GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 24, 2022

Linda Hirt and Jeffrey Hirt
6920 Austhof Woods Dt
Alto, MI 49302

RE: License #: AS410405484
Investigation #: 2022A0583026
Alto AFC

Dear Linda Hirt and Jeffrey Hirt:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410405484
Investigation #:	2022A0583026
Complaint Receipt Date:	04/28/2022
Investigation Initiation Date:	04/29/2022
Report Due Date:	05/28/2022
Licensee Name:	Linda Hirt and Jeffrey Hirt
Licensee Address:	6920 Austhof Woods Dr, Alto, MI 49302
Licensee Telephone #:	(616) 366-5125
Administrator:	Linda Hirt
Licensee Designee:	N/A
Name of Facility:	Alto AFC
Facility Address:	8546 Whitneyville Ave. SE, Alto, MI 49302
Facility Telephone #:	(616) 366-5125
Original Issuance Date:	01/18/2022
License Status:	TEMPORARY
Effective Date:	01/18/2022
Expiration Date:	07/17/2022
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Licensee Linda Hirt consumes alcohol during work hours.	Yes
Facility staff engaged in verbal alterations in the presence of residents.	Yes
Facility staff allowed Resident A to have access to knives despite being placed on “suicide watch”.	Yes
Residents were emotionally traumatized when Licensee Jeffrey Hirt physically assaulted a dog while in their presence.	No
The facility’s medication cart is left unlocked at night.	No
Facility residents are underfed.	No
Additional Findings	Yes

III. METHODOLOGY

04/28/2022	Special Investigation Intake 2022A0583026
04/28/2022	APS Referral
04/29/2022	Special Investigation Initiated - On Site Licensee Linda Hirt, Staff Samantha Hirt, Resident A, Resident B, Resident C, Resident D
05/02/2022	Contact - Telephone Licensee Jeffrey Hirt
05/04/2022	Contact - Document Received Licensee Linda Hirt
05/04/2022	Contact – Email Licensee Linda Hirt
05/24/2022	Exit Conference Licensee Linda Hirt

ALLEGATION: Licensee Linda Hirt consumes alcohol during work hours.

INVESTIGATION: On 04/28/2022 I received complaint allegations from Adult Protective Services Centralized intake which were screened out for formal Adult Protective Service (APS) investigation. The complaint alleged that Licensee Linda Hirt “frequently abuses alcohol during work hours to the point where residents can

smell it on her". The complaint further alleged that Licensee Linda Hirt's "alcohol use leads to her behaving erratically and scaring the residents".

On 04/28/2022 I completed a file review for the facility and discovered Special Investigation 2022A053018 which contained similar allegations of alleged alcohol consumption by Licensee Linda Hirt during working hours. This allegation was not substantiated through the previous investigation due to insufficient evidence.

On 04/29/2022 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Linda Hirt, Staff Samantha Hirt, Resident A, Resident B, Resident C and Resident D.

Licensee Linda Hirt stated that she has a history of alcohol abuse and acknowledged she suffered an alcohol relapse in July 2020 but stated she has now been sober for two years. Ms. Hirt stated she has not consumed alcohol during work hours or in her free time for approximately two years. Ms. Hirt stated she recently ordered an at-home breathalyzer test machine because no one believes she is sober. Ms. Hirt stated facility residents believe she is drinking alcohol when she is not.

Staff Samantha Hirt, daughter of Jeffrey and Linda Hirt, confirmed that Licensee Linda Hirt has a history of alcohol abuse. Samantha Hirt reported however that she has not observed any indication of current alcohol use by Linda Hirt.

Resident A stated that "twice this week" he has smelled alcohol on Linda Hirt's breath. Resident A stated he has smelled alcohol on Linda's Hirt's breath often and she typically "acts more mellow" when she smells of alcohol. Resident A stated Linda Hirt often falls asleep in a "lazy boy chair" for up to an hour when she smells of alcohol. Resident A stated Linda Hirt recently left the facility to adopt a new cat and when Linda Hirt returned to the facility she smelled of alcohol. Resident A stated he recently texted Licensee Jeffrey Hirt and informed him that Linda Hirt smelled of alcohol while working at the facility. Resident A stated Jeffrey Hirt confronted Linda Hirt regarding her alcohol consumption however she continues to deny her use.

