

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

July 21, 2022

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

> RE: License #: AS120407514 Investigation #: 2022A1032010 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,

Dw. Jude

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

Licopoo #	A \$ 120 40 7E1 4
License #:	AS120407514
	0000044000040
Investigation #:	2022A1032010
Complaint Receipt Date:	06/03/2022
Investigation Initiation Date:	06/06/2022
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Report Due Date:	07/03/2022
Licensee Name:	Agnus Dei AFC Home Inc.
Licensee Address:	1307 42nd St.
Licensee Address:	
	Allegan, MI 49010
Licensee Telephone #:	(269) 686-8212
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
Facility relephone #.	(317) 838-1027
Original Jacuares Data:	07/00/0004
Original Issuance Date:	07/23/2021
License Status:	REGULAR
Effective Date:	01/23/2022
Expiration Date:	01/22/2024
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Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED
Fiogrann Type.	DEVELOPMENTALLY DISABLED
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	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff do not adequately provide Resident A with transportation	No
Staff verbally abuse Resident A	No
Staff do not provide proper meals	No
Additional Findings	No

III. METHODOLOGY

06/03/2022	Special Investigation Intake 2022A1032010
06/06/2022	Special Investigation Initiated - Telephone
06/10/2022	Contact - Telephone call made Left Voicemail for On Point Case Manager Kaitlin Clemens
06/13/2022	Contact - Telephone call received Contact made with Kaitlin Clemens
06/14/2022	Inspection Completed On-site
06/21/2022	Exit Conference Conducted via email with James Saintz, Licensee Designee

ALLEGATION:

Staff do not adequately provide Resident A with transportation.

INVESTIGATION:

On 6/7/22, I interviewed the complainant by telephone. They confirmed the allegations with no more information shared.

On 6/13/22, I interviewed Allegan County CMH Authority, On Point case manager Kaitlin Clemens by telephone. She reported that she is Resident A's assigned case manager. She stated that as part of the home's contract, they are required to provide transportation. She stated that as far as she was aware, the home has been providing transportation for Resident A's major appointments and was therefore in compliance with this requirement of their contract.

On 6/14/22, I interviewed Resident A at the home. She reported that the staff transport her to her medical appointments. She stated that recently she did have to walk but the place was close. She walked to Greenhouse Care and her doctor's office, which were within a mile of the home. Resident A stated that she was aware, at the time that she made the appointments, that staff would not be able to provide transport because she did not give enough notice but felt that because the appointments were a mile away that she would walk. She stated that on the day in question there were not enough staff to manage the home and provide transport.

On 6/14/22, I interviewed staff member Patricia Torres at the home. Ms. Torres stated that they do provide transportation but there was a day that there was not enough staff to provide transportation. She stated that they ask residents to make their appointments with enough notice, and it so happened that Resident A made her appointment on a Wednesday when there was not enough time to ensure coverage and transportation. Ms. Torres reported that Resident A does not have guardian and can go into the community unsupervised.

I interviewed Resident B. He denied any issues with transportation or otherwise with staff. He was engaged in a recreational activity and quickly returned to it.

APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self- esteem, self-direction, independence, and normalization.

ANALYSIS:	Resident A reported that staff do provide transportation when given sufficient notice. She advised that it was her choice to walk to a nearby appointment. Ms. Clemens had confidence in the home's compliance with transportation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff verbally abuse Resident A.

INVESTIGATION:

During Resident A's interview she denied that staff were verbally abusive. She stated that if there is conflict it tends to be resolved using a conflict resolution model, where parties explain their differences. She stated that there has been conflict in the past but denied that staff yell at her or other residents. She reported that the staff have taken precautions to be more vigilant if she and certain other residents are in the common areas. She stated that this plan is posted in the staff office.

Ms. Torres stated that the plan is posted in the office to make staff aware and be on alert.

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:	Resident A denied the allegation. The home had posted interventions for resident protection to limit the possibility of abuse.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff do not provide adequate meals.

INVESTIGATION:

Resident A denied problems with the food at the home. She stated BBQ wings and tater tots were to be served for lunch.

Ms. Torres denied that the home does not provide adequate meals.

APPLICABLE RULE	
R 400.15402	Food service.
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	Resident A registered her satisfaction with meal service. She denied that inadequate meals were supplied and was aware of the menu.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 6/21/22, I conducted an exit conference with licensee James Saintz. Mr. Saintz agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

Dw.V.F.

7/21/22

Dwight Forde Licensing Consultant

Approved By:

Russell Misias

7/21/22

Russell B. Misiak Area Manager Date

Date