GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 30, 2023

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

RE: License #: AS410405484
Investigation #: 2023A0583017
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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS410405484
Investigation #:	2023A0583017
Complaint Receipt Date:	01/24/2023
Investigation Initiation Date:	01/24/2023
Report Due Date:	02/23/2023
Licensee Name:	Linda Hirt and Jeffrey Hirt
Licensee Address:	6920 Austhof Woods Dt 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:	1ST PROVISIONAL
Effective Date:	08/10/2022
Expiration Date:	02/09/2023
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

Violation

	Established?
Licensees Jeffrey and Linda Hirt direct Resident A to sit on the floor of the facility for punishment.	Yes
Facility residents are not provided an adequate diet.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/24/2023	Special Investigation Intake 2023A0583017
01/24/2023	APS Referral
01/24/2023	Special Investigation Initiated - Telephone APS Kevin Souser
01/24/2023	Contact - Telephone call made Audrey Kaptein
01/25/2023	Inspection Completed On-site
01/26/2023	Contact - Document Received Licensee Linda Hirt
01/26/2023	Contact - Telephone call received APS Kevin Souser
01/26/2023	Contact – Telephone Workforce Background Check
01/27/2023	Contact – Email Licensee Linda Hirt
01/27/2023	Contact – Email Staff Rachil Ezinga
01/27/2023	Contact – Telephone Relative 1
01/30/2023	Contact – Telephone Professional Guardian Veronica Smith

ALLEGATION: Licensees Jeffrey and Linda Hirt direct Resident A to sit on the floor of the facility for punishment.

INVESTIGATION: On 01/24/2023, I received complaint allegations from Adult Protective Services Staff Kevin Souser via telephone. Mr. Souser stated he was assigned to investigate the complaint allegations and has referred the allegations to the Kent County Sheriff's Department. Mr. Souser stated the Kent County Sheriff's Department has reported they will not be investigating the complaint allegations until a review of the completed Adult Protective Services investigation warrants such action. Mr. Souser stated complaint allegations stated that an unnamed male resident "is made to sit on the floor as a form of punishment".

On 01/24/2023, I interviewed Staff Audrey Kaptein via telephone. Ms. Kaptein stated she has worked at the facility since "September/October 2022". Ms. Kaptein stated Resident A often attempts to eat cat poop from a cat litter pan, dog poop from the facility floor, cat food, trash from a trashcan, sugar packets, and other items. Ms. Kaptein stated approximately two weeks ago she was working downstairs in the facility and came upstairs to hear Licensees Jeffrey and Linda Hirt stating that Resident A had gotten into cat food. Ms. Kaptein stated she observed Mr. and Mrs. Hirt tell Resident A he could no longer use his lazy boy recliner chair located in the facility common living room area and Resident A was forced to sit on the floor. Ms. Kaptein stated she heard Ms. Hirt state, "if Resident A can't keep his hands off things" Resident A was no longer allowed to sit in his recliner chair. Ms. Kaptein stated she observed Mr. Hirt "flip Resident A's recliner upside down" so that Resident A could no longer sit in the recliner chair. Ms. Kaptein stated Resident A has not been given access to the recliner chair since the incident and Resident A is forced to sit on the floor or a kitchen chair located next to the cat litter pan in the common living room. Ms. Kaptein stated the common living room does not contain a communal couch as residents are assigned individual recliner chairs.

On 01/25/2023, I completed an unannounced onsite investigation at the facility with Adult Protective Services Staff Kevin Souser. I interviewed Licensee Linda Hirt, Staff Rachil Ezinga, Resident A, Resident B, Resident C, and Resident D.

On 01/25/2023, Licensee Linda Hirt stated Resident A eats cat poop located in an uncovered liter pan in the common living room and trash from the trash receptacle. Ms. Hirt stated she has not removed the uncovered liter pan from the common living room because "what am I supposed to do with it?" Ms. Hirt stated each resident is supplied their own assigned recliner chairs located in the facility common living room area. Ms. Hirt stated there was an incident in which Resident A was observed "in the cat food" which is also housed in the common living room area. Ms. Hirt stated she and Mr. Hirt took Resident A's recliner chair away "for a day" and the recliner chair was given back to Resident A the following day. Ms. Hirt stated while the recliner was "taken away" for a day, Resident A was told to sit on a wood kitchen chair located next to Mr. Hirt "to be supervised" in the common living room area. Ms. Hirt stated during a separate incident Resident A urinated in his clothing while sitting

in his recliner and subsequently Mr. Hirt asked Resident A to sit on the floor until the chair could be cleaned. Ms. Hirt stated Resident A has access to his recliner chair and denied Resident A was forced to sit on a wooden kitchen chair or the floor as a consequence for behaviors.