Resident B stated Licensee Linda Hirt often smells of alcohol. Resident B stated she observed Linda Hirt drink a "light beer" in the facility living room. Resident B stated she has never observed Linda Hirt "walk like she's drunk". Resident B stated Linda Hirt has smelled of alcohol while driving facility residents.

Resident C stated he has not observed Licensee Linda Hirt smell of alcohol.

Resident D stated Licensee Linda Hirt frequently smells of alcohol while working at the facility. Resident D stated Linda Hirt smelled of alcohol yesterday. Resident D stated when Linda Hirt smells of alcohol she often sleeps "for over an hour in a lazy boy chair" located in the facility's living room. Resident D stated Linda Hirt has driven residents in an automobile while smelling of alcohol.

On 05/02/2022 I interviewed Licensee Jeffrey Hirt via telephone. Mr. Hirt stated that although Linda Hirt has a history of alcoholism, Mr. Hirt doesn't think she is currently consuming alcohol. Mr. Hirt stated he has been getting complaints from multiple residents that Linda Hirt is consuming alcohol while working at the facility. Mr. Hirt stated he received a text message from Resident A on 04/28/2022 stating Linda Hirt smelled strongly of alcohol while working at the facility. Mr. Hirt stated he contacted Linda Hirt via telephone and asked her if she had been consuming alcohol while working at the facility. Mr. Hirt stated Linda Hirt denied consuming alcohol while working at the facility or at all in her personal time. Mr. Hirt stated Linda Hirt "was not slurring her words" during the telephone conversation. Mr. Hirt stated he does not see Linda Hirt in person very often because they are both working numerous hours at separate adult foster care homes. Mr. Hirt stated Linda Hirt has ordered a "breathalyzer" machine as a means to provide evidence that she is not consuming alcohol.

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Linda Hirt stated she disputes the rule violation substantiation of R 400.14201 (9) because although she has a history of alcohol abuse, she is not currently consuming alcohol, has secured an at home breathalyzer devise, is invested in individual counseling, and regularly attends Alcoholics Anonymous classes. Linda Hirt stated she will be requesting a Compliance Conference.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	Resident C stated he has not observed Licensee Linda Hirt smell of alcohol. Licensee Linda Hirt denies alcohol consumption while working at the facility. Resident A, Resident B and Resident D each reported smelling alcohol on Licensee Linda Hirt's breath during working hours. Resident B stated she observed Licensee Linda Hirt drink a "light beer" in the facility living room. Staff Samantha Hirt stated she has not observed Licensee Linda Hirt to smell of alcohol while working at the facility.

	Mr. Hirt stated he has been getting complaints from multiple residents that Linda Hirt is consuming alcohol while working at the facility and confirmed that she has a history of alcoholism. Mr. Hirt stated he does not see Ms. Hirt very often but he does not think she is currently drinking. A preponderance of evidence was discovered during the special investigation to substantiate a violation of the applicable rule as a result of Staff Linda Hirt consuming alcohol while working at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff engaged in verbal alterations in the presence of residents.

INVESTIGATION: On 04/28/2022 I received complaint allegations from Adult Protective Services Centralized intake. The complaint alleged that Licensee Jeffrey Hirt, Licensee Linda Hirt, and staff Samantha Hirt have “loud verbal altercations while working in front of or near the residents”.

On 04/29/2022 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Linda Hirt, staff Samantha Hirt, Resident A, Resident B, Resident C and Resident D.

Licensee Linda Hirt and staff Samantha Hirt denied the allegation. Linda Hirt and Samantha Hirt, both reported no one works in the home other than themselves and Jeffrey Hirt and denied that they have engaged in any verbal altercations in the presence of residents.

