GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Timothy Rantz
Ferny AFC Home, LLC
1564 N. M 63
Benton Harbor, MI 49022

June 4, 2024

RE: License #: AL110388345
Investigation #: 2024A0579021
Golden Shore

Dear Mr. Rantz:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110388345
Investigation #:	2024A0579021
Complaint Receipt Date:	04/08/2024
Investigation Initiation Date:	04/10/2024
Report Due Date:	06/07/2024
Licensee Name:	Ferny AFC Home, LLC
Licensee Address:	1564 N. M 63, Benton Harbor, MI 49022
Licensee Telephone #:	(269) 449-5400
Administrator:	Timothy Rantz
Licensee Designee:	Timothy Rantz
Name of Facility:	Golden Shore
Facility Address:	1564 N. M 63, Benton Harbor, MI 49022
Facility Telephone #:	(269) 932-5537
Original Issuance Date:	11/07/2017
License Status:	REGULAR
Effective Date:	12/02/2022
Expiration Date:	12/01/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/AGED

II. ALLEGATION(S)

	Violation Established?
Direct Care Workers are not trained to provide adequate personal care.	No
Meals are not nutritious.	No
The home is not in an orderly condition.	Yes
Resident B was inappropriately discharged from the home.	No

III. METHODOLOGY

04/08/2024	Special Investigation Intake 2024A0579021
04/10/2024	Special Investigation Initiated - Face to Face Resident A, Timothy Rantz (Licensee Designee), Kimberly Davis (Direct Care Worker), and Patricia Zahui (Direct Care Worker)
05/02/2024	Contact- Telephone Call Received Complainant 2
05/03/2024	Contact- Document Sent Timothy Rantz, Licensee Designee
05/22/2024	Contact- Telephone Call Made Relative B
05/24/2024	Contact- Document Sent Timothy Rantz, Licensee Designee
06/05/2024	Exit Conference Timothy Rantz, Licensee Designee

ALLEGATION:

Direct Care Workers are not trained to provide adequate personal care.

INVESTIGATION:

On 4/8/24, I reviewed the referral which alleged direct care workers are not adequately trained so they provide poor personal care.

On 4/10/24, I completed an unannounced on-site investigation. Private interviews were completed with Resident A, Timothy Rantz (Licensee Designee), Kimberly Davis (Direct Care Worker), and Patricia Zahui (Direct Care Worker).

I observed verification of direct care worker ("DCW") trainings in the home. The trainings were initialed as completed by DCWs and dated. Attached to the initialed page, the training material pages listed what was discussed and/or a quiz regarding each training topic required, including resident care and "What is Adult Foster Care?"

Mr. Rantz reported his secretary Sandie Pullins oversees formal DCW training including the training verifications I observed. He stated prior to working a shift, DCWs meet each resident and are explained their supervision, protection, and personal care needs. He stated DCWs "shadow" experienced workers to ensure they are comfortable caring for residents. He denied the allegations that DCWs are not trained and therefore do not provide adequate care.

Ms. Davis said she does not recall her specific training for this home aside from meeting residents and being told their specific care needs. Ms. Davis stated she has previously worked in an AFC home, so she was experienced prior to working at this home. She stated residents at this home are taken care of better than at previous homes she has worked at.

Ms. Zahui stated she had experience providing adult foster care prior to working at this home so she felt she was adequately trained prior to coming to this home. She stated she does not recall her specific training but confirmed she did meet residents and learn their care needs prior to working on her own.

Resident A denied concerns for her care and reported, although she is the most independent person in the home, she sees DCWs care for other residents appropriately.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualification and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:

	(d) Personal care, supervision, and protection

ANALYSIS:	I observed training verification that DCWs initialed and dated confirming they were trained on resident care as well as training materials and/or quizzes. Mr. Rantz, Ms. Davis, and Mr. Zahui reported DCWs are introduced to residents and trained on their care needs prior to working independently. Ms. Davis and Ms. Zahui reported they had experience providing supervision, protection, and personal care in other homes prior to working at this home as well. Resident A denied concerns for her care and the care of other residents. Based on the interviews completed and observations made, there is insufficient evidence that DCWs were not trained and competent in personal care, supervision, and protection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Meals are not nutritious.

