee Name:** | McAnally AFC Facility, Inc. |
| | |
| **Licensee Address:** | 325 E. Hunt<br>Adrian, MI 49221 |
| | |
| **Licensee Telephone #:** | (517) 263-8745 |
| | |
| **Licensee Designee:** | Vicky Cates |
| | |
| **Name of Facility:** | McAnallys AFC Facility |
| | |
| **Facility Address:** | 325 E. Hunt<br>Adrian, MI 49221 |
| | |
| **Facility Telephone #:** | (517) 263-8745 |
| | |
| **Original Issuance Date:** | N/A |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 05/06/2022 |
| | |
| **Expiration Date:** | 05/05/2024 |
| | |
| **Capacity:** | 11 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established?** |
|---|---|
| The home did not assist Resident A in renewing medications or having durable medical equipment repaired. | No |
| The home does not provide Resident A with proper meals. | No |
| The home does not assist Resident A with hygiene. | No |
| | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 06/26/2023 | Special Investigation Intake<br>2023A1032042 |
| 06/27/2023 | Special Investigation Initiated - On Site |
| 08/9/2023 | Contact - Document Received<br>Resident Care Agreement and Assessment Plan |
| 08/17/2023 | Exit Conference |

**ALLEGATION:**

**The home did not assist Resident A in renewing medications or having durable medical equipment repaired.**

**INVESTIGATION:**

On 6/27/23, I interviewed employee Kateresa Edwards in the home. Ms. Edwards stated that Resident A had run out of his medications because he missed a med review with his psychiatrist. She stated that Resident A had been prompted several times about attending the review and had been provided bus tokens. Ms. Edwards

explained that she tried to renew the medications online but was unsuccessful. She stated that Resident A's community mental health case manager had been able to facilitate the medication renewal but acknowledged that Resident A had been without his medications for about three weeks.

I interviewed Resident A in the home. Resident A stated that he had been out of his medications for about three weeks. He stated that the home should have facilitated the renewal, but an excuse was provided that he missed a medication review with a psychiatrist. He stated that his condenser was fixed and his oxygen tanks were refilled, which he attributed to his community mental health workers.

On 8/9/23, I reviewed Resident A's Resident Care Agreement and Assessment Plan. The Resident Care Agreement reflects that the home provides bus tokens for residents to attend medical appointments.

On 8/17/23, I interviewed licensee Vicky Cates. Ms. Cates stated that Resident A has often declined to provide the home with appointment information, and she has asked that appointments scheduled on his behalf not be made in the morning because Resident A tends to sleep through his appointments. She advised that she will seek ways to improve coordination between the home and Resident A's various community medical providers, to make sure that the home is aware of Resident A's appointments, and will continue to prompt him to attend his meetings.

| **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:**<br>**(a) Medications.**<br>**(b) Special diets.**<br>**(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.**<br>**(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.** |

| ANALYSIS: | Resident A was provided bus tokens, and reportedly reminded to attend his psychiatric medication review. Community Mental Health personnel acknowledged that the home took steps to have Resident A's condenser and oxygen tanks replaced. The Resident did not have a valid prescription order for the home to administer the medications despite the resident having case management services. |
|---|---|
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The home does not provide Resident A with proper meals.**

**INVESTIGATION:**

On 6/27/23, Resident A denied that there were issues with the food provided.

I reviewed the menus posted, and the meals posted reflected cuisine that was of proper form and consistency.

| **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 A denied any problems with the food provided in the home. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The home does not assist Resident A with hygiene.**

**INVESTIGATION:**

On 6/27/23, Ms. Edwards stated that Resident A is prompted to take showers. Ms. Edwards stated that residents are provided towels, wash cloths and soap.

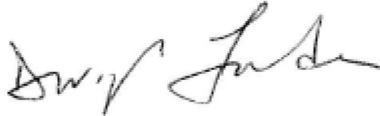
Resident A acknowledged that he is prompted by employees to take showers. He stated that he is provided washcloths but is currently out of soap.

| APPLICABLE RULE | |
|---|---|
| **R 400.14314** | **Resident hygiene.** |
| | **(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.** |
| **ANALYSIS:** | Resident A acknowledged being prompted to take showers and stated that he was provided with washcloths to do so. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

On 8/17/23, I conducted an exit conference with licensee Vicky Cates. I shared my findings and Ms. Cates agreed with the conclusions reached.

## IV. RECOMMENDATION

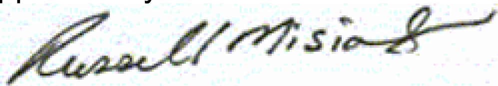
I recommend the status of the license remain unchanged.



8/24/23

Dwight Forde — Date
Licensing Consultant

Approved By:



8/28/23

Russell B. Misiak — Date
Area Manager