STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 24, 2021

Joseph Gatu
7 Tony Tiger TRL
Springfield, MI 49037

RE: License #: AF130369560
Investigation #: 2021A1029010
JoAnne Foster Care

Dear Mr. Gatu:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On June 2, 2021, you submitted an acceptable written corrective action plan along with documentation of compliance.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (517) 284-9730.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AF130369560
Investigation #:	2021A1029010
Complaint Receipt Date:	04/29/2021
Investigation Initiation Date:	04/29/2021
Report Due Date:	06/28/2021
Licensee Name:	Joseph Gatu
Licensee Address:	7 Tony Tiger Trail, Springfield, MI 49037
Licensee Telephone #:	(269) 883-6339
Administrator:	N/A
Licensee Designee:	Joseph Gatu
Name of Facility:	JoAnne Foster Care
Facility Address:	7 Tony Tiger Trail, Springfield, MI 49037
Facility Telephone #:	(269) 274-1298
Original Issuance Date:	07/15/2015
License **Status:**	REGULAR
Effective Date:	01/16/2020
Expiration Date:	01/15/2022
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Licensee, Mr. Gatu was not cooperating with Hospice of Southwest after Resident A was given a written 30-day eviction notice because Mr. Gatu would not provide Relative A1 with records needed to begin services with Hospice of Southwest Michigan.	No
JoAnne AFC staff did not pass Resident A's medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/29/2021	Special Investigation Intake 2021A1029010
04/29/2021	Special Investigation Initiated – Telephone to Dawn Campbell who spoke with complainant to initiate complaint
04/30/2021	APS Referral -Telephone call to CI to make APS referral. Spoke with Megan.
05/03/2021	Contact - Telephone call made to Relative A1
05/03/2021	Contact - Telephone call made to Jennifer Stockford - APS
05/03/2021	Contact - Telephone call made to Danielle Lucas, RN, LM
05/03/2021	Contact - Telephone call received from Danielle Lucas, RN from Hospice
05/03/2021	Inspection Completed On-site
05/03/2021	Contact - Face to Face with Resident A, Licensee Joe Gatu and Michaela Browne
05/14/2021	Contact - Telephone call received from Tracey St. John, Medical Examiner office
05/17/2021	Contact – Email and phone call with Ms. Browne

5/24/2021	Contact – Telephone call and voicemail message left to Danielle Lucas, RN Case manager, Hospice Care of South West MI.
05/25/2021	Contact – Telephone call to social worker, Brianna Combest from Hospice of Southwest MI.
05/25/2021	Contact – Telephone call to Val Savina, nurse practitioner from Hospice of Southwest MI.
05/26/2021	Exit Conference with Joseph Gatu – Left a message for Mr. Gatu. Email from Ms. Browne stated he will return call on June 1, 2021.
06/01/2021	Contact – Telephone call from Joseph Gatu to complete the Exit Conference.
06/02/2021	Contact – Telephone call received from Relative A1.

ALLEGATION:

Licensee, Mr. Gatu was not cooperating with Hospice of Southwest Michigan after Resident A was given a written 30-day eviction notice because Mr. Gatu would not provide Relative A1 with records needed to begin services with Hospice of Southwest Michigan.

INVESTIGATION:

A complaint was received that JoAnne AFC issued a written 30 day discharge notice to Resident A because his care exceeded what facility direct care staff members were able to provide. Complainant alleged licensee, Joseph Gatu was not cooperating with Hospice of Southwest Michigan and Relative A1 by giving the necessary documents from Resident A's resident record.

On May 5, 2021, I interviewed Relative A1. She stated that Resident A is still residing at JoAnne's AFC. The family is in the process of moving Resident A to a Hospice facility in Battle Creek but they were on the waiting list. She stated the discharge notice was given on April 24, 2021 and Mr. Gatu gave him 30 days because facility direct care staff members were not able to meet his care needs. Also written on the 30 day notice was a statement that the family would provide Hospice care until his move.