INVESTIGATION:

On 4/8/24, I reviewed the referral which alleged meals are not nutritious.

I observed the kitchen. I found the commercial refrigerator full of a variety of foods including fruit, vegetables, protein, and dairy. I found a shelving unit that was full of canned fruits, vegetables, sauces, stocks, and boxed grains.

I observed the weekly menu which showed a nutritionally balanced diet. The menu had items crossed out, indicating it was modified to reflect what residents consumed.

Mr. Rantz reported the menu reflects what residents consume and they are provided a nutritionally balanced diet. He denied the allegations.

Ms. Davis stated residents eat very well at this home. She stated the menu in the home is followed and is nutritionally balanced. She denied the allegations.

Ms. Zahui stated residents eat what is on the menu, the menu is followed, and the meals are nutritionally balanced. She denied the allegations.

Resident A stated she likes the food in the home and feels it is healthy. She denied any concerns about the food in the home.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.
ANALYSIS:	I observed nutritionally balanced fresh and canned/boxed food items in the home. I observed a nutritionally balanced menu that was modified to reflect what residents consume. Resident A denied concerns for the food in the home and reported it is healthy. Mr. Rantz, Ms. Davis, and Ms. Zahui reported the nutritionally balanced menu is followed, there is nutritionally balanced food in the home, and denied the allegations. Based on the interviews completed and observations made, there is insufficient evidence that meals do not meet the nutritional allowances established by this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home is not in an orderly condition.

INVESTIGATION:

On 4/8/24, I reviewed the referral which alleged the cleanliness of the home is lacking and that carpeting was taken out of resident rooms “months ago.” Resident rooms are now concrete with residual carpet glue on them. For months, boxes blocked the hallway impairing movement for residents in wheelchairs.

On 4/10/24, I saw a small stack of boxes at the end of a hallway in the home. Due to the width of the hallway, the boxes did not block resident mobility and it was reported residents do not go to that area of the home.

I observed four resident bedrooms that did not have carpet or flooring. The floor in the rooms was subfloor covered with residual black carpet glue.

Mr. Rantz reported he removed the flooring in these rooms with the intention of replacing them, but he has not decided on the type of flooring he would like to replace them with. He stated no one has complained to him about the flooring and if anyone expressed concerns, he would more immediately decide regarding replacing the flooring. He stated the floors, although they make not be aesthetically pleasing, are functional and still cleaned daily. He stated they are safe and safer than the previous flooring.

Ms. Davis stated she started in the home “last fall”, approximately eight months ago, and there has not been flooring in the rooms I observed during that time. She stated the floors are regularly cleaned and residents have not complained about the flooring in their room.

Ms. Zahui stated it has been several months since the carpet was removed from the rooms I observed. She stated the floors are still cleaned regularly and residents have not complained about the condition of the floor.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	I observed four bedrooms that had carpeting removed. The floors were subfloor covered in residual carpet glue. Ms. Davis stated the rooms had not had carpeting or other flooring since she began working at the home approximately eight months ago. Ms. Zahui confirmed there has not been flooring for several months. Mr. Rantz stated he removed the carpeting from the rooms with the intention of replacing the

	flooring, however he has not decided which type of flooring to replace it with. Based on the interviews completed, there is sufficient evidence that the flooring is not finished in a way that is in good repair due to four resident room floors being subfloor covered in glue that have been in that condition for over approximately eight months at the time the interviews were completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B was inappropriately discharged from the home.

INVESTIGATION:

On 5/2/24, I received a telephone call from Complainant 2 who stated Resident B was inappropriately discharged from the home. Complainant 2 expressed concern that Mr. Rantz manipulated Relative B, who is 94 years old, into taking Resident B into Relative B's home because Mr. Rantz refused to allow Resident B to return to the home when Resident B was inappropriately discharged. Complainant 2 stated Relative B did not know Resident B's rights and took Resident B home even though a proper discharge notice was never issued. Complainant 2 stated Relative B acknowledges they removed Resident B's belongings from the home when Mr. Rantz verbally reported Resident B could not return even though a discharge notice was not given. Complainant 2 expressed concern that Mr. Rantz's behavior is inappropriate, that he took advantage of Relative B being elderly, and he put Relative B and Resident B in "a tough" and potentially unsafe situation where Relative B felt the only option was to take Resident B in Relative B's home and care. Complainant 2 stated when discussing the discharge with Relative B, and advising Relative B that Relative B did not have to take Resident B home or remove Resident B's belongings without proper notice, Relative B said, "Oh no, I did the wrong thing." Complainant 2 advised Relative B, it was not Relative B's fault and Mr. Rantz should not have handled Resident B's discharge this way. Complainant 2 stated Mr. Rantz will not communicate with Relative B's case management to discuss this discharge and defers to Ms. Pullins who does not respond. Complainant 2 stated when case management attempts to communicate with Mr. Rantz he is verbally aggressive and dishonest. I advised I would need to speak to Relative B and Relative B's contact information was provided. Complainant 2 reported they will advise Relative B he should speak to me.