Resident A stated Jeffrey Hirt, Linda Hirt and Samantha Hirt engage in “a good amount of arguing” while in the presence of residents. Resident A stated facility staff “argue” over things such as the facility running out of milk. Resident A stated he has not observed any of the Hirts curse at one another however the verbal exchanges are loud and make him feel uncomfortable.

Resident B stated Jeffrey Hirt, Linda Hirt and Samantha “argue, yell, and scream” at one another while in the presence of residents. Resident B stated Jeffrey Hirt, Linda Hirt, and Samantha have “anger issues” as evidenced by their loud arguing. Resident B stated Jeffrey Hirt, Linda Hirt, and Samantha have been observed arguing over things such as who has to pass medications or being woke up. Resident B stated she has not observed Jeffrey Hirt, Linda Hirt and Samantha call each other names or curse.

Resident C stated he has not observed Jeffrey Hirt, Linda Hirt and Samantha engage in verbal altercations while in the presence of residents. Resident D stated she has often observed Jeffrey Hirt, Linda Hirt and Samantha “yell at each other” while in the presence of residents. Resident D stated Jeffrey Hirt, Linda Hirt and Samantha “swear at each other a lot” and “don’t get along”. Resident D stated she has observed Jeffrey Hirt, Linda Hirt, and Samantha call one another “stupid”.

On 05/02/2022 I interviewed Jeffrey Hirt via telephone. Jeffrey Hirt stated he and other staff “obviously have disagreements” but try to take it into the office away from facility residents. Jeffrey Hirt stated he has never raised his voice in front of facility residents and has never called Linda or Samantha Hirt “stupid”. Jeffrey Hirt stated he has never cursed or used profanity while in the presence of facility residents.

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Linda Hirt stated she disputes the rule violation substantiation of R 400.14304 (1)(o)(2). Linda Hirt acknowledged that she and other staff members have engaged in disagreements with a raised volume level in the facility office with the door open, however she stated staff were not “yelling”.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A stated Jeffrey Hirt, Linda Hirt, and Samantha Hirt engage in “a good amount of arguing” while in the presence of facility residents. Resident B stated Jeffrey Hirt, Linda Hirt, and Samantha “argue, yell, and scream” at one another while in the presence of facility residents. Resident C stated he has not observed Jeffrey Hirt, Linda Hirt, and Samantha engage in verbal altercations in the presence of facility residents.

	Resident D stated she has often observed Jeffrey Hirt, Linda Hirt and Samantha "yell at each other" while in the presence of facility residents. Resident D stated Jeffrey Hirt, Linda Hirt and Samantha swear at each other a lot and "don't get along". Linda Hirt, Jeffrey Hirt and Samantha Hirt each denied engaging in loud verbal altercations while working in front of residents. A preponderance of evidence was discovered during the special investigation to substantiate a violation of the applicable rule as a result of Mr. and Mrs. Hurt engaging in loud arguments in the presence of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff allowed Resident A to have access to knives despite being placed on "suicide watch".

INVESTIGATION: On 04/28/2022 I received complaint allegations from Adult Protective Services Centralized intake. The complaint alleged that Licensee Jeffrey Hirt, Licensee Linda Hirt, and staff Samantha Hirt allowed Resident D "access to several knives and is not supervised, despite having a history of multiple suicide attempts".

On 04/29/2022 I completed an unannounced onsite investigation at the facility and privately interviewed Linda Hirt, Samantha Hirt, and Resident D.

Linda Hirt stated Resident A was assessed by Dr. Marrouf and determined to be "suicidal" and Dr. Marrouf informed her that Resident A was to be placed on a "seventy-two hour suicide watch" from 04/21/2022 until 04/24/2022. Ms. Hirt stated that this directive by Dr. Marrouf was made verbally and no documentation regarding the directive was provided. Ms. Hirt acknowledged from 04/21/2022 until 04/24/2022 Resident A was allowed to do the facility's dishes and have access to knives. Ms. Hirt acknowledged that from 04/21/2022 until current the facility's knives were not restricted from residents' access. Ms. Hirt stated the facility's knives have always been and are currently unlocked in the facility's kitchen drawer. Ms. Hirt acknowledged that Resident A had access to the knives without staff present because they were not locked in the kitchen. Ms. Hirt stated Resident A's previous suicide attempts never involved knives, but rather swallowing things that could hurt her. Ms. Hirt stated it did not occur to her to secure the knives, and this was something she overlooked.

