GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2021

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

RE: License #: AS120407514
Investigation #: 2022A0007004
Agnus Dei AFC Home #4

Dear Mr. Saintz:

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.
- Be signed and dated.

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AS120407514
Investigation #:	2022A0007004
Complaint Receipt Date:	10/20/2021
Investigation Initiation Date:	10/21/2021
Report Due Date:	12/19/2021
Licensee Name:	Agnus Dei AFC Home Inc.
Licensee Address:	1307 42nd St. Allegan, MI 49010
Licensee Telephone #:	(269) 686-8212
Administrator:	James Saintz
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:	TEMPORARY
Effective Date:	07/23/2021
Expiration Date:	01/22/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was admitted to the hospital on 10/9/2021 due to aggressive behaviors. It was unknown to the hospital that he was allergic to Ativan. Home manager fails to return hospitals multiple calls regarding Resident A being ready for discharge. Resident A was abandoned without 30-day notice.	Yes

III. METHODOLOGY

10/20/2021	Special Investigation Intake - 2022A0007004
10/20/2021	APS Referral Received.
10/21/2021	Special Investigation Initiated - On Site – Unannounced - Face to face contact with Employee #1, Resident C, Resident D, Resident E, Resident F and Home Manager #1.
10/21/2021	Contact - Telephone call received - Message from Mr. Saintz, Licensee Designee.
10/22/2021	Contact - Telephone call made to Mr. Saintz, Case discussion.
11/09/2021	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1, Resident A, Resident D and Resident F.
12/20/2021	Exit Conference conducted with Mr. Saintz, Licensee Designee.

ALLEGATIONS:

Resident A was admitted to the hospital on 10/9/2021 due to aggressive behaviors. It was unknown to the hospital that he was allergic to Ativan. Home manager fails to return hospitals multiple calls regarding Resident A being ready for discharge. Resident A was abandoned without 30-day notice.

INVESTIGATION:

On October 21, 2021, I conducted an unannounced on-site investigation and made face to face contact with Employee #1, Resident C, Resident D, Resident E, Resident F and Home Manager #1.

It should be noted that I was also following up on another matter, a request for a minor to be placed in this home. Home Manager #1 informed me that there were six residents placed in the home and that she would send me their diagnoses. We also discussed the staffing patterns and levels of staff supervision.

I inquired about Resident A and Home Manager #1 informed me that he (Resident A) was still in the hospital. There was an incident involving Resident B and Resident C, which upset Resident A. Resident A and Resident B were friends. According to Home Manager #1, Resident B took a hit of Resident C's vape (electronic cigarette). Resident A was very upset with Resident B for taking the hit. Resident B, who is 18 years of age, stated that she is her own person. I inquired how Resident C, who is 20 years of age, had possession of the electronic cigarette and Home Manager #1 stated she came to the home with it.

It should be noted that when I arrived at the facility, Resident C and Employee #1 were outside on the side of the facility. Resident C had a blanket wrapped around her shoulders and it appeared that she was smoking.

Home Manager #1 informed me that there was an issue with Resident A's medications and after the medication change, there were behavioral issues. Resident A's caseworker was contacted regarding that matter. Resident A was sent to the hospital due to the aggressive behaviors. He has been there for about two weeks. Home Manager #1 stated that she spoke to Mr. Saintz, Licensee Designee, regarding this situation. Home Manager #1 stated that staff didn't feel safe with Resident A returning to the home, so staffing would be increased. I inquired if she spoke to anyone from the hospital and she informed me that Mr. Saintz, was in contact with Hospital Worker #1 at the Coldwater hospital. I inquired about the plan, and Home Manager #1 informed me that the plan was for Resident A to return to the home and then Mr. Saintz would place him at one of his other homes on November 1, 2021.

While at the facility, I also attempted to speak with Resident C; however, she did not want to talk.

On October 21, 2021, I received a voicemail message from Mr. Saintz, Licensee Designee. He informed me that he was having difficulty finding placement for Resident A. In addition, that he did not have good reception on his cell phone.