According to Relative A1, Danielle Lucas, RN, from Hospice of Southwest MI that is providing care to Resident A and Resident A has dementia and would not be able to communicate with a social worker or complete an interview. Relative A1 has taken several pictures of the inside of his room and other areas of the house. She stated Resident A's body is red but he does not have any bed sores. Ms. Browne is currently providing most of the care. According to Relative A1, Resident A has been at the home

for four years and has received excellent care and until his decline a month ago. She stated Ms. Browne failed to provide her the resident record for Resident A so she could meet with Hospice on April 29, 2021. I reviewed several pictures from Relative A1 which consisted of the bathroom, toilet, old wax on the bathroom counter, his bedside table, and pictures of Resident A laying in his bed. The wax on the counter or the bathroom conditions did not present a safety concern to Resident A since he was bedridden at that time.

On May 3, 2021, I interviewed Jennifer Stockford, adult protective services worker for Calhoun County Department of Health and Human Services (DHHS). She stated she interviewed licensee, Mr. Gatu and he denied there was any concerns. Ms. Stockford also stated Resident A stated he liked it there and he was not losing weight. Ms. Stockford stated Relative A1 reported wanting the documents to meet with Hospice on April 29, 2021. Responsible person Ms. Browne stated she did not deny them any documents but would not give her the entire resident record. Ms. Browne mentioned to Ms. Stockford that Relative A1 has been hostile towards herself and Mr. Gatu.

On May 3, 2021, I interviewed Danielle Lucas, RN from Hospice Care Southwest Michigan. Ms. Lucas felt there was additional training needed for this level of care in regard to medications for Ms. Browne and Mr. Gatu but that Resident A was being cared for properly. She did not have concerns regarding Mr. Gatu not working with Hospice or providing the needed paperwork so Resident A could have the necessary care.

On May 3, 2021, I interviewed responsible person Michaela Browne and licensee, Joseph Gatu at JoAnne AFC. Resident A has lived in the home for four years. They both stated there was a decline in his health the last month. Both also stated Relative A1 would complain he was sleeping too much or not eating enough. Both also stated Resident A within the last couple weeks, Resident A began soiling himself more and would need two showers and bedding changes daily. Mr. Gatu and Ms. Browne were in constant contact with Relative A1 regarding Resident A's declining health.

Ms. Browne stated there has been a long relationship with Resident A since he lived there for four years. She has had several contacts with Relative A1 in the past, but lately since the discharge notice was issued, Ms. Browne stated Relative A1 has been hostile toward herself and Mr. Gatu.

Ms. Browne stated she did not refuse to give them the necessary forms needed for the meeting with Hospice, but she would not give Relative A1 the whole resident record. She was able to provide the records to Hospice so they could begin care.

I was able to review Resident A's resident records to review his health care appraisal and medication records.

On May 14, 2021, I received a phone call from Tracey St. John from the Medical Examiner's office requesting information regarding his care at JoAnne AFC. She

informed me that Resident A passed away the morning of Friday, May 14, 2021 and he was on a hold at the funeral home while a determination was made if an autopsy would be completed.

On May 17, 2021, I sent an email to Ms. Browne and Mr. Gatu expressing condolences regarding Resident A's passing and explaining the procedure for his belongings and discarding the medications. Immediately after the email was sent, a telephone call was received from Michaela Browne from JoAnne AFC. Ms. Browne said that Relative A1 moved him from their home on Tuesday, May 11, 2021 to Rose Arbor Hospice. Ms. Browne stated she was sad to see him go but he needed 24-hour care. They rotated him every two hours and checked him hourly. Ms. Browne stated she took detailed notes of the care provided to Resident A when Hospice was involved since she knew that Relative A1 was upset with the care provided by the family home. I reviewed these notes after she sent them by email after the phone call. Relative A1 came to the home on Friday, May 14, 2021, to collect the pro-rated rent money and his belongings and told them "they could rot in hell" but did not inform them of Resident A's passing.

Ms. Browne stated the current prescribed medications, and his belongings went with him on Tuesday when he was moved. They disposed of the medications he was no longer taking at the Battle Creek Veteran's Affairs Medical Center.

Ms. Browne stated she felt his family was upsetting him when they would come to visit by making statements such as "Say Hi to Mom in heaven for us." Many times, when they would visit, he would keep his eyes closed during the visit with family and after they left, he would talk to Ms. Browne and Mr. Gatu.

On May 24, 2021, I contacted Danielle Lucas, RN and left her a message.