Linda Hirt's daughter and facility staff Samantha Hirt confirmed that from 04/21/2022 until 04/24/2022 Resident A was allowed to do the facility's dishes and have access to knives. Samantha Hirt stated the facility's knives have always been unlocked in the facility's kitchen drawer.

Resident A stated she was placed on “suicide watch” by her physician for two days. Resident A stated during the two days she was allowed unrestricted access to the facility’s knives which are located in an unlocked kitchen drawer. Resident A stated she washed the dishes multiple times during the two-day period which allowed her access to the facility’s knives.

While onsite I observed three knives were located in an unlocked kitchen drawer.

On 05/02/2022 I interviewed Jeffrey Hirt via telephone. Mr. Hirt stated he last worked at the facility on 04/21/2022 and was unsure if Resident A had access to knives during her “suicide watch”. Mr. Hirt stated that “sometimes the knives are locked up and sometimes they are not”. Mr. Hirt acknowledged it was a mistake to allow Resident A unsupervised access to knives while she was on suicide watch.

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Ms. Hirt stated she disputes the rule violation substantiation of R 400.14305 (3). Ms. Hirt stated facility knives are typically “put away in the laundry room” of the facility in an unlocked cabinet however the knives happened to be in the kitchen unlocked drawer the day of the LARA onsite inspection. Ms. stated Resident A no longer resides at the facility.

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:	Licensee Linda Hirt stated Resident A was assessed by Dr. Marrouf and found to be “suicidal” and Dr. Marrouf verbally placed Resident A on a seventy-two hour suicide watch from 04/21/2022 until 04/24/2022. Ms. Hirt acknowledged that despite being on suicide watch from 04/21/2022 until 04/24/2022, Resident A was still allowed to do the facility’s dishes and have access to knives. Staff Samantha Hirt stated Resident A confirmed she was allowed access to knives from 04/21/2022 until 04/24/2022 despite being on suicide watch. Resident A stated she was placed on “suicide watch” by her physician for two days. Resident A stated during the two days she was allowed unrestricted access to the facility’s knives which are located in an unlocked kitchen drawer.

	A preponderance of evidence was discovered through this special investigation to substantiate a violation of the applicable rule as a result of Resident A having access to knives despite being placed on “suicide watch”.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **See Special Investigation 2022A0583018**

ALLEGATION: Residents were emotionally traumatized when Licensee Jeffrey Hirt physically assaulted a dog while in their presence.

INVESTIGATION: On 04/28/2022 I received complaint allegations from Adult Protective Services Centralized intake. The complaint alleged that on one occasion Licensee Jeffrey Hirt picked up a small dog and proceeded to punch the dog in the ribs three times in front of the residents.

On 04/29/2022 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Linda Hirt, staff Samantha Hirt, Resident A, Resident B, Resident C, and Resident D.

Linda Hirt stated she and Jeffrey Hirt drove facility residents to a local park in the facility’s van. Ms. Hirt stated she allowed their personal “Yorkipoo” named “Sikka” to ride in the van with residents to the local park. Ms. Hirt stated while at the park Sikka jumped “excitedly” onto Resident D’s chest while they were still in the van and accidentally scratched Resident D’s chest. Ms. Hirt stated Jeffrey Hirt “grabbed Sikka by the scruff of her neck” and proceeded to “spank” her on the butt one time. Ms. Hirt stated the dog was not injured.

Staff Samantha Hirt stated she was not present during the incident however she has observed the dog to be uninjured since the incident.

Resident A stated facility residents recently went to a local park and Linda and Jeffrey Hirt’s dog “Sikka” came along. Resident A stated Sikka became “excited” while in the van and proceeded to jump onto Resident D’s chest. Resident A stated Jeffrey Hirt yelled at the dog to “get down, get down”. Resident A stated Jeffrey Hirt grabbed the dog and “punched” the dog “three times in the butt”. Resident A stated the dog yelped but appeared uninjured.