On 01/25/2023, Staff Rachil Ezinga stated she has worked at the facility since 10/27/2022. Ms. Ezinga stated Resident A often eats cat poop, cat food, dog poop, and trash. Ms. Ezinga stated "a bunch of times" she has observed Licensees Jeffrey and Linda Hirt verbally reprimand Resident A for eating cat poop, cat food, dog poop, and trash. Ms. Ezinga stated that on one occasion Resident A was observed with cat food in his pockets and Mr. and Mrs. Hirt stated Resident A was no longer allowed to sit in his recliner as a consequence. Ms. Ezinga stated Resident A was told he could sit on the floor. Ms. Ezinga stated Resident A has not been given his recliner back since in the incident and is currently allowed to sit on a wooden kitchen chair located next to the cat litter pan in the common living room.

On 01/25/2023, Resident A stated he "got in the trash" and Licensees Jeffrey and Linda Hirt told Resident A to "sit on the floor" after the incident. Resident A stated he is now allowed to sit on a kitchen chair in the common living room area and he is no longer allowed to sit in his recliner chair. Resident A stated his back and buttocks "hurts" as a result of sitting on the kitchen chair. Resident A asked several times if Adult Protective Services Kevin Souser and me would ask Mr. and Mrs. Hirt to give Resident A his recliner back.

On 01/25/2023, Resident B stated Resident A eats cat litter and food from the trash because Resident A is hungry. Resident B stated on one occasion Resident B observed Licensees Jeffrey and Linda Hirt became upset with Resident A for eating cat food and in response informed Resident A he had to sit on the floor. Resident B stated Resident A is allowed to sit on the floor or a kitchen chair and is not allowed to sit in his recliner chair.

On 01/25/2023, Resident C stated he does not stay the facility often and does not know if Resident A is forced to sit on the floor of the facility.

On 01/25/2023, Resident D stated Resident A states he is hungry and often eats dog poop located on the facility floor, cat poop, and cat food. Resident D stated Resident A "has to sit on the floor" because Licensees Jeffrey and Linda Hirt "took away Resident A's lazy boy chair" after Resident A was observed eating cat food.

On 01/27/2023, I received an email from Licensee Linda Hirt. I reviewed the email contained Resident A's Assessment Plan for AFC Resident signed 08/23/2022. I reviewed the document does not indicate Resident A displays behaviors consistent with PICA. I reviewed the document states Resident A requires staff assistance with "Eating/Feeding" but does not identify what assistance is required.

On 01/27/2023, I interviewed Relative 1 via telephone. Relative 1 stated she is Resident D's sister and payee. Relative 1 stated that on 01/24/2023 she visited the facility for a "few minutes". Relative 1 stated she found it "odd" that Resident A was sitting separately from other residents seated in recliners chairs in the common living room. Relative 1 stated Resident A was sitting in a hard kitchen chair by himself by the wall of the common living room area.

On 01/30/2023, I interviewed professional public guardian Veronica Smith via telephone. Ms. Smith stated she has it the legal public guardian of Resident A, Resident B, Resident C, Resident E, and Resident F. Ms. Smith stated she has been Resident A's legal guardian for over a year, and she has been provided no documentation indicating Resident A has historically suffered from PICA. Ms. Smith stated approximately a week and a half ago Licensee Linda Hirt served Ms. Smith with a 30-Day discharge notice for Resident A due to his PICA behaviors. Ms. Smith stated she was in the process of securing a physical examination for Resident A to evaluate a "possible vitamin deficiency" which could be causing said behaviors. Ms. Smith stated Resident A has historically been "tall and slender" in stature.