On May 25, 2021, I talked to the social worker, Brianna Combest, from Hospice Care of Southwest Michigan. She had minimal contact with them and visited the home. Ms. Combest stated she talked to Resident A and he was able to communicate with her. Resident A seemed that he was comfortable. Ms. Combest stated during her visits, she saw nothing to indicate he was not being cared for as required. According to Ms. Combest, there was some concerns regarding Relative A1's interactions with the licensee, Mrs. Gatu and Ms. Browne. While Ms. Combest was on the phone with Relative A1, she told her that she was "so mad that she could kill somebody." There was one minute where she seemed calm on the phone and then was very upset. She did not have concerns that Mr. Gatu was not cooperating and providing the necessary copies for Hospice, but rather that Relative A1 was upset with them for the discharge notice.

On May 25, 2021, I interviewed nurse practitioner, Val Savina who provided care to Resident A during one visit at JoAnne AFC home. She felt that both Mr. Gatu and Ms. Browne were in full cooperation with Relative A1 regarding his care that Hospice was providing however, she knew that Relative A1 was upset with them regarding his care and the discharge notice.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(17) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested and as determined appropriate by the resident or his or her designated representative. A fee charged for copies of resident records shall not exceed the cost to the licensee for making the copies available.
ANALYSIS:	Mr. Gatu issued a written 30-day discharge for Resident A which was given to Relative A1 due to his care needs exceeding what they could provide at JoAnne AFC home. After the discharge notice, Ms. Browne stated she would not give the whole resident record to Relative A1 but Ms. Browne did provide the necessary documentation. Ms. Lucas and Ms. Savina did not have any concerns regarding Ms. Browne and Mr. Gatu not cooperating with Hospice of Southwest Michigan by providing the necessary documentation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

JoAnne AFC staff did not pass Resident A's medication as prescribed.

INVESTIGATION:

On May 3, 2021, I interviewed Danielle Lucas, RN from Hospice Care Southwest Michigan. RN Lucas stated Resident A was on Metoprolol for his blood pressure and during a visit with Resident A on Wednesday, April 28, 2021, his blood pressure was low to mid 90s but Ms. Browne did not seem to be aware of this. RN Lucas stated Resident A's brief has been clean each time she was there, and his skin looks good. There were no bed sores or open wounds on him. Ms. Lucas applied some barrier cream. She did not know if they were using an aloe cream, but if so, this would also be a barrier cream that would be appropriate.

On May 3, 2021, I interviewed Mr. Gatu and Ms. Browne at JoAnne AFC and it was observed they did have all medications at the home that were prescribed at that time. I observed medication administration records filled out documenting that his medication was given to him. Hospice of Southwest MI staff did change the medications when they

started working with him however, before moving out he was prescribed the following medications:

1. Digoxin
2. Pantoprazole
3. Aspirin – This was discontinued on May 7, 2021
4. Escitalopram Oxalate
5. Ferrous Sulfate - This was discontinued on May 7, 2021
6. Citalopram Hydrobromide
7. Haldol (PRN that he did not need)
8. Senna (This was a new medication that he started on May 9, 2021)
9. Refresh eye drops (Ms. Browne stated these were never received by the AFC)
10. Bisacodyl (This was a new medication he started on May 10, 2021)

Resident A was prescribed Metoprolol until April 30, 2021 for blood pressure. Ms. Browne stated she was told by Ms. Lucas to stop giving it to him on April 29, 2021 but to keep the medication in case it was needed in the future. While at the home, I observed a text message from Relative A1 sent to Ms. Browne that the medications were "fine if he received the blood pressure medication". Ms. Browne stated she was told by Relative A1 that Resident A's doctor instructed this to be given each day without checking the blood pressure. However, on the bottle there was directions to check the blood pressure daily and only take the medication if his blood pressure if the blood pressure met the criteria. Ms. Browne and Mr. Gatu acknowledged they did not check his blood pressure first but instead, went by what Relative A1 advised and gave the medication. Ms. Browne and Mr. Gatu both denied calling the physician's office or the pharmacist to confirm this information but instead went by what Relative A1 told them since she would not allow them to attend the doctor appointments. After this time, Ms. Browne sent detailed notes that she kept after Hospice became involved and after instructed to do so, she checked Resident A's blood pressure daily.