On 5/3/24, I emailed Mr. Rantz inquiring about Resident B's discharge from the home and requesting a copy of his discharge notice. Mr. Rantz responded with a list of reasons that Resident B was not suitable for the home that he reported he

verbally discussed with Relative B. He stated he then requested Relative B to start looking for a new placement on 4/1/24 and Relative B immediately removed Resident B from the home before a discharge notice could be given. The typed list was dated 5/3/24 and addressed to Relative B. It included that Resident B does not cooperate with dialysis and needs Relative B to be present, Resident B is not aware of his actions, Resident B refuses to cooperate with physical therapy, stating he does not want to walk, which makes it harder to transfer Resident B and puts extra strain on direct care workers, Resident B threatening to hurt staff, kicking, and swinging at a direct care worker, Resident B defecating and smearing it on himself, his wall, and bedding, “No power of attorney. If [Relative B] pass[es] away, [Resident B’s] bill may not be paid”, and “Throwing a tantrum and losing control of his wheel chair (*sic*) down the ramp. A staff member has been off work for 1.5 years on workman’s compensation and had surgery and still is off work. Claims have exceeded 100k and far from over.”

I also received a second letter dated 5/3/24 that was addressed to me which stated:

> *With Resident B refusing [physical therapy], and weighing 212 pounds, he would soon hurt another employee.*
>
> *April 1, 2024, I had my secretary, Sandie, call [Relative B] to have him start looking for a new home and was told of the issues we had here at Golden Shore with [Resident B]. The same day all [Resident A’s] room belongings were removed without I or my secretary being told. He left on his own accord, so no discharge notice was given. Later in the same day [Relative B] asked for his April rent returned, which I promptly did. I immediately went to my wait list and accepted a new client.*
>
> *Later in the week it was brought to my attention that placement was difficult and I explained I did not have an opening.*

On 5/22/24, I attempted a telephone interview with Relative B. The call was not answered. A voicemail message was left requesting a return phone call. A return phone call was not received at the time of report disposition.

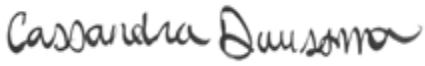
On 5/24/24, I emailed Mr. Rantz discussing the full allegations listed here, as we had only previously discussed the discharge of Resident B. He denied allegations he or Ms. Pullens failed to communicate or communicated aggressively or inappropriately with anyone involved in this matter.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Complainant 2 expressed concern that Mr. Rantz manipulated Relative B, who did not know the rights of Resident B, into taking Resident B into Relative B's care by verbally reporting Resident A could not return to the home, which Relative B complied with. Mr. Rantz reported he expressed concerns for Resident B to Relative B and requested Relative B begin looking for new placements but did not issue a discharge notice. He stated Relative B immediately removed Resident B and his belongings from the home, requested reimbursement for April 2024, and Mr. Rantz immediately reimbursed him. Relative B did not respond to a voicemail message left requesting a return phone call. Based on the interviews completed, there is insufficient evidence to support allegations that Resident B was not given a 30-day written notice prior to discharge from the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/4/24, I completed an exit conference with Mr. Rantz who did not dispute my findings or recommendations.

IV. RECOMMENDATION

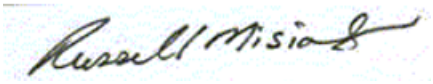
Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.



5/28/24

Cassandra Duursma Date
Licensing Consultant

Approved By:



6/4/24

Russell B. Misiak Date
Area Manager