GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 20, 2023

Jeffrey Hunter
720 Hancock
Saginaw, MI 48602

RE: License #:	AF730281796
Investigation #:	2023A0872064
	Hope AFC

Dear Jeffrey Hunter:

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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

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 #:	AF730281796
Investigation #:	2023A0872064
Complaint Receipt Date:	08/24/2023
Investigation Initiation Date:	08/28/2023
Report Due Date:	10/23/2023
Licensee Name:	Jeffrey Hunter
Licensee Address:	720 Hancock Saginaw, MI 48602
Licensee Telephone #:	(989) 928-2720
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Hope AFC
Facility Address:	720 Hancock Saginaw, MI 48602
Facility Telephone #:	(989) 790-3056
Original Issuance Date:	09/09/2008
License Status:	REGULAR
Effective Date:	08/19/2021
Expiration Date:	08/18/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident B has severe dementia, and the licensees leave her unattended upstairs for hours.	Yes
The licensees do not help Resident B with her basic needs and on one occasion, Resident B had to clean up her own feces when she made a mess in the bathroom.	Yes

III. METHODOLOGY

08/24/2023	Special Investigation Intake 2023A0872064
08/24/2023	APS Referral This complaint was referred by APS. Jessire Ramos is the APS Worker
08/28/2023	Special Investigation Initiated - Telephone
08/29/2023	Contact - Telephone call received I spoke to APS Worker Jessire Ramos about this complaint
08/29/2023	Contact - Document Received I received documentation from APS Ramos
08/31/2023	Contact - Face to Face I interviewed Resident A at her friend's house
08/31/2023	Inspection Completed On-site Unannounced
09/19/2023	Contact - Document Sent I emailed APS Ramos
09/20/2023	Contact - Telephone call made I interviewed Guardian B1
09/20/2023	Contact - Document Sent I exchanged emails with APS Ramos
09/20/2023	Exit Conference

	I conducted an exit conference with the licensee, Jeffrey Hunter
09/20/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- **Resident B has severe dementia, and the licensees leave her unattended upstairs for hours.**
- **The licensees do not help Resident B with her basic needs and on one occasion, Resident B had to clean up her own feces when she made a mess in the bathroom.**

INVESTIGATION: On 08/29/23, I spoke to Adult Protective Services (APS) Worker, Jessire Ramos via telephone. APS Ramos said that she went to Hope Adult Foster Care (AFC) facility on 08/25/23 at approximately 2:30pm. She said that she went to the back door which is the main entrance for the facility. According to APS Ramos, the main door was open, but the screen was shut. APS Ramos kept yelling inside, saying “Hello? Adult Protective Services! Hello?” After several minutes, a man came to the door with no shirt on, saying that he had not heard her because he was taking a nap and he just woke up. The man identified himself as the licensee, Jeffrey Hunter and said that his wife, Chris Hunter was also taking a nap. Chris Hunter eventually joined Jeff Hunter and they allowed APS Ramos to enter their home to discuss the complaint.

J. Hunter and C. Hunter told APS Ramos that they currently have 3 residents living at their facility. They confirmed that Resident B is diagnosed with dementia and said that she is currently taking a nap. APS Ramos expressed concern that since the door was wide open and the licensees were taking a nap, what would happen if Resident B wandered outside of the home. J. Hunter and C. Hunter told APS Ramos that Resident B has lived with them for years and she has never tried to wander outside of the home.

APS Ramos met with Resident B who was in her room, sleeping. APS Ramos said that she was able to wake Resident B up and interact with her. APS Ramos found Resident B to be clean with no evidence of an odor. APS Ramos reviewed the allegations with J. Hunter and C. Hunter, and they said that C. Hunter assists Resident B with bathing, and she was last bathed approximately one week ago. C. Hunter told APS Ramos that the other residents do not need assistance with bathing or personal care.

On 08/31/23, I conducted a face-to-face interview with Resident A at her friend’s house. Resident A said that she lived at Hope AFC for approximately two months, and she moved out on 08/24/23. According to Resident A, Resident B has dementia, and she would have accidents in the bathroom and on her clothing. Resident A said that on a couple of occasions, Resident B soiled on herself and smeared feces on the walls of the bathroom. Resident A stated that the Hunters would get upset with Resident B and would tell the other residents, “Get her out of the fucking bathroom! Push her if you have to or pull her by the arm but get her the fuck out!” Resident A told me that when

Resident B made a mess, the Hunters made her clean up the feces herself stating, “that’s not in my job description.” She said that the Hunters stood and watched while Resident B cried and cleaned up the feces in the bathroom. Resident A said C. Hunter often refused to help Resident B bathe and refused to help her with personal hygiene, stating, “that’s not my job.”

Resident A stated that J. Hunter and C. Hunter nap from 12pm-4pm every day and tell the residents that they need to stay upstairs and not answer the door if someone knocks. Resident A said that C. Hunter gives all the residents lunch and before she and J. Hunter go to their room to take a nap, they tell the residents not to bother them. Resident A stated that while the Hunters napped, Resident B “just wandered around upstairs.”

On 08/31/23, I conducted an unannounced onsite inspection of Hope AFC. I interviewed J. Hunter and C. Hunter and Resident C and obtained AFC paperwork related to this complaint. I also observed Resident B who was sleeping in her room. She appeared clean as did her room, with no evidence of an odor.

J. Hunter and C. Hunter confirmed that they take naps “for an hour or so” most days because they get up early in the morning. C. Hunter said that she gets up at 4:30am-5:00am and gets tired so she naps after lunch. J. Hunter said that usually, while C. Hunter naps he will lay down and nap with her or watch television in their bedroom. According to the Hunters, the residents stay in their rooms or in their living room area while they nap. C. Hunter confirmed that Resident B has dementia “really bad” but said that she has never tried to elope from the facility, and she has never had an accidents or incidents while she and J. Hunter nap. C. Hunter said that there is a camera in the living room of the residents’ living quarters and if the residents need anything, she can see them on the camera.

I interviewed Resident C in his bedroom. Resident C told me that he has lived at this facility for 32-years. He said that J. Hunter and C. Hunter sometimes take a nap during the day and said that he will often take a nap when they do. I asked Resident C what he does if he needs something while the Hunters are napping, and he said he waits until they get up. I asked him if he is allowed to go downstairs and knock on their bedroom door and he said, “only if there is an emergency.” I asked Resident C what Resident B does while the Hunters are napping, and he said that she usually just stays in her room or in the living room upstairs. He said that Resident B only goes downstairs to eat meals.

I asked Resident C if Resident B ever has accidents. He said that she often goes into the bathroom and will stay in there “for a long time” and sometimes will make a mess. He said that “a long time ago” Resident B “put poop in the tub and on the window.” I asked him what the Hunters did when this happened and he said, “they gave her a rag and told her to clean up the poop.” I asked him if J. Hunter or C. Hunter helped Resident B clean up the mess and he said no. Resident C told me, “If she makes the mess, she has to clean it up.”

J. Hunter and C. Hunter confirmed that on one occasion, Resident B smeared feces in the bathroom but they denied making her clean up the mess herself. C. Hunter said that she cleaned up the mess. The Hunters told me that Resident B does try to "hang out" in the bathroom and she will tell the other residents that they can tell her to get out of the bathroom if she is taking too long. C. Hunter said that if the one of the residents is unable to get Resident B out of the bathroom, she will go upstairs and get her out. The Hunters denied ever swearing at the residents or cussing at them to get Resident B out of the bathroom.

According to Resident B's Assessment Plan, she requires staff assistance with eating/feeding, toileting, dressing, walking/mobility, and stair climbing. Under the section moves independently in community, it says, "her sister takes care of it. She is the only one that takes her out of the house." According to Resident B's Health Care Appraisal, she is diagnosed with dementia, hypertension, uterine prolapse, and hypokalemia.

On 09/20/23, I exchanged emails with APS Ramos. APS Ramos said that she has closed her APS complaint. She said that she substantiated neglect regarding Resident B due to the home being unlocked and Resident B not being supervised properly.

On 09/20/23, I interviewed Guardian B1 via telephone. Guardian B1 said that Resident B has lived at this facility for approximately 2.5 years. She said that over the past several years, Resident B's dementia has gotten worse, and her functioning has declined. She confirmed that Resident B stays upstairs at this facility and the licensees do not provide much care or supervision to her. I asked Guardian B1 if she knew that Resident B had an accident a while ago and she smeared feces in the bathroom. Guardian B1 said that C. Hunter told her what had happened. I asked Guardian B1 if C. Hunter told her who cleaned up the mess. Guardian B1 said, "Chris told me that she had (Resident B) help her clean it up so she would know not to poop on the floor, and she has to poop in the toilet." She said that J. and C. Hunter gave her a discharge notice telling her that Resident B needs to move out of their facility by the end of October 2023.

On 09/20/23, I conducted an exit conference with the licensee, Jeffrey Hunter. I told him that I have concluded my investigation and explained that I will be requesting a corrective action plan. J. Hunter confirmed that he gave Guardian B1 a discharge notice to move by the end of October 2023. J. Hunter confirmed that Resident B's level of care has increased to the point that they are no longer able to meet her needs.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians' instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a written assessment is made and it is

	determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.**
ANALYSIS:	Resident B has severe dementia. On 08/25/23, APS Worker Jessire Ramos found Resident B unattended upstairs while the licensees napped downstairs. The door was wide open at that time, and it took a long time for the licensees to answer APS Ramos' knocking. APS Ramos substantiated neglect regarding Resident B's lack of supervision. Resident A said that the licensees, Jeffrey, and Chris Hunter nap every day from approximately 12pm-4pm, leaving Resident B upstairs unattended. Resident A said that Resident B has dementia, and she just wanders around upstairs. Resident C said that the licensees nap during the day and he and the other residents are not to disturb them unless "it is an emergency." Jeffrey Hunter and Chris Hunter confirmed that they sometimes nap during the day, leaving Resident B upstairs, unattended. The Hunters told me that they have a camera in the common area of the resident's living quarters and if the residents need anything, they can see and respond. J. Hunter said that Resident B's functioning has declined, and her needs have increased above the level of what care they are able to provide so they have issued her a discharge notice. Guardian B1 confirmed that Resident B's dementia has "gotten really bad" over the past couple of years and the licensees leave her upstairs during the day unattended. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
ANALYSIS:	**(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's**

	designated representative 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.**
	Resident A said that Resident B had an accident in the bathroom, and she smeared feces all over the walls. The licensees made Resident B clean up the feces, stating that it was not their job to do so. Resident C said that on one occasion, Resident B "pooped" in the tub and on the windowsill. Resident C said that Resident B cleaned up her own feces because "if she makes the mess, she needs to clean it up." Jeffrey and Chris Hunter confirmed that on one occasion, Resident B had an accident in the bathroom, and she smeared feces. The Hunters denied making Resident B clean up the mess herself. Guardian B1 said that Chris Hunter told her that on one occasion, Resident B had an accident in the bathroom, and she had Resident B "help her clean it up so she would know not to poop on the floor, and she has to poop in the toilet." I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

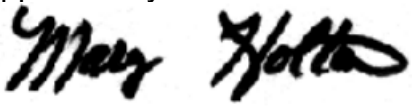
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

September 20, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



September 20, 2023

Mary E. Holton Area Manager	Date