GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 27, 2022

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

RE: License #: AS120407514
Investigation #: 2022A1032005
Agnus Dei AFC Home #4

Dear Mr. 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,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(616)-240-3850

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

I. IDENTIFYING INFORMATION

License #:	AS120407514
Investigation #:	2022A1032005
Complaint Receipt Date:	05/02/2022
Investigation Initiation Date:	05/03/2022
Report Due Date:	06/01/2022
Licensee Name:	Agnus Dei AFC Home Inc.
Licensee Address:	1307 42nd St. Allegan, MI 49010
Licensee Telephone #:	(269) 686-8212
Administrator/ Licensee Designee:	James Saintz
Name of Facility:	Agnus Dei AFC Home #4
Facility Address:	738 East Grant Street Bronson, MI 49028
Facility Telephone #:	(517) 858-1027
Original Issuance Date:	07/23/2021
License Status:	REGULAR
Effective Date:	01/23/2022
Expiration Date:	01/22/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
• Staff are verbally abusive towards residents. • Staff do not protect residents from other residents.	No
Staff do not provide adequate meals	No
Additional Findings	No

III. METHODOLOGY

05/02/2022	Special Investigation Intake 2022A1032005
05/03/2022	Special Investigation Initiated - Telephone APS investigator.
05/10/2022	Contact - Face to Face
05/10/2022	Inspection Completed On-site
05/25/2022	Contact - Document Received Incident Report reflecting staff intervention with Resident A and Resident B.
06/01/2022	Exit Conference

ALLEGATION:

- **Staff are verbally abusive towards residents.**
- **Staff do not protect residents from other residents.**

INVESTIGATION:

On 5/3/22, I confirmed the stated allegations with the complainant.

On 5/10/22, I interviewed Resident A at the home with Deputy Brad McConn and adult protective services (APS) worker Michelle Lock. Resident A reported that she had been touched inappropriately by Resident B. She reported that it happened a

few months ago. She reported that in one instance Resident B touched her buttocks. She advised that Resident B also tried to place keys on her breasts. She stated that staff had done nothing about the incident. Resident A also reported that the staff had refused to take her to an appointment to have a birth control device removed.

Deputy McConn stated that he had responded to the call related to Resident B touching Resident A on her buttocks. He stated that the behavior did not rise to the level of a crime and that he had spoken to Resident B about stopping the behavior. He advised that Resident B was wheelchair bound and that it was highly unlikely that he would be able to reach up to resident A's breast area to place keys.

Ms. Lock stated that there did not appear to be a preponderance of evidence that Resident A had been placed in danger. Ms. Lock indicated that Resident A's boyfriend had recently left the home and had been heard telling resident A to do everything in her power to shut the home down.

On 5/10/22, I interviewed staff member Patricia Torres at the home. She denied that the staff do not take steps to intervene when residents behave inappropriately. She stated that Resident A has a very controlling boyfriend who was recently removed from the home and placed in a more specialized program. She stated that he has been advising Resident A that she should remove her contraceptive device. She further explained that the boyfriend has told Resident A that should she become pregnant that she could make use of his family resources. She denied that staff refused to take Resident A to a doctor's appointment but stated that they did explain to her that she should fully examine the consequences of her decision. Ms. Torres stated that the appointment would be rescheduled should Resident A choose to do so. She denied that staff verbally abuse Resident A.

On 5/25/22, I reviewed an incident report dated 9/25/21 in which Resident B touched Resident A inappropriately and staff intervened appropriately.

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:	There was no evidence to suggest that staff are rude to Resident A. An incident report was generated when Resident A was touched inappropriately by another resident. Police were called to the home and addressed the behavior with the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff do not provide adequate meals.

INVESTIGATION:

Resident A stated that sometimes she does not like the meals prepared.

Ms. Torres stated that Resident A and her boyfriend would often lay in bed and ignore calls for meals, then get upset meals had been missed. She further stated that sometimes they just did not like what was prepared. Ms. Torres showed me the home's menu posted in the kitchen area.

I found the menu to be appropriate, with a variety of meal options. Meal times appeared to be in compliance with licensing rules.

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 was unclear in discussing the meal complaint. It does not appear that the home was not providing food, but it appeared that Resident A did not like what was being prepared.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/1/22, I conducted the exit conference with licensee designee James Saintz. He agreed with my findings

IV. RECOMMENDATION

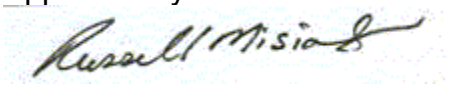
I recommend no change to the status of this license.

6/17/22

Dwight Forde
Licensing Consultant

Date

Approved By:



7/27/22

Russell B. Misiak
Area Manager

Date