On October 22, 2021, I spoke with Mr. Saintz, Licensee Designee. He stated that Resident A had been picked up from the hospital. Mr. Saintz provided some background information regarding incidents that led to Resident A being sent to the hospital. Mr. Saintz stated that the residents and the staff were afraid of Resident A.

Resident A was upset about Resident B being in possession of a vape. The direct care staff did not give her the vape. Resident A was stating that the FBI was going to get a call regarding Resident B having the vape. Resident A was also antagonizing Resident C. Resident A contacted the police about the vaping, but they were not going to do anything about it. According to Mr. Saintz, the crisis team responded to the facility (specific date unknown), as there had been too many calls to 911, placed by Resident A. Case Manager #1 and Case Manager #2 from Pines Behavioral Health responded to the home. The next day, Resident A made a threat at Resident C. The police and crisis team arrived at the home again. According to Mr. Saintz, Case Manager #1 petitioned the court to have Resident A admitted. When they (case management and law enforcement) arrived at the home, Resident A stated that if he had to leave this home, then he's going to run. Resident A then takes off running and the police took him down. During the incident, Resident A's arm gets broken.

Mr. Saintz reported that Resident A has a history of seizures and was prescribed Depakote. Resident A was going from one neurologist to another. He was taken off Depakote and placed on Kepra. They immediately noticed behavioral changes. They had been in contact with Doctor #1 regarding the medication issues.

Mr. Saintz stated that Resident A can present well but he can also be "delusional," as he was stating that he's dating a police officer. According to Mr. Saintz, the nurses at the hospital were also afraid of Resident A. There was a concern that Resident A was "a narcissist," his background was pulled and based on that information, others would be put in danger if he returned.

While at the hospital, Resident A was given Ativan. Resident A broke a computer while at the hospital. Resident A claimed to be allergic to Ativan. Mr. Saintz stated that Resident A was having outburst before the Ativan was given. Mr. Saintz stated that he did not abandon Resident A, and that Resident A needed to be assessed to make sure his medications were working.

Resident A is from another county, and there was a question regarding coverage and who would complete the assessments etc. Resident A was supposed to have an assessment for placement at another AFC facility but that did not happen. There was also an opening at another facility, but they decided to move the assessment to Monday.

Overall, Mr. Saintz stated that Resident A needs a therapist that can provide him with the treatment he needs and Zoom meetings are not working. Mr. Saintz stated that he was of the assumption that Resident A was going to be placed somewhere else and transitioned there from the hospital. Mr. Saintz questioned why Resident A did not get admitted and stated that the ball had been dropped. Mr. Saintz stated that Resident A needed help, he needed a psychiatric evaluation, and when Case Manager #1 assessed Resident A, he was not admitted into the hospital. Mr. Saintz stated that the nurse said that Resident A had been doing fine for five days.

Mr. Saintz stated that he did not abandon Resident A, and that he's home, but he still needs services to help him. Mr. Saintz stated that they also tried to call Doctor #2 and they would not make an appointment. Resident A is back home and taking his medications as prescribed.

On November 9, 2021, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #1, Resident A, Resident D and Resident F.

While at the facility, I interviewed Resident A. Resident A stated that he was friends with Resident B, as he was previously a camp counselor, and Resident B was a camper. Resident A stated that Resident B's mother was abusive towards Resident B.

Regarding the incident, Resident A informed me that he checked into the laws and a person is supposed to be 21 years of age in order to vape. Resident C is 20 years old. According to Resident A, Resident C convinces Resident B to do things that are not healthy, such as vaping or drinking energy drinks, staying up all night, then being tired in school the next day. Resident A contacted Mr. Saintz about his concerns and Resident A stated that if he saw it happening (vaping), he would contact the police himself. Resident A stated this is why he had the evaluation.

Resident A was refusing to go to the hospital. He also had a seizure during the incident. Resident A stated that his father used to be a judge and now he is an attorney. Resident A reported that he could file a lawsuit against the police due to the things that occurred. Resident A stated that he has breathing issues.

I inquired about the Ativan and Resident A stated that he was "deathly allergic" to that medication. Regarding the broken computer, Resident A stated that the hospital was not going to sue. Resident A stated that he had a psychological evaluation and they said nothing was wrong with him. Resident A stated "I was cleared for 8 days, and no one was answering the phone or picking me up from the hospital.

