GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 4, 2022

Clara Schultheis
Agape Care Systems Inc
3060 Van Geisen Rd
Caro, MI 48723

RE: License #: AS790088128
Investigation #: 2022A0572055
Agape Care Systems Inc.

Dear Mrs. Bristow:

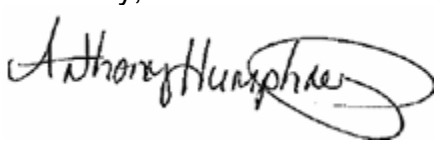
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS790088128
Investigation #:	2022A0572055
Complaint Receipt Date:	09/16/2022
Investigation Initiation Date:	09/16/2022
Report Due Date:	11/15/2022
Licensee Name:	Agape Care Systems Inc
Licensee Address:	3060 Van Geisen Rd Caro, MI 48723
Licensee Telephone #:	(989) 673-7360
Administrator:	Clara Schultheis
Licensee Designee:	Clara Schultheis
Name of Facility:	Agape Care Systems Inc.
Facility Address:	3060 Van Geisen Road Caro, MI 48723
Facility Telephone #:	(989) 673-7360
Original Issuance Date:	11/03/1999
License **Status:**	REGULAR
Effective Date:	07/23/2022
Expiration Date:	07/22/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Was informed by Resident A on 09/13/2022, that licensee, Tanya Bristow was taking Resident A's pain medication (Norco) and replacing with Tylenol. He reported the incident took place "about 6 weeks ago". Administrator for Agape confirmed incident did happen and that Ms. Bristow admitted to it. The Administrator stated, "I told her she either had to resign and sign the license over in my name or I would fire her". Tanya resigned and is no longer working at the home. This issue is no longer going on.	**Yes**
The AFC Home is limiting Resident A's food access and refusing to give him seconds at mealtime if he asks for it. It is unknown if it is due to one of his medical conditions or for another reason.	No
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

09/16/2022	Special Investigation Intake 2022A0572055
09/16/2022	APS Referral. APS is involved in investigation.
09/16/2022	Special Investigation Initiated - Letter APS, Tyler Erla.
09/16/2022	Contact - Telephone call made APS, Tyler Erla.
09/19/2022	Inspection Completed-BCAL Sub. Compliance
09/19/2022	Inspection Completed On-site Staff, Denise Stine, Staff, Amanda Brill, Resident A and Resident B.
11/02/2022	Contact - Face to Face Administrator, Clara Schultheis.
11/02/2022	Contact - Face to Face Staff, Amanda Brill.

11/02/2022	Contact - Telephone call made Ex-Licensee Designee; Tonya Bristow.
11/02/2022	Exit Conference Clara Schltheis, in place of Tonya Bristow.
11/03/2022	Contact - Telephone call made APS Investigator, Tyler Erla.
11/03/2022	Contact - Telephone call made Chief Simmenson.

ALLEGATION:
Was informed by Resident A on 09/13/2022, that licensee, Tanya Bristow was taking Resident A's pain medication (Norco) and replacing with Tylenol. He reported the incident took place "about 6 weeks ago".

INVESTIGATION:
On 09/16/2022, the local licensing office received a complaint for investigation. APS and law enforcement were also involved with their own investigation.

On 09/16/2022, contact was made with APS Investigator, Tyler Erla regarding the investigation. He informed that it appears to be true as the Licensee Designee has admitted that she took Resident A's pain medication and replaced them with Tylenol.

On 09/19/2022, an unannounced onsite was made at Agape Care Systems, located in Tuscola County Michigan. Interviewed were, Staff, Denise Stine, Staff, Amanda Brill, Resident A and Resident B.

On 09/19/2022, I interviewed Resident A regarding the allegation. He informed that it was true that Licensee Designee, Tanya Bristow switched his medication with Tylenol. He explained that Staff, Amanda Brill was working in the afternoon, and she was preparing to administer his medications. The medications were obviously not the same and he has taken them for so long, that he questioned the look of them. Him and Ms. Brill went online to see what type of pill he had, and it was the Tylenol.

