GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 29, 2024

Vicky Cates
3960 Sharp Rd.
Adrian, MI 49256

RE: License #: AM460064217
Investigation #: 2024A1032015
On The Hill AFC Home

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 #:	AM460064217
Investigation #:	2024A1032015
Complaint Receipt Date:	01/10/2024
Investigation Initiation Date:	01/11/2024
Report Due Date:	03/10/2024
Licensee Name:	Vicky Cates
Licensee Address:	3960 Sharp Rd. Adrian, MI 49256
Licensee Telephone #:	(517) 902-3950
Administrator:	Vicky Cates
Name of Facility:	On The Hill AFC Home
Facility Address:	3446 East US 223 Adrian, MI 49221
Facility Telephone #:	(517) 264-2203
Original Issuance Date:	05/15/1996
License Status:	REGULAR
Effective Date:	03/21/2022
Expiration Date:	03/20/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not properly cared for in the days leading up to his death.	No
Additional Findings	Yes

III. METHODOLOGY

01/10/2024	Special Investigation Intake 2024A1032015
01/11/2024	Special Investigation Initiated - Telephone
01/25/2024	Inspection Completed On-site
02/05/2024	Contact - Document Received Health Care Appraisal; Medication Administration Record
02/06/2024	Contact - Face to Face Interview with employee Amanda Cilley
02/28/2024	Exit Conference With licensee designee Vicky Cates

ALLEGATION:

Resident A was not properly cared for in the days leading up to his death.

INVESTIGATION:

On 1/11/24, I interviewed Adult Protective Services (APS) specialist Samantha Garcia by telephone. Ms. Garcia stated that she received information that Resident A suffered from gastrointestinal issues for three days leading up to his death. She advised that the home had been helping Resident A clean himself up. The morning that the ambulance was called, he had a bout of diarrhea at night, which would account for him having dried feces on his body and clothing. Ms. Garcia shared that the employees reportedly did not have time to clean him up since it was against the home's policy to move a person who is in need of emergency medical treatment.

She reported that Resident A's guardian had been contacted, and that the guardian had expressed satisfaction with the way the situation was handled.

On 1/25/23, I interviewed employee Barbara Proffitt in the home. Ms. Proffitt stated that she called emergency medical services on the day that Resident A was sent to the hospital. She stated that when she reported for duty, she checked on Resident A and realized that he was having difficulty breathing. She mentioned noticing that he had defecated on himself, tried to get him up to be cleaned, then he collapsed. She advised that she called EMS and made no further effort to assist Resident A physically so as to avoid worsening the medical emergency. She posited that since he was not cleaned up, this would have accounted for him presenting as dirty when EMS transported him to the hospital. Ms. Proffitt stated that when she left for vacation three days earlier, Resident A did not present with any respiratory issues. Ms. Proffitt stated that she did have to assist Resident A with toileting prior to her vacation, where she was off work for three days before returning to work and sending Resident A to the hospital. She denied observing any respiratory issues prior to leaving on vacation.

I interviewed Resident B in the home. Resident B reported that he heard Resident A coughing in the night prior to Resident A's hospitalization and had shared his observations with employees. Resident B also shared that he had seen employees helping Resident A clean up after soiling himself.

I interviewed Resident C in the home. Resident C shared that she had seen employees assisting with Resident A's care in the home.

I was not able to interview Resident A because he was deceased.

On 2/5/24, I reviewed Resident A's *Health Care Appraisal* and *Medication Administration Record* (MAR) for December 2023. The appraisal does not reflect any respiratory conditions, and the MAR does not reflect any use of over-the-counter medications for cough/cold symptoms.

On 2/6/24, I interviewed employee Amanda Cilley in the home. Ms. Cilley reported that she had showered Resident A two days in a row leading up to his hospitalization. She reported that Resident A did not present with any other indication that he was in distress other than his apparent gastrointestinal issues. She denied that he requested any over the counter cold/flu medication. She acknowledged that he did have a brief cough but did not detect any issues with obstructed breathing during her shifts.

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:	I reviewed Resident A's health care appraisal, and there was no indication that he had any existing respiratory ailments. I reviewed Resident A's MAR which reflected no use of over the counter medication for cold or flu related symptoms. Employees interviewed stated that Resident A was changed in the days leading up to his death, except the day that he was transported to the hospital. The explanation provided appears consistent with the home's policy of not moving individuals experiencing a medical crisis. Residents in the home were interviewed. They acknowledged that employees did assist Resident A with toileting and changing dirty clothing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 2/28/24, 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 no change to the status of this license.

2/29/24

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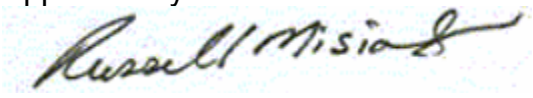
Dwight Forde Date
Licensing Consultant

Approved By:



3/6/24

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Russell B. Misiak Date
Area Manager