Resident B stated facility residents recently went to a local park and Linda and Jeffrey Hirt’s dog “Sikka” accompanied them. Resident B stated Sikka became “excited” while in the van and proceeded to jump onto Resident D’s chest. Resident B stated Jeffrey Hirt “slapped” the dog “hard multiple times”. Resident B stated the dog “whined” after the incident occurred.

Resident C stated he has not observed Jeffrey Hirt strike the dog at any time.

Resident D stated facility residents recently went to a local park and Linda and Jeffrey Hirt's dog "Sikka" accompanied them. Resident D stated Sikka became "hyper" and jumped onto her chest. Resident D stated Jeffrey Hirt grabbed the dog "by the neck" and proceeded to "punch" the dog "three times in the ribs".

On 05/02/2022 I interviewed Jeffrey Hirt via telephone. Mr. Hirt stated their family dog named "Sikka" had jumped onto Resident D while Resident D was sitting in the facility's van because the dog "wanted attention". Mr. Hirt stated the dog is of small stature weighing approximately seven pounds. Mr. Hirt stated he grabbed the dog "by the scruff" of the dog's neck and proceeded to "spank" the dog one time with an open hand. Mr. Hirt stated he told the dog "no" and she was not injured. Mr. Hirt stated the dog "yelped a little bit" after he spanked the dog.

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Linda Hirt stated she agreed with the findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Linda Hirt stated that while in the presence of facility residents, Jeffrey Hirt grabbed their small dog "by the scruff of her neck" and proceeded to "spank" the dog on the butt one time. Resident A stated Jeffrey Hirt grabbed the dog and "punched" the dog "three times in the butt". Resident B stated Jeffrey Hirt "slapped" the dog "hard multiple times". Resident B stated the dog "whined" after the incident occurred. Resident D stated Jeffrey Hirt grabbed the dog "by the neck" and proceeded to "punch" the dog "three times in the ribs". Jeffrey Hirt stated he grabbed the dog "by the scruff" of the dog's neck and proceeded to "spank" the dog one time with an open hand. Mr. Hirt stated he told the dog "no" and she was not

	injured. Licensee Jeffrey Hirt stated the dog “yelped a little bit” after he spanked the dog. A preponderance of evidence was not discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered during the Special Investigation does not indicate that residents experienced emotional trauma as a result of the incident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility’s medication cart is left unlocked at night.

INVESTIGATION: On 04/28/2022 I received complaint allegations from Adult Protective Services Centralized intake. The complaint alleged that the facility's medication cart is left out and unlocked overnight.

On 04/29/2022 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Linda Hirt, staff Samantha Hirt, Resident A, Resident B, Resident C, and Resident D.

Both Linda Hirt and Samantha Hirt stated the facility’s medication cart is never left unlocked at night or at any other time.

Resident A, Resident B and Resident C each stated they have never observed the facility’s medication cart left unlocked at night or at any other time.

Resided D stated she has observed the facility’s medication cart unlocked “multiple times” after staff have administered evening medications.

On 05/02/2022 I interviewed Licensee Jeffrey Hirt via telephone. Mr. Hirt stated the facility’s medication cart is never left unlocked at night.

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Ms. Hirt stated she agreed with the findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the

	requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resided D stated she has observed the facility's medication cart unlocked "multiple times" after staff have administered evening medications. Linda Hirt, Jeffrey Hirt and Samantha Hirt each stated the facility's medication cart is never left unlocked at night or at any other time. Resident A, Resident B and Resident C each stated they have never observed the facility's medication cart left unlocked at night or at any other time. A preponderance of evidence was not discovered during the special investigation to substantiate a violation of the applicable rule. Evidence discovered through the Special Investigation does not support the allegation that the facility's medication cart is left unlocked.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility residents are underfed.

INVESTIGATION: On 04/28/2022 I received complaint allegations from Adult Protective Services Centralized intake. The complaint alleged that "one of the residents has lost 13 pounds in the last month due to being underfed".