On 09/19/2022, I interviewed Staff, Amanda Brill regarding the allegation. She informed that she was working on 08/04/2022 and there were 6 Norcos left, but on Friday when she was preparing Resident A's meds, there were 11 pills. She suspected something was wrong because they looked different, and it was more than he had before. She noticed pills had come up missing before but didn't think nothing of it, but this time it was more obvious, and she knew that this was intentional. Being that she knew what Resident A had left in his pill bottle the day before, made it even more obvious to her. She let Administrator, Clara Schultheis

who is also the owner of the corporation know what happened and she had Ms. Brill and Ms. Bristow get drug tested that Monday, on 08/08/2022. Ms. Brill passed but Ms. Bristow tested positive. Ms. Bristow admitted that she took the medication. Ms. Brill was interviewed by Chief Simmonson and APS Investigator, Tyler Erla on 09/15/2022. Ms. Bristow was forced to resign. Ms. Schultheis is moving back into the role of the Licensee Designee. They are switching to bubble packs and the medications have been good since Ms. Bristow is no longer employed.

On 09/19/2022, I interviewed Staff, Denise Stine regarding the allegation. She informed that she was not working at the time but heard that Ms. Bristow had taken Resident A's pills. She is unaware if this has happened before. She informed that Ms. Bristow is no longer employed at the facility.

On 09/19/2022, I reviewed all of the residents' medications and they appeared to be in order. Staff, Amanda Brill informed that when she found that the medications were switched, she deposed of the Tylenol because it was not prescribed to anyone in the home. The residents are switching to bubble packs next month.

On 11/02/2022, an unannounced onsite was conducted at Agape Care Systems. Contact was made with Administrator, Clara Schultheis regarding the allegation. She informed that it was a hard thing to do in letting her daughter, Ms. Bristow, go from the company. She indicated that after Ms. Bristow did not pass the drug test, as she tested positive for Opiates and THC. She then gave her an ultimatum which was either to resign or she would terminate her employment and she chose to resign. She initially heard it from Staff, Amanda Brill and then later from Resident A. Law Enforcement were contacted she believes by Region 7 and she was interviewed by officers. Law Enforcement told her that she did the right thing by removing Ms. Bristow from the company. As of now, Law Enforcement has been unable to reach Ms. Bristow. Ms. Bristow has obtained a lawyer and her attorney has advised her not to speak to law enforcement unless he is present.

On 09/19/2022, I reviewed the Incident Report regarding the allegation. Ms. Brill was getting Resident A's meds ready for 6pm, but when she opened his pill bottle, she found Tylenol 500 in the bottle instead of Norco. The action taken by Ms. Brill was contacting her boss, Ms. Clara Schultheis. The Corrective Measure was staff were to take a substance abuse test and they are switching to the bubble packs.

On 11/02/2022, contact was made with Ms. Tonya Bristow regarding the allegation. She informed that she does not believe that she can answer any of my questions regarding the allegation due to the advise of her legal counsel.

On 11/03/2022, contact was made with APS Investigator, Tyler Erla. He informed that he has enough evidence to substantiate. He had spoken to Law Enforcement and the officer informed that charges will be brought and sent to the Prosecutor's Office. He has completed all of his interviews but has been unable to interview Ms. Tonya Bristow.