He also recalled that he should not be prescribed Risperdal, as his heart stopped in the past, and this medication causes him to have chest pains. Resident A stated that he has already sued in the past for being prescribed this medication and the doctor put him back on this medication.

On December 17, 2021, I interviewed Hospital Worker #1. She stated that Resident A had been in the emergency room for a very long time. He arrived at the ER on October 9, 2021, and he remained there until October 21, 2021.

Resident A was taken to the hospital due to behavioral issues and aggression. In the beginning, there were issues with coverage and who would make the referral etc.

due to Resident A being from another county. Case Manager #3 from CMH in Allegan County was contacted regarding the contract issues.

While at the hospital, Resident A was administered Ativan. Resident A had a negative reaction to the medication. Resident A broke a computer while in the hospital. They learned of the history of negative side effects from this medication from his mother (Guardian). On Saturday, October 9, 2021, Hospital Worker #1 received a call that Resident A was ready to go back to the AFC home. He also needed to take his medication as prescribed. According to Hospital Worker #1, Resident A had no behaviors from October 10, 2021, with the exception of refusing his medications.

Hospital Worker #1 informed me that Case Manager #3 from CMH also called and emailed Mr. Saintz.

Hospital Worker #1 reported that she called Mr. Saintz on October 14, 2021, and left a voicemail, asking that he return her call.

Hospital Worker #1 recalled that there was no returned phone call from Mr. Saintz on October 15, 2021, therefore she left him another message.

Hospital Worker #1 contacted CMH case management because she could not reach Mr. Saintz. CMH was looking for another placement, to help out the hospital staff. Case Manager #3 was aware that Mr. Saintz was not accepting Resident A back into the home; therefore, she started looking for another placement.

Hospital Worker #1 informed me that there were multiple attempts to contact Mr. Saintz on October 18, 2021.

Hospital Worker #1 also followed up with the nursing staff on October 20, 2021, and no one had spoken to Mr. Saintz. According to Hospital Worker #1, Mr. Saintz did not return her calls. Mr. Saintz finally called the hospital after APS was contacted. Ms. Saintz reported to Hospital Worker #1 to be concerned about the allegations of abandonment.

According to Hospital Worker #1, Resident A was picked up from the hospital on October 21, 2021, at 6:30 p.m.

On December 20, 2021, I contacted Mr. Saintz, as I had some follow-up questions, and to conduct the exit conference. I inquired about the facility protocol to address Resident C vaping. Mr. Saintz informed me that she brought the vapes with her when she was admitted into the home. They thought they were just flavored vapes without nicotine; however, after conducting some research, they learned that it's illegal for anyone under the age of 21 to possess vapes. I asked if Resident C smoked cigarettes and Ms. Saintz stated she did not. I informed him that I observed Resident C and Employee #1 outside and it appeared that she was smoking. I didn't

confirm if it was a cigarette or an electronic cigarette. Mr. Saintz informed that Resident C would follow staff outside, even on their smoke breaks.

I explained that I would be substantiating a violation regarding the minors vaping, and I noted that this was one of the reasons that prompted the incident involving Resident A. Mr. Saintz acknowledged that this was an oversight on their part, and he agreed to submit a written corrective action plan. He informed that they now have protocols in place and this information would be addressed in the written corrective action plan. Mr. Saintz informed me that Resident C is no longer in the home and Resident B no longer wants anything to do with vaping.

During this conversation, I also informed Mr. Saintz that I would be substantiating the allegations as Resident A remained in the emergency department for too long. Mr. Saintz reported that he did not agree with this finding. He stated that he would just have to take the hit for this one. He stated that he is aware that he is responsible to pick up the resident from the hospital, but Case Manager #1 told him that they were going to petition the court and remove him from the home, as the other residents were not safe with him there. Mr. Saintz stated that he was told not to pick up Resident A. I inquired if he had a copy of the petition and Mr. Saintz stated he did not. He reiterated that the understanding was Case Manager #1 would petition the court as there was a need for a psychological assessment and an assessment related to Resident A's seizure activity. Ms. Saintz stated that when Case Manager #1 and Case Manager #2 arrived at the facility he asked her (Case Manager #1) for a business card and she told him he didn't need her card, she had his contact information, and she would reach out to him. In addition, that she could be reached if he contacted 911. The case managers made arrangements, but it wasn't with Allegan County.