On 04/29/2022 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Linda Hirt, staff Samantha Hirt, Resident A, Resident B, Resident C, and Resident D.

Licensee Linda Hirt stated residents are provided three nutritious meals daily plus snacks that are of proper nutrition and size. Ms. Hirt stated she follows the posted menu and "no substitutions have been made in a month". Ms. Hirt stated that when the menu states "sandwich" that would include "an egg salad sandwich or tuna sandwich. Ms. Hirt stated Resident B has lost since entering the facility because Resident B is "overweight" and "wants to lose weight. Ms. Hirt stated residents are weighted monthly.

Staff Samantha Hirt stated residents are provided three nutritious meals daily plus snacks that are of proper nutrition and size. Samantha Hirt stated she follows the

posted menu however substitutions are made and documented. Samantha Hirt stated residents are weighed monthly and she has observed no indication of residents losing an excessive amount of weight.

Resident A stated he has lost approximately five pounds since residing at the facility for “a month and a half” due to not getting enough food. Resident A stated he is served small portion sizes and facility staff do not follow the posted menu.

Resident B stated she has lost some weight because residents are not provided with enough food. Resident B stated facility staff don’t follow the menu because they often run out of grocery items. Resident B stated they are often served “banquet meals” and “a lot of cereal”.

Resident C stated he is happy with the food provided and feels it is of adequate portion size. Resident C stated facility staff do offer substitutions from the posted menu on occasion.

Resident D stated she has lost weight since residing at the facility for approximately two months. Resident D stated facility staff are not feeding residents enough and the portion sizes are too small. Resident D stated facility staff do not follow the posted menu. Resident D stated recently residents were supposed to be served lasagna but were instead served only soup.

While on site I observed groceries for the facility had just been purchased that morning. I observed an adequate amount of food in the facility’s kitchen including frozen personal pizzas and frozen chicken nuggets.

While onsite I observed the facility’s posted menu. I observed Sunday’s meals include cereal and cranberry juice for breakfast, Mac and cheese and pizza for lunch, ribs and veggie for dinner. I observed Monday’s meals include bagels and apple juice for breakfast, sandwiches and pudding for lunch, and spaghetti and meatballs and veggie for dinner. I observed Friday’s meals include cereal and OJ for breakfast, rigatoni and pudding for lunch, and hamburger helper and veggie for dinner.

On 05/02/2022 I interviewed Licensee Jeffrey Hirt via telephone. Mr. Hirt stated residents are provided three nutritious meals daily plus healthy snacks. Mr. Hirt stated residents are provided adequate portion sizes. Mr. Hirt stated facility staff follow the posted menu but “occasionally” offer substitutions that are documented. Mr. Hirt stated Resident B is losing weight “because she needs to eat better and is overweight”. Mr. Hirt stated Resident B would like more access to unhealthy foods however it is in her best interest to eat healthier because she has diabetes.

On 05/04/2022 I reviewed an email from Linda Hirt. The email contained the weight records for Resident A, Resident B, Resident C, Resident D and a meal substitution form. Resident A was first weighed at the facility on 03/11/2022 and was recorded to

weigh 161.8 lbs. Resident A was last weighed on 04/29/2022 and was recorded to weigh 163.5 lbs. Resident A has gained 1.7 lbs. in approximately a month and a half. Resident B was first weighed at the facility on 03/11/2022 and was recorded to weigh 266 lbs. Resident B was last weighed at the facility on 04/29/2022 and was recorded to weigh 253.4 lbs. Resident B has lost 12.6 lbs. in approximately a month and a half. Resident C was first weighed at the facility on 02/25/2022 and was recorded to weigh 161.8 lbs. Resident C was last weighed at the facility on 04/29/2022 and weighed 164.8 lbs. Resident C has gained 3 lbs. in two months. Resident D was first weighed at the facility on 02/14/2022 and was recorded to weigh 151.6 lbs. Resident D was last weighed at the facility on 04/29/2022 and weighed 155.2 lbs. Resident D has gained 3.6 lbs. in two months.