On May 25, 2021, I interviewed nurse practitioner, Val Savina who provided care to Resident A at JoAnne AFC on one occasion. Ms. Savina stated she felt Mr. Gatu was concerned about getting the medications correct although he seemed disorganized since the medication administration records were not in a binder, but just loose pages. Mr. Gatu and Ms. Browne denied checking his blood pressure before giving the Metoprolol. According to the instructions, if the blood pressure is less than 100 on the top number or less than 60 on the bottom or the heart rate is less than 60, then they hold the Metoprolol. Since they were not following the instructions on the bottle, it is possible he received the medication on days it should have been held.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(b) Not adjust or modify a resident's prescription medication without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any adjustments or modifications of a resident's prescription medication.**
ANALYSIS:	Resident A was on Metoprolol for his blood pressure. Mr. Gatu and Ms. Browne were not checking his blood pressure before they were giving the Metoprolol and they were giving it to him each day based on Relative A1's instructions to them rather than the instructions listed on the prescription medication bottle. They also did not confirm with the physician or pharmacist how the medication should be given.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There were concerns that Resident A was not eating and lost weight while residing at JoAnne AFC home.

INVESTIGATION:

During the on-site inspection on May 3, 2021, there was no indication that Mr. Gatu and Ms. Browne were not feeding Resident A since his health has declined. Although he was eating small amounts of food, he was also under the care of Hospice and they followed their direction on what to feed him and how often to feed Resident A.

On May 3, 2021, I interviewed Danielle Lucas, RN from Hospice Care Southwest Michigan who was providing care to Resident A at JoAnne AFC. Resident A was on the waiting list for Glenn Arbor Hospice. There was a cup of water on the table and he is only eating a couple bites at dinner. She did not have concerns that Mr. Gatu and Ms. Browne were not feeding Resident A.

On May 3, 2021, I interviewed responsible person Michaela Browne and licensee, Joseph Gatu at JoAnne AFC. Resident A has been there for four years. Mr. Gatu stated he was able to get out of bed and eat dinner with them until recently and there was a sharp decline in the last month. Both stated Relative A1 would complain he was sleeping too much or not eating enough. In the last couple weeks, he began soiling

himself more and would need two showers and bedding changes daily. They were in constant contact with Relative A1 regarding his decline and changes.

Ms. Browne also kept detailed notes about what she was offering him for food after his health declined. Although he was eating very little, she was attempting to feed him. Both health professionals who visited the home, Ms. Lewis, and Ms. Savina, indicated eating very little at the end of life was common and likely what was occurring leading to the weight loss.

According to Ms. Browne's documentation he was offered food on a regular basis. There were some days he declined what she offered and she would give him something else. He ate a variety of foods according to her documentation. A week before he passed away, his food intake did decrease and there were times she asked if he wanted to eat, and he declined. On May 9, 2021, Ms. Browne documented he was having a hard time swallowing and after that time most foods were a soft consistency such as fruit cups or yogurt. He was moved to another facility on May 11, 2021.

On May 24, 2021, Hospice social worker, Ms. Combest stated Resident A was minimally eating and barely getting up from the bed which is also a natural part of the dying process. He was enrolled with Hospice of Southwest MI starting on April 27, 2021 and passed away May 14, 2021.

On May 25, 2021, I interviewed nurse practitioner, Val Savina who also provided care to Resident A on one visit to JoAnne AFC home. Ms. Savina stated Mr. Gatu seemed interested in his well-being and was concerned regarding his rapid change. It was evident he was not used to providing personal care for someone needing 24-hour care. She completed a physical examination for Resident A while she was there. Ms. Savina stated she did not notice any signs of neglect or have concerns he was not eating. When Ms. Savina was there, she gave him water to drink which was available at his bedside table. She did not notice any signs of dehydration while she was there. She did examine his mouth and there was no oral thrush or yeast present.

APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular nutritious meals daily. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	There is no indication that Resident A was not being fed in the home. Ms. Browne kept detailed documentation of the meals he was offered after Hospice of Southwest Michigan began providing services. He was eating regularly until two days before his discharge when he started having a hard time swallowing and was then offered soft foods.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on May 3, 2021 there were no weights recorded on the *Resident Weight Record (BCAL-3485)* since April 2020. Mr. Gatu acknowledged that he has not weighed Resident A in the last year.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	There were no weights recorded on the *Resident Weight Record (BCAL-3485)* for Resident A since April 2020.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend no change in the status of the license.

06/04/2021

Jennifer Browning Date
Licensing Consultant

Approved By:

06/24/2021

Dawn N. Timm Date
Area Manager