Mr. Saintz stated that once Resident A was at the hospital and he faked a seizure and tore up the place, breaking the computer, the nurse said she would not bring him back to the facility. The nurses were saying he was unstable. In addition, the doctor at the hospital stated that after the incident at the hospital, he did not have the ability to place Resident A because no one would accept the placement. There were modifications to Resident A's medications while he was at the hospital.

Mr. Saintz stated he went to the hospital the following day and visited Resident A. Mr. Saintz stated that he did call hospital staff back and he even spoke to the social worker. He stated that the social worker told him that if she was involved in the beginning, she could have assisted. I informed Ms. Saintz that I understood that there was some confusion but reiterated that too much time had passed for Resident A to be in the emergency room. I informed that he did not have specific dates that he spoke to the nursing staff and the information I received was that multiple attempts were made to contact him without success. I encouraged him to keep a record of his contacts when a resident is in the hospital in the future. Mr. Saintz stated that Resident A is still in the home, and things are better. There was an allocation for additional staffing hours which has helped. A 30-day discharge notice has also been

given. Mr. Saintz stated that he has a clause in the notice that if the behavior changes, the notice can be rescinded. Resident A wants to remain in the home so he's acting better.

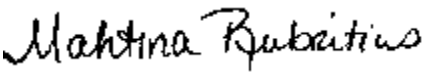
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Resident A reported to be upset because Resident C was encouraging Resident B to get involved with unhealthy behaviors. Resident B took a hit of Resident C's vape (e-cigarette). At the time of this complaint, Resident B and Resident C were under the age of 21. Resident A was taken to the hospital due to aggressive behaviors. Resident A received Ativan while he was at the hospital. Resident A reported to be allergic to the medication. While at the hospital, Resident A had an episode, breaking a computer. In the beginning, while Resident A was at the hospital, there were issues with coverage and who would make the assessment referrals etc. due to Resident A being from another county. Mr. Saintz stated that he was of the assumption that Resident A was going to be placed somewhere else and transitioned there from the hospital. Mr. Saintz questioned why Resident A did not get admitted into the hospital and stated that the ball had been dropped. Mr. Saintz stated that Resident A needed help, he needed a psychiatric evaluation, and when Case Manager #1 assessed Resident A, he was not admitted into the hospital. Mr. Saintz stated that he did not abandon Resident A, and that Resident A needed to be assessed to make sure his medications were working. Resident A stated that he had a psychological evaluation and they said nothing was wrong with him. Resident A stated "I was cleared for 8 days, and no one was answering the phone or picking me up from the hospital. According to Hospital Worker #1, Resident A had been in the emergency room for a very long time. He arrived at the ER on October 9, 2021, and he remained there until October 21, 2021. Hospital Worker #1 reported that she made multiple attempts to contact Mr. Saintz regarding Resident A being ready to be picked up from the hospital. According to Hospital Worker #1, CMH was looking for another placement, to help out the hospital staff. Case Manager #3 was

	aware that Mr. Saintz was not accepting Resident A back into the home; therefore, she started looking for another placement. While it's understandably difficult to sort out coverage and caseload responsibilities when a resident is placed in an out county, Resident A remained in the emergency room for too long. Multiple attempts, over the course of several days, were made to contact Mr. Saintz, Licensee Designee without success. Even if Resident A was going to be transitioned to another facility, contact with the Mr. Saintz would still be necessary in order to coordinate the efforts of relocation. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not treated with dignity and his personal needs, including protection and safety were not attended to at all times in accordance with the provisions of the act. In addition, it's concluded that Resident B and Resident C, minors who utilized an e-cigarette and vaped, were not treated with dignity and their personal needs, including protection and safety were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



12/20/2021

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

12/21/2021

Ardra Hunter — Date
Area Manager