I reviewed the facility's meal substitution form which was blank.

On 05/04/2022 I received an email from Linda Hirt stating that the facility's meal substitution form is blank because "we have never had to use it that's why it's blank".

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Ms. Hirt stated she agreed with the findings.

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:	In reviewing resident weights, it was noted that three of the four residents in the home have gained weight since the home was opened. Resident A stated he is served small portion sizes and facility staff do not follow the posted menu. Resident B stated she has lost some weight because residents are not provided enough food. Resident B stated facility staff don't follow the menu because they often run out of grocery items. Resident B stated they are often served "banquet meals" and a lot of cereal. Resident D stated facility staff are not feeding residents enough and the portion sizes are too small. Resident D stated facility staff do not follow the posted menu. Resident D stated recently residents were supposed to be served lasagna but were instead served only soup.

	A preponderance of evidence was not discovered through this special investigation to substantiate a violation of the applicable rule. Evidence discovered through this Special Investigation does not support the allegation that residents are “underfed”.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: More than fourteen hours elapsed between the evening and morning meal.

INVESTIGATION: While onsite 04/29/2022 Licensee Linda Hirt acknowledged that more than fourteen hours elapsed between the evening and morning meal. Ms. Hirt stated facility residents were served dinner on 04/28/2022 at 6:30 PM and served breakfast on 04/29/2022 at 9:45 AM.

Resident D stated residents were served dinner on 04/28/2022 at approximately 6:30 PM and served breakfast on 04/29/2022 at 10:00 AM.

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Ms. Hirt stated she agreed with the substantiation of rule violation R 400.14313 (1). Ms. Hirt stated the incident of “was a onetime occurrence”.

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 D stated facility residents were served dinner on 04/28/2022 at approximately 6:30 PM and served breakfast on 04/29/2022 at 10:00 AM. Licensee Linda Hirt acknowledged facility residents were served dinner on 04/28/2022 at 6:30 PM and served breakfast on 04/29/2022 at 9:45 AM. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates that more than 14 hours elapsed between 4/28/2022 dinner and 04/29/2022 breakfast.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Meals lack proper nutrition.

INVESTIGATION: While onsite 04/29/2022 Licensee Linda Hirt stated residents are provided three nutritious meals daily plus snacks that are of proper nutrition and size. Ms. Hirt stated she follows the posted menu and “no substitutions have been made in a month”. Ms. Hirt stated that when the menu states “sandwich” that would include “an egg salad sandwich or tuna sandwich.

Staff Samantha Hirt stated residents are provided three nutritious meals daily plus snacks that are of proper nutrition and size. Samantha Hirt stated she follows the posted menu however substitutions are made and documented.

Resident A stated he is served small portion sizes and facility staff do not follow the posted menu.

Resident B stated facility staff don’t follow the menu because they often run out of grocery items. Resident B stated they are often served “banquet meals” and “a lot of cereal”.

Resident C stated he is happy with the food provided and feels it is of adequate portion size. Resident C stated facility staff do offer substitutions from the posted menu on occasion.

Resident D stated facility staff are not feeding residents enough and the portion sizes are too small. Resident D stated facility staff do not follow the posted menu. Resident D stated recently residents were supposed to be served lasagna but were instead served only soup.

While on site I observed groceries for the facility had just been purchased that morning. I observed an adequate amount of food in the facility’s kitchen including frozen personal pizzas and frozen chicken nuggets.

While onsite I observed the facility’s posted menu. I noted the menu lacks specificity of meals and does not follow 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. I observed Sunday’s meals include cereal and cranberry juice for breakfast, Mac and cheese and pizza for lunch, ribs and veggie for dinner. I observed Monday’s meals include bagels and apple juice for breakfast, sandwiches and pudding for lunch, and spaghetti and meatballs and veggie for dinner. I observed Friday’s meals include cereal and OJ for breakfast, rigatoni and pudding for lunch, and hamburger helper and veggie for dinner.

On 05/02/2022 I interviewed Licensee Jeffrey Hirt via telephone. Mr. Hirt stated residents are provided three nutritious meals daily plus healthy snacks. Mr. Hirt stated residents are provided adequate portion sizes. Mr. Hirt stated facility staff

follow the posted menu but “occasionally” offer substitutions that are documented. Mr. Hirt stated Resident B is losing weight “because she needs to eat better and is overweight”. Mr. Hirt stated Resident B would like more access to unhealthy foods however it is in her best interest to eat healthier because she has diabetes.

I reviewed the facility’s meal substitution form which was blank.

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Ms. Hirt stated she agreed with the substantiation of rule violation R 400.14313 (2). Ms. Hirt stated she has since redone the facility’s food menus to align with nutritional guidelines akin to the rule.

APPLICABLE RULE	
R 400.14313	**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:	The menu lacks specificity of meals and does not follow 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. Sunday’s meals include cereal and cranberry juice for breakfast, Mac and cheese and pizza for lunch, ribs and veggie for dinner. Monday’s meals include bagels and apple juice for breakfast, sandwiches and pudding for lunch, and spaghetti and meatballs and veggie for dinner. Friday’s meals include cereal and OJ for breakfast, rigatoni and pudding for lunch, and hamburger helper and veggie for dinner. Resident A stated he is served small portion sizes and facility staff do not follow the posted menu. Resident B stated facility staff don’t follow the menu because they often run out of grocery items. Resident B stated they are often served “banquet meals” and “a lot of cereal”.

	Resident C stated he is happy with the food provided and feels it is of adequate portion size. Resident C stated facility staff do offer substitutions from the posted menu on occasion. Resident D stated facility staff are not feeding residents enough and the portion sizes are too small. Resident D stated facility staff do not follow the posted menu. Resident D stated recently residents were supposed to be served lasagna but were instead served only soup. A preponderance of evidence was discovered through this special investigation to substantiate a violation of the applicable rule. Evidence discovered during the Special Investigation indicates meals provided to resident lack proper nutrition.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Menu substitutions are not noted.

INVESTIGATION: While onsite 04/29/2022 Licensee Linda Hirt stated she follows the posted menu and “no substitutions have been made in a month”.

Staff Samantha Hirt stated she follows the posted menu however substitutions are made and documented.

Resident A stated facility staff do not follow the posted menu.

Resident B stated facility staff don’t follow the menu because they often run out of grocery items.

Resident C stated facility staff do offer substitutions from the posted menu on occasion.

Resident D stated facility staff do not follow the posted menu. Resident D stated recently residents were supposed to be served lasagna but were instead served only soup.

On 05/02/2022 I interviewed Licensee Jeffrey Hirt via telephone. Mr. Hirt stated facility staff follow the posted menu but “occasionally” offer substitutions that are documented.

On 05/04/2022 I reviewed an email from Linda Hirt. The email contained a meal substitution form which was blank.

On 05/04/2022 I received an email from Linda Hirt stating that the facility's meal substitution form is blank because "we have never had to use it that's why it's blank".

On 05/24/2022 I completed an Exit Conference with Licensee Linda Hirt via telephone. Ms. Hirt stated she agreed with the substantiation of rule violation R 400.14313 (4). Ms. Hirt stated she was not aware that other staff were making food substitutions prior to the special investigation.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Staff Samantha Hirt stated she follows the posted menu however substitutions are made and documented. Resident A, B and D stated facility staff do not follow the posted menu. Resident C stated facility staff do offer substitutions from the posted menu on occasion. Licensee Jeffrey Hirt stated facility staff follow the posted menu but "occasionally" offer substitutions that are documented. Licensee Linda Hirt documented in an email that the facility's meal substitution form is blank because "we have never had to use it that's why it's blank". A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates that menu substitutions are not noted.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend revocation of the Adult Foster Care license.

05/24/2022

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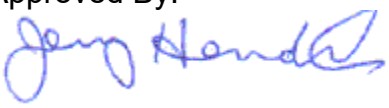
Toya Zylstra Date
Licensing Consultant

Approved By:



05/24/2022

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Jerry Hendrick Date
Area Manager