GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 27, 2023

Laura Esese
Ascension Health III AFC
3640 BRAMBLEBERRY DR NW
Comstock Park, MI 49321

RE: License #: AS410386016
Investigation #: 2024A0583007
Ascension Health III AFC

Dear Ms. Esese:

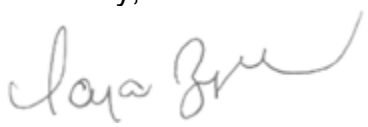
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (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 #:	AS410386016
Investigation #:	2024A0583007
Complaint Receipt Date:	11/08/2023
Investigation Initiation Date:	11/09/2023
Report Due Date:	12/08/2023
Licensee Name:	Ascension Health III AFC
Licensee Address:	3640 Brambleberry Drive NW, Comstock Park, MI 49321
Licensee Telephone #:	(616) 856-9191
Administrator:	Laura Esese
Licensee Designee:	Laura Esese
Name of Facility:	Ascension Health III AFC
Facility Address:	1947 Millbank St SE, Grand Rapids, MI 49508
Facility Telephone #:	(616) 805-4203
Original Issuance Date:	02/09/2017
License Status:	REGULAR
Effective Date:	08/09/2023
Expiration Date:	08/08/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's personal funds are missing.	No
Additional Findings	Yes

III. METHODOLOGY

11/08/2023	Special Investigation Intake 2024A0583007
11/09/2023	APS Referral
11/09/2023	Special Investigation Initiated - Letter Ed Wilson, Recipient Rights
11/14/2023	Inspection Completed On-site
11/27/2023	Exit Conference Licensee Designee Laura Esese

ALLEGATION: Resident A's personal funds are missing.

INVESTIGATION: On 11/08/2023 I received complaint allegations from the BCAL online reporting system. The allegation was reported by an anonymous complainant and stated that "guardian/brother requested resident funds from AFC to take sister/ward out to eat after medical appointment on 11/2 and was informed that there was only $6.00 remaining in resident funds". The complaint further stated that, "guardian had understanding there should be at least $400.00 in resident fund maintained by the home and home owner was not available to provide explanation of how her personal funds were spent".

On 11/09/2023 I emailed the complaint allegation to Ed Wilson of Network 180 Recipient Rights.

On 11/09/2023 I emailed the complaint allegation to adult protective services intake.

On 11/09/2023 I received an email from Adult Protecive Services staff Kevin Souser. Mr. Souser confirmed that he was assigned to investigate the complaint allegation at the facility. Mr. Souser stated that on 11/09/2023 he completed an onsite inspection at the facility and interviewed Relative 1. Mr. Souser stated that Relative 1 reported that on 11/02/2023 he requested ten dollars from Resident A's personal fund account and was informed by facility staff that Resident A had no funds in her personal funds account. Mr. Souser stated that Relative 1 reported that Resident A should have over one hundred dollars in her personal funds account.

On 11/14/2023 I completed an onsite investigation at the facility and interviewed licensee designee Laura Esese, and Resident A. Adult Protective Services staff Kevin Souser was present.

While onsite I reviewed Resident A's Resident Care Agreement, signed 05/04/2023, which states Relative 1 agreed to pay the basic fee of "SSI Rate monthly". The document does not specify an exact rate for the fee for services.

While onsite I examined Resident A's Resident Funds Ledger which appeared appropriately documented and indicated Resident A's had no spending money deposited into her account since December 2022.

Licensee designee Laura Esese stated that Resident A's legal guardian is Relative 1 and he negotiates and signs all of Resident A's legal documents. Ms. Esese stated that Resident A's rent amount is the "SSI rate". Ms. Esese stated that January 2023 Resident A's SSI rate increased from $998.50 to $1027.50. Ms. Esese stated that she contacted Relative 1 via a letter in December 2022 and informed Relative 1 that Resident A's rate was increasing to the new SSI rate effective January 2023. Ms. Esese stated that Relative 1 did not pay the increase until Ms. Esese contacted Relative 1 via telephone in March 2023 and thereafter Relative 1 sent Ms. Esese a check for "the difference" to catch up Resident A's rent. Ms. Esese stated that in 2022 Relative 1 would send Ms. Esese one monthly electronic transfer which included $998.50 rent plus $44.00 personal spending money for a total of $1042.50. Ms. Esese stated that she always deposited the $44.00 in Resident A's Facility Resident Funds for "spending money". Ms. Esese stated Resident A has not had personal spending money deposited into her account because Relative 1 has not been sending Resident A spending money since the January 2023 SSI rate increase. Ms. Esese stated that Resident A's resident funds ledger is accurate, and no funds have been mismanaged by facility staff.

On 11/19/2023 I received an email from licensee designee Laura Esese. I observed that the email contained electronic funds transfer copies from Relative 1 to Ms. Esese for $1027.50 monthly from April 2023 through November 2023.