A LARA file review indicates Special Investigation 2022A0583018 dated 03/28/2022 resulted in violation of R400.14305 (3) due to Mr. Hirt verbally mistreating residents. A Correction Action Plan signed by Licensees Jeffrey and Linda Hirt on 04/02/2022 indicated Mr. Hirt would attending counseling, trainings, and treat residents with an appropriate demeanor. A LARA file review further indicates Special Investigation 2022A0583026 dated 05/24/2022 resulted in repeat violation of R400.14305 (3) due to a facility resident being allowed access to knives despite being placed on "suicide watch". A Corrective Action Plan signed by Mr. and Mrs. Hirt on 08/10/2022 indicated sharps objects would be removed from resident access. A Provisional License was issued due to Special Investigation 2022A0583026.

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 there was an incident in which Resident A was observed "in the cat food" which is also housed in the common living room area. Ms. Hirt stated she and Mr. Hirt took Resident A's recliner chair away "for a day" and the recliner chair was given back to Resident A the following day.

	Staff Rachil Ezinga stated that on one occasion Resident A was observed with cat food in his pockets and Mr. and Mrs. Hirt stated Resident A was no longer allowed to sit in his recliner as a consequence. Ms. Ezinga stated Resident A was told he could sit on the floor. Ms. Ezinga stated Resident A has not been given his recliner back since in the incident and is currently allowed to sit on a wooden kitchen chair located next to the cat litter pan in the common living room. Resident A stated he "got in the trash" and Licensees Jeffrey and Linda Hirt told Resident A to "sit on the floor" after the incident. Resident A stated he is now allowed to sit on a kitchen chair in the common living room area and he is no longer allowed to sit in his recliner chair. Resident B stated on one occasion Resident B observed Licensees Jeffrey and Linda Hirt became upset with Resident A for eating cat food and in response informed Resident A he had to sit on the floor. Resident D stated Resident A "has to sit on the floor" because Licensees Jeffrey and Linda Hirt "took away Resident A's lazy boy chair" after Resident A was observed eating cat food. 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 Resident A was not treated with dignity as a result of being directed to sit on the facility floor and/or a kitchen chair for punishment.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2022A0583018 dated 03/28/2022.** **SIR # 2022A0583026 dated 05/24/2022.**

ALLEGATION: Facility residents are not provided an adequate diet.

INVESTIGATION: On 01/24/2023 I received complaint allegations from Adult Protective Services Staff Kevin Souser via telephone. Mr. Souser stated complaint allegations stated, "residents are getting tea for breakfast and one tv dinner for lunch and dinner".

On 01/24/2023 I interviewed staff Audrey Kaptein via telephone. Ms. Kaptein stated residents are provided multiple selections of breakfast foods including juice, coffee,

and oatmeal. Ms. Kaptein stated residents are served a “TV dinner” and vegetable for lunch daily. Ms. Kaptein explained a “TV dinner” as a “pizza meal” or “chicken nuggets”. Ms. Kaptein stated residents are served various items for dinner such as spaghetti. Ms. Kaptein stated she follows the posted menu but has made substitutions without documenting. Ms. Kaptein stated residents are provided snacks such as “dunakroos”. Ms. Kaptein stated meal portion sizes are “small” and residents should “get more” however “seconds are not” available.

On 01/25/2023, I completed an unannounced onsite investigation at the facility with Adult Protective Services Staff Kevin Souser. I interviewed Licensee Linda Hirt, Staff Rachil Ezinga, Resident A, Resident B, Resident C, and Resident D.

On 01/25/2023, 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 rarely makes substitutions. Ms. Hirt stated residents are rarely request a second helping of food and are provided such upon their requests. Ms. Hirt acknowledged residents are provided “tv dinners” regularly for lunch. Ms. Hirt stated residents are weighted monthly. Ms. Hirt stated the facility currently lacked any fresh fruit or vegetables.

On 01/25/2023, I observed the facility lacked any fresh fruit or vegetables. I observed the facility’s freezer was stocked with tv dinners and other prepared meals. I observed the facility menu appeared nutritionally adequate.

On 01/25/2023, Staff Rachil Ezinga stated “four out of seven days a week” residents are provided an adequate volume of food. Ms. Ezinga stated “sometimes” she does not follow the menu and she does not document food substitutions. Ms. Ezinga stated residents are routinely served “TV dinners” containing pizza or chicken nuggets. Ms. Ezinga stated “some residents complain” of hunger after meals however Licensees Jeffrey and Linda Hirt inform residents “you don’t get more” food.