On 11/03/2022, contact was made with Chief Simmenson. He informed that he interviewed the owner, Clara Schultheis, staff and Resident A. He informed that Ms. Tonya Bristow will be formally charged and following up with the prosecutor's office and completing the Police Report is on his to-do-list. He informed that he was unable to interview Ms. Bristow because she obtained an attorney.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The Licensee Designee, Tonya Bristow failed a substance abuse test after being accused of switching Resident A's Norcos with Tylenol 500. She currently has an attorney and is not answering questions for this investigation. Staff and Resident A both indicated that it was true, and they both noticed that the pills appear to look different and found that they were different once they researched it online. Ms. Brill also remember how many Norco pills that Resident A had on the day before. The next day he had a different amount of pills and they were a different medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the 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: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Former Licensee Designee, Tonya Bristow used Resident A's prescribed Norco medication for her own personal use. She is not suitable to provide supervision and care to vulnerable adults.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
The AFC Home is limiting Resident A's food access and refusing to give him seconds at mealtime if he asks for it. It is unknown if it is due to one of his medical conditions or for another reason.

INVESTIGATION:
On 09/19/2022, I interviewed Resident A regarding the allegation. He informed that Ms. Clara Schultheis is telling staff not to feed them seconds, but it's kind of hard not to think that this isn't directed towards him because he is the only resident who has the capacity to question things that goes on at the home. Resident A informed that he is diabetic and have to watch what he eats, such as carbs, but there are no dietary needs. Resident A had a recent leg amputation due to his diabetic condition.

On 09/19/2022, I interviewed Staff, Amanda Brill regarding the allegation. She informed that Resident A does not receive a set diet and there is plenty of food. If he wants more food, he can get it. They just have to watch what he eats as he is diabetic.

On 09/19/2022, I interviewed Resident B regarding the allegation. He informed that there is plenty of food for them to eat. Resident B indicated that he was 130 pounds when he first moved into the home and he's now 187 pounds, so he never goes hungry.

On 09/19/2022, I observed Resident A and other residents eating a meal. It appears that they were having a sandwich and chips. Resident A did not ask for seconds.

On 09/19/2022, I interviewed Staff, Denise Stine regarding the allegation. She informed that she gives Resident A a second helping all the time. There is plenty of food and the residents do not go hungry. She does have to watch his blood sugar levels because he is diabetic, so they offer sugar-free Jell-O. Ms. Stine showed me where all the food was in the home. There was a fruit and vegetable freezer, two extra freezers in the garage and another freezer in the pole barn. An oversized pantry and a freezer/refrigerator in the kitchen. There was more than enough food at the facility.

On 11/02/2022, I interviewed Administrator, Clara Schultheis regarding the allegation. She informed that the residents gets seconds all the time. They have plenty of food throughout the home and don't want it to go to waste. She informed that Resident A's weight record would show that he is not going hungry.

On 11/02/2022, I reviewed Resident A's Weight Record. On 02/01/2022, Resident A weighed 355 pounds and has gradually gone up to 380 pounds.

On 11/02/2022, I reviewed Resident A's Health Care Appraisal and it indicates that he is on a Healthy Heart Diet. Ms. Schultheis informed that they must watch his carbs and meat should be the size of the palm of his hands.

On 11/02/2022, I interviewed Ms. Tonya Bristow regarding the allegation. She informed that Resident A always got seconds when she worked there and denies that any residents are going hungry. She is not aware of any staff or Ms. Schultheis denying any residents of second helpings as there is plenty to eat.

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 A informed that he is not getting seconds when asked. Staff, Resident B, Ms. Schultheis and former Licensee Designee, Tonya Bristow denies this allegation, and all indicated that there is plenty to eat at the home. In review of Resident A's Weight Record, he has gained 25 pounds in the 9 months that he has resided at the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/02/2022, an Exit Conference was held with Administrator, Clara Schultheis in place of Tonya Bristow. She was informed of the violation and that she would have to send me a corrective action plan within 15 days of receipt of this special investigation report.

IV. RECOMMENDATION

I recommend that no changes be made to the license of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (Capacity 1-6).

11/04/2022

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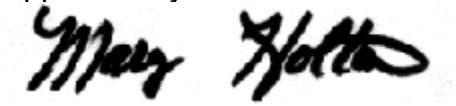
Anthony Humphrey Date
Licensing Consultant

Approved By:



11/04/2022

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Mary E. Holton Date
Area Manager