On 11/20/2023 I interviewed Relative 1 via telephone. Relative 1 stated he is the legal guardian of Resident A. Relative 1 stated that the agreed monthly rate for Resident A's care at the facility is the SSI rate. Relative 1 stated that during the year of 2022 he sent licensee designee Laura Esese a monthly electronic funds transfer of $1042.50 which included $998.50 for rent and $44.00 for personal spending money. Relative 1 stated he did speak to licensee designee Laura Esese at the beginning of "2023" and agreed that the SSI rate for 2023 increased to $1027.50 monthly. Relative 1 stated that at the beginning of November 2023 he visited the facility and "was surprised to learn" that Resident A had no spending money in her resident funds account because Relative 1 believed he had been sending the facility spending money monthly via the electronic funds transfer. I informed Relative 1 that I had observed electronic funds transfer copies indicating Relative 1 was paying

$1027.50 per month since at least 04/2023 and there was no extra spending money included in the payment. Relative 1 stated Resident A does receive $1071.50 per month in social security payments, and he had forgotten to send the $44.00 per month in spending money. Relative 1 stated it was his mistake that he didn't send the $44.00 in spending money and agreed that the facility had managed Resident A's funds adequately.

On 11/27/2023 I completed an Exit Conference with licensee designee Laura Esese via telephone. Ms. Esese stated she agreed with the findings.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	Relative 1 stated Resident A does receive $1071.50 per month in social security payments, and he had forgotten to send the $44.00 per month in spending money. Relative 1 stated it was his mistake that he didn't send the $44.00 in spending money and agreed the facility had managed Resident A's funds adequately.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: The facility is insufficiently staffed to meet the needs of the residents.

INVESTIGATION: On 11/09/2023 I received an email from Kevin Souser of Kent County Adult Protective Services. Mr. Souser stated that on 11/09/2023 he completed an unannounced onsite investigation at the facility. Mr. Souser stated that he knocked on the front door of the facility and observed residents inside, no one answered the door, and no staff were visible. Mr. Souser stated that he proceeded to sit in his vehicle outside the facility for approximately twenty minutes before observing staff Dorothy Thompson drive up to the facility with Resident C in the vehicle. Mr. Souser stated Ms. Thompson admitted residents were inside the facility alone while she was gone to pick up Resident C and she was gone for a short time.

On 11/14/2023 I completed an onsite investigation at the facility and interviewed staff Dorothy Thompson. Ms. Thompson stated that on 11/09/2023 she was the sole staff working at the facility. Ms. Thompson stated that on the afternoon of 11/09/2023 she was unloading personal food items from her vehicle to bring inside the facility when she observed Resident C walking towards the facility with bags in

her hands. Ms. Thompson stated that she drove her vehicle down the street to pick up Resident C and immediately drove Resident C back to the facility. Ms. Thompson stated that the situation lasted less than ten minutes and she has never left residents alone at the facility in the past.

On 11/15/2023 I completed an unannounced onsite investigation at the facility and interviewed Resident B and Resident C.

Resident B stated that staff Dorothy Thompson has left the facility while she was scheduled to be working independently on multiple occasions. Resident B stated Ms. Thompson will leave Resident B in charge of the other residents while Ms. Thompson is gone. Resident B stated Ms. Thompson is typically gone for "fifteen to twenty minutes" but has been gone up to "half an hour". Resident B stated Ms. Thompson typically leaves the facility to get herself coffee, gas, or retrieve food from the food pantry.

Resident C stated that on 11/09/2023 she was walking down Milbank Street when she observed staff Dorothy Thompson driving her vehicle. Resident C stated Ms. Thompson stopped her vehicle and instructed Resident C to get into Ms. Thompson's vehicle. Resident C stated that Ms. Thompson drove the two individuals to a food pantry where Ms. Thompson left Resident C in the vehicle while Ms. Thompson collected food from the food pantry. Resident C stated she was in the vehicle alone less than ten minutes and subsequently Ms. Thompson drove the two individuals back to the facility. Resident C stated that other residents were alone waiting at the facility when they returned to the facility as well as Adult Protective Services staff Kevin Souser. Resident C stated that the 11/09/2023 outing lasted approximately thirty minutes. Resident C stated Ms. Thompson has left Resident C and other residents alone at the facility multiple times while Ms. Thompson went to get food from the food pantry. Resident C stated Ms. Thompson "leaves Resident B in charge" of the residents when Ms. Thompson is gone.

On 11/27/2023 I completed an Exit Conference with licensee designee Laura Esese via telephone. Ms. Esese stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.

ANALYSIS:	APS staff Kevin Souser stated that on 11/09/2023 he completed an unannounced onsite investigation at the facility. Mr. Souser stated that he knocked on the front door of the facility and observed residents inside, no one answered the door, and no staff were visible. Mr. Souser stated that he proceeded to sit in his vehicle for approximately twenty minutes before observing staff Dorothy Thompson drive up to the facility with Resident C in the vehicle. Mr. Souser stated Ms. Thompson admitted residents were inside the facility alone while she was gone to pick up Resident C. Resident C stated that on 11/09/2023 she was walking down Milbank Street when she observed staff Dorothy Thompson driving her vehicle. Resident C stated Ms. Thompson stopped her vehicle and instructed Resident C to get into Ms. Thompson's vehicle. Resident C stated that Ms. Thompson drove the two individuals to a food pantry where Ms. Thompson left Resident C in the vehicle while Ms. Thompson collected food from the food pantry. Resident C stated that other residents were alone waiting at the facility when they returned to the facility as well as Adult Protective Services staff Kevin Souser. Resident C stated that the 11/09/2023 outing lasted approximately thirty minutes. Resident B stated that staff Dorothy Thompson has left residents unsupervised on multiple occasions. Resident B stated Ms. Thompson is typically gone for "fifteen to twenty minutes" but has been gone up to "half an hour". A preponderance of evidence supports violation of the applicable rule occurred as a result of staff