On 01/25/2023, Resident A was interviewed. Resident A stated he receives an adequate amount of food.

On 01/25/2023, Resident B stated food is limited at the facility and lacks fresh ingredients. Resident B stated residents are routinely served tv dinners and portion sizes are “small”. Resident B stated residents are denied more than one small serving.

On 01/25/2023, Resident C was interviewed. Resident C stated that the “food is fine”.

On 01/25/2023, Resident D stated residents are “mostly tv dinners for lunch and dinner.” Resident D stated facility staff “warm up frozen meals” to serve to residents regularly. Resident D stated portion sizes are “small”, and residents are often “still

hungry”. Resident D stated in the past residents requested “seconds” however facility staff stated, “that is not allowed”.

On 01/27/2023, I received an email from Licensee Linda Hirt. I observed the email contained resident weight records from 08/02/2022 until 01/24/2023. I reviewed the weight records indicated Resident A lost 4 lbs., Resident B lost 7 lbs., Resident C lost 4 lbs., Resident D lost 10 lbs., and Resident F lost 1lb. I observed the weight record for Resident E from 09/06/2022 until 01/24/2023, Resident E lost 6 lbs..

On 01/27/2023, I interviewed Relative 1 via telephone. Relative 1 stated Resident D often complains of facility staff serving “banquet meals” often with a lack of fresh food and variety.

A LARA file review indicates Special Investigation 2022A0583026 dated 05/24/2022. resulted in violation of R400.14313 (1) due to more than 14 hours elapsing between 4/28/2022 dinner and 04/29/2022 breakfast. A Corrective Action Plan signed by Licensees Jeffrey and Linda Hirt on 08/10/2022 indicated meal times were changed to comply with licensing rules.

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:	Staff Audrey Kaptein stated meal portion sizes are “small” and residents should “get more” however “seconds are not” available. Staff Rachil Ezinga stated “four out of seven days a week” residents are provided an adequate volume of food. Ms. Ezinga stated residents are routinely served “TV dinners” containing pizza or chicken nuggets. Ms. Ezinga stated “some residents complain” of hunger after meals however Licensees Jeffrey and Linda Hirt inform residents “you don’t get more” food. Resident B stated food is limited at the facility and lacks fresh ingredients. Resident B stated residents are routinely served tv dinners and portion sizes are “small”. Resident B stated residents are denied more than one small serving.

	Resident D stated residents are “mostly tv dinners for lunch and dinner”. Resident D stated facility staff “warm up frozen meals” to serve to residents regularly. Resident D stated portion sizes are “small”, and residents are often “still hungry.” Resident D stated in the past residents requested “seconds” however facility staff stated, “that is not allowed.” While onsite I observed the facility lacked any fresh fruit or vegetables. I observed the facility’s freezer was stocked with tv dinners and other prepared meals. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates residents are not served nutritious meals of adequate portion.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2022A0583026 dated 05/24/2022.**

ADDITIONAL FINDINGS:

INVESTIGATION: While onsite on 01/25/2023 Licensee Linda Hirt stated Staff Audrey Kaptein has been working at the facility since 09/23/22 and a Workforce Background check has not been completed. Ms. Hirt stated Staff Rachil Ezinga has been working at the facility since 10/27/22 and a Workforce Background check has not been completed. Ms. Hirt stated a Staff Katie Hall has been working at the facility since 12/23/2022 and a Workforce Background check has not completed. Ms. Hirt stated she does not have profile and pin set up to access the Workforce Background check database.

On 01/26/2023 I completed an email audit and located a 12/02/2022 email sent to Licensee Linda Hirt educating her on the use of the Workforce Background Check system for direct care staff fingerprinting.

On 01/26/2023 I interviewed Workforce Background Staff via telephone. I was notified that Licensees Jeffrey and Linda Hirt had not completed Workforce Background Checks for Staff Audrey Kaptein, Staff Katie Hall, and Staff Rachil Ezinga. I was notified that the Workforce Background Check data indicates a request for fingerprinting of Ms. Kaptein, Ms. Hall, and Ms. Ezinga was made into the system today and fingerprinting appointments have been scheduled.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	As of 01/26/2023, a Workforce Background check had not been completed for Staff Audrey Kaptein, Staff Katie Hall, and Staff Rachil Ezinga. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates the licensee did not complete required workforce background checks on Staff Rachil Ezinga and Staff Katie Hall to ensure they do not have a criminal history.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While onsite on 01/25/2023 Licensee Linda Hirt stated Staff Rachil Ezinga was hired on 10/272023 and has never worked at the facility independently. Ms. Hirt stated Ms. Ezinga has not completed all required trainings. Ms. Hirt stated she could not recall the trainings Ms. Ezinga has completed to date.

On 01/25/2023, Staff Rachil Ezinga stated she was hired on 10/27/2023 and has worked at the facility independently “most mornings from 8:00 AM until 10:00 AM” and “occasional” evenings while Licensees Linda and Jeffrey Hirt “went out to dinner. Ms. Ezinga stated she has dispensed resident medications independently “most mornings” prior to completing medication administration training. Ms. Ezinga stated she has completed approximately “half” of the LARA required trainings.

Resident B and Resident D each stated Staff Rachil Ezinga has worked at the facility independently in the mornings and has dispensed residents’ medications during that time.

On 01/27/2023, I received an email from Staff Rachil Ezinga which I reviewed contained training verification forms. I observed Ms. Ezinga completed Reporting Requirements 01/27/2023, Personal Care, Supervision, and Protection 01/21/2023, Resident Rights 01/26/2023, Safety and Fire Prevention 01/25/2023, and Medication Administration 01/26/2023. I observed no training verifications were received for Cardiopulmonary Resuscitation, First Aid, and Prevention of Communicable Diseases.

On 01/27/2023, I received an email from Licensee Linda Hirt. I observed the email stated Staff Audrey Ezinga is “signed up for first aid cpr training on Feb 11 @ 9am @ New Ground”.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Licensee Linda Hirt stated staff Rachil Ezinga was hired on 10/272023 and has never worked at the facility independently. Ms. Hirt stated Ms. Ezinga has not completed all required trainings. Staff Rachil Ezinga stated she was hired on 10/27/2023 and has worked at the facility independently “most mornings from 8:00 AM until 10:00 AM” and “occasional” evenings while Licensees Linda and Jeffrey Hirt “went out to dinner. Ms. Ezinga stated she has dispensed resident medications independently “most mornings” prior to completing medication administration training. Ms. Ezinga stated she has completed approximately “half” of the LARA required trainings. Resident B and Resident D each stated Staff Rachil Ezinga has worked at the facility independently in the mornings and has dispensed resident’s medications during that time. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates Staff Rachil Ezinga has worked at the facility independently without completing required trainings.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 01/24/2023, I interviewed Staff Audrey Kaptein via telephone. Ms. Kaptein stated she was hired “September/October 2022” and has not completed a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of her physical health.

While onsite on 01/25/2023 Licensee Linda Hirt stated Staff Audrey Kaptein was hired on 09/23/2022 and Staff Rachil Ezinga was hired on 10/272023 and have been providing resident care since their hire. Ms. Hirt stated she has not received verification of either staff member’s physical health.

Staff Rachil Ezinga stated has not completed a physical health form and forwarded the document to Ms. Hirt.

On 01/27/2023, I received an email from Licensee Linda Hirt. I reviewed that the email stated Ms. Ezinga **“**is not able to get the medical release form signed until next week her Dr. is out”.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	Staff Audrey Kaptein stated she was hired “September/October 2022” and has not completed a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of her physical health. Licensee Linda Hirt stated Staff Audrey Kaptein was hired on 09/23/2022 and Staff Rachil Ezinga was hired on 10/272023 and have been providing resident care since their hire. Ms. Hirt stated she has not received verification of either staff member’s physical health.

	Staff Rachil Ezinga stated has not completed a physical health form and forwarded the document to Ms. Hirt. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates Staff Audrey Kaptein and Staff Rachil Ezinga have not completed a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 01/24/2023, I interviewed Staff Audrey Kaptein via telephone. Ms. Kaptein stated she was hired “September/October 2022” and has not completed a communicable tuberculosis test despite performing resident care since her date of hire.

While onsite on 01/25/2023 Licensee Linda Hirt stated Staff Audrey Kaptein was hired on 09/23/2022 and has been performing resident care since her hire date. Ms. Hirt stated she has not secured verification stating Ms. Kaptein has been tested for communicable tuberculosis.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.

ANALYSIS:	Staff Audrey Kaptein stated she was hired “September/October 2022” and has not completed a communicable tuberculosis test despite performing resident care since her date of hire. Licensee Linda Hirt stated Staff Audrey Kaptein was hired on 09/23/2022 and has been performing resident care since her hire date. Ms. Hirt stated she has not secured verification stating Ms. Kaptein has been tested for communicable tuberculosis. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates Staff Audrey Kaptein provides resident care despite not securing communicable tuberculosis testing.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While onsite on 01/25/2023 Staff Rachil Ezinga stated Licensees Jeffrey and Linda Hirt often threaten to take away Resident A’s meals and snacks as a consequence for eating cat food, dog food, and/or trash. Ms. Ezinga stated she has observed Mr. Hirt tell Resident A “Do you want lunch taken away, I already took your snack away” and “I’m taking your lunch away”. Ms. Ezinga stated Resident A has had multiple meals and snacks removed by Mr. and Mrs. Hirt as a direct consequence of eating items Resident A should not have eaten.

Resident B and Resident D each stated Licensees Jeffrey and Linda Hirt have removed Resident A’s snacks and meals as a consequence of eating items such as cat food, dog food, animal feces, and trash.

Resident C stated he has never observed Resident A have meals removed as a consequence of eating items he should not have eaten.

While onsite I observed Resident A to be of thin and slender stature.

On 01/26/2023 I received an email from Licensee Linda Hirt. Ms. Hirt stated, “No neither of us have withheld a meal from Resident A”.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.**
ANALYSIS:	Staff Rachil Ezinga stated Licensees Jeffrey and Linda Hirt often threaten to take away Resident A's meals and snacks as a consequence for eating cat food, dog food, and/or trash. Ms. Ezinga stated Resident A has had multiple meals and snacks removed by Mr. and Mrs. Hirt as a direct consequence of eating items Resident A should not have eaten. Resident B and Resident D each stated Licensees Jeffrey and Linda Hirt have removed Resident A's snacks and meals as a consequence of eating items such as cat food, dog food, animal feces, and trash. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates Licensees Jeffrey and Linda Hirt have withheld food as a consequence of inappropriate behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 01/24/2023 while onsite I observed two prescription medications unsecured and located atop of the facility medication cart in the communal living room. I observed the first unsecured medication as Resident D's Nicotine Transdermal System Patch. I observed the second unsecured medication as Lactulose Sol 10 GM/15 03/09/2022 which was prescribed to Resident G.

Licensee Linda Hirt stated Resident G does not reside at the facility but was a prospective resident from the past. Ms. Hirt stated she has been administering Resident G's Lactulose to Resident C because they are prescribed the same medication.

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:	I observed two prescription medications unsecured and located atop of the facility medication cart in the communal living room. I observed the first unsecured medication as Resident D's Nicotine Transdermal System Patch. I observed the second unsecured medication as Lactulose Sol 10 GM/15 03/09/2022 which was prescribed to Resident G. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates prescription medications were not stored in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 01/24/2023 while onsite I observed two prescription medications unsecured and located atop of the facility medication cart in the communal living room. I observed the first unsecured medication as Resident D's Nicotine Transdermal System Patch. I observed the second unsecured medication as Lactulose Sol 10 GM/15 03/09/2022 which according to the bottle was prescribed to Resident G.

Licensee Linda Hirt stated Resident G does not reside at the facility but was a prospective resident from the past. Ms. Hirt stated she has been administering Resident G's Lactulose to Resident C because Resident C is prescribed the same medication.

On 01/27/2023 I received an email from Licensee Linda Hirt. I observed the email contained Resident C's Medication Administration Record. I reviewed Resident C's Medication Administration Record does not indicate that Resident C is prescribed Lactulose Sol 10 GM.

On 01/27/2023 I received an email from Licensee Linda Hirt which stated Resident E is prescribed Lactulose Sol 10 GM/15, not Resident C.

On 01/27/2022 I received an email from Licensee Linda Hirt which I observed contained Resident E's Medication Administration Record. I observed Resident E is prescribed Lactulose Sol 10 GM as needed as directed.

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:	On 01/25/2023 I observed unsecured medication labeled as Lactulose Sol 10 GM/15 03/09/2022 which according to the bottle was prescribed to Resident G. Licensee Linda Hirt stated Resident G does not reside at the facility but was a prospective resident from the past. Ms. Hirt stated she has been administering Resident G's Lactulose to Resident E because Resident E is prescribed the same medication. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates Licensee Linda Hirt has been administering Lactulose Sol 10 GM to Resident E although said medication belonged to Resident G.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 01/25/2023, Licensee Linda Hirt stated staff Rachil Ezinga was hired on 10/27/2023 and has not independently dispensed residents' medications prior to completing medication administration training. Ms. Hirt stated one occasion she has dispensed residents' medications and allowed Ms. Ezinga to initial residents' Medication Administration Records as the staff who dispensed the medication.

On 01/25/2023, Staff Rachil Ezinga stated she was hired on 10/27/2023 and has worked at the facility independently "most mornings from 8:00 AM until 10:00 AM". Ms. Ezinga stated she has dispensed resident medications independently "most mornings" prior to completing medication administration training.

Resident B and Resident D each stated Staff Rachil Ezinga has worked at the facility independently in the mornings and has dispensed residents' medications during that time.

On 01/27/2023, I received an email from Staff Rachil Ezinga which I reviewed contained training verification forms, Resident C's Medication Administration Record, and Resident D's Medication Administration Record. I observed the resident Medication Administration Records did not indicate Ms. Ezinga administered any resident medications. I observed Ms. Ezinga completed Medication Administration 01/26/2023.

On 01/27/2023, I forwarded Resident C and Resident D's Medication Administration Record to Staff Rachel Ezinga via email. Ms. Ezinga responded via email and stated Ms. Ezinga did administer residents' medications and signed the Medication Administration Records each time. Ms. Ezinga reported that Licensees Jeffrey and Linda secured new Medication Administration Records from the pharmacy.

On 01/27/2023, I interviewed Betty Jo Rayner of New Walker Pharmacy. Ms. Rayner confirmed that staff from the Alto AFC personally visited the pharmacy and requested "five months' worth" of new blank Medication Administration Records for three facility residents on 01/25/2023. Ms. Rayner stated facility staff personally picked up blank a blank Medication Administration Record for Resident E today.

On 01/27/2023, I received Resident D's Medication Administration Record via email from Licensee Linda Hirt. I reviewed the email contained Resident D's Medication Administration Record which indicates Staff Rachel Ezinga did not administer Resident D's medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Licensee Linda Hirt stated staff Rachil Ezinga was hired on 10/272023 and has not independently dispensed residents' medications prior to completing medication administration training.
	Staff Rachil Ezinga stated she was hired on 10/27/2023 and has worked at the facility independently "most mornings from 8:00 AM until 10:00 AM". Ms. Ezinga stated she has dispensed resident medications independently "most mornings" prior to completing medication administration training. Resident B and Resident D each stated Staff Rachil Ezinga has worked at the facility independently in the mornings and has dispensed resident's medications during that time. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates Staff Rachil Ezinga independently dispensed residents' medications prior to completing medication administration training.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 01/25/2023, I completed an unannounced onsite investigation at the facility with Adult Protective Services Staff Kevin Souser. I interviewed Licensee Linda Hirt, Staff Rachil Ezinga, Resident A, Resident B, Resident C, and Resident D.

On 01/25/2023, Licensee Linda Hirt stated does not verbally mistreat residents and no knowledge of Mr. Hirt verbally mistreating residents.

On 01/25/2023, Staff Rachil Ezinga stated she has observed Licensees Jeffrey and Linda Hirt verbally mistreat Resident A. Ms. Ezinga stated she has observed Mr. Hirt "scream" at Resident A while stating, "you live under my roof" and "do you want lunch taken away, I already took your snack away". Ms. Ezinga stated she observed Ms. Hirt call Resident A a "trash eater" after Resident A was observed eating from the trash.

On 01/25/2023, Resident B stated he has observed Licensee Linda Hirt ask Resident C "where the fuck are you going" and observed Licensees Jeffrey Hirt called Resident A a "dirty mother fucker". Resident B stated Mr. and Mrs. Hirt have

threatened him not to cooperate with licensing investigations and adult protective services investigations.

On 01/25/2023, Resident C stated he has not observed licensees Jeffrey and Linda Hirt to verbally mistreat facility residents.

On 01/25/2023, Resident D stated she observed Licensee Jeffrey Hirt tell Resident A “you don’t fucking do that”.

On 01/27/2023, I interviewed Relative 1 via telephone. Relative 1 stated Resident D reported Licensee Jeffrey Hirt “yells” a lot and Resident D stated she “didn’t want to get on his bad side”. Relative 1 stated Resident D reported Mr. Hirt “has a temper”.

A LARA file review indicates Special Investigation 2022A0583018 dated 03/28/2022 resulted in violation of R400.14305 (3) due to Mr. Hirt verbally mistreating residents. A Correction Action Plan signed by Licensees Jeffrey and Linda Hirt on 04/02/2022 indicated Mr. Hirt would attending counseling, trainings, and treat residents with an appropriate demeanor. A LARA file review further indicates Special Investigation 2022A0583026 dated 05/24/2022 resulted in repeat violation of R400.14305 (3) due to a facility resident being allowed access to knives despite being placed on “suicide watch”. A Corrective Action Plan signed by Mr. and Mrs. Hirt on 08/10/2022 indicated sharps objects would be removed from resident access. A Provisional License was issued due to Special Investigation 2022A0583026.

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:	Staff Rachil Ezinga stated she has observed Licensees Jeffrey and Linda Hirt verbally mistreat Resident A. Resident B stated he has observed Licensee Linda Hirt ask Resident C “where the fuck are you going” and observed Licensees Jeffrey Hirt called Resident A a “dirty mother fucker”. Resident D stated she observed Licensee Jeffrey Hirt tell Resident A “you don’t fucking do that”. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule.

	Evidence discovered through this Special Investigation indicates Licensees Jeffrey and Linda Hirt verbally mistreated facility residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR# 2022A0583018 dated 03/28/2022**. **SIR # 2022A0583026 dated 05/24/2022.**

INVESTIGATION: While onsite on 01/25/2023 Licensee Linda Hirt stated Resident A has a public guardian named Veronica Smith. Ms. Hirt stated Ms. Smith sends Ms. Hirt a monthly check for approximately "$40" to be utilized for Resident A's spending money and a separate check for rent. Ms. Hirt stated she cashes the checks and subsequently gives the money directly to Resident A. Ms. Hirt stated she does not complete a resident funds form to document the transactions.

Staff Rachel Ezinga stated she has never observed Resident A with funds in his procession. Ms. Ezinga stated Licensee Linda Hirt stated Resident A "gets no money" from his guardian.

Resident A stated Licensee Linda Hirt "holds my money sometimes". Resident A stated he currently had no money in his procession.

On 01/30/2023 I interviewed Public Guardian Veronica Smith via telephone. Ms. Smith stated she sends Licensee Linda Hirt a monthly check for Resident A's rent and a second monthly check in the amount of "$44" for spending money.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Licensee Linda Hirt stated Resident A has a public guardian named Veronica Smith. Ms. Hirt stated Ms. Smith sends Ms. Hirt a monthly check for approximately "$40" to be utilized for Resident A's spending money. Ms. Hirt stated she cashes the

	check and subsequently gives the money directly to Resident A. Ms. Hirt stated she does not complete a resident funds form to document the transaction. Public Guardian Veronica Smith stated she sends Licensee Linda Hirt a monthly check for Resident A's rent and a second monthly check in the amount of "$44" for spending money. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates Licensee Linda Hirt failed to complete a resident funds form for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

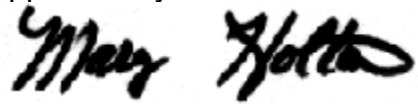
IV. RECOMMENDATION

Due to the eminent risk of harm to the residents a Summary Suspension and Revocation of the license is recommended.

01/30/2023

Toya Zylstra — Date
Licensing Consultant

Approved By:



01/30/2023

Mary E. Holton — Date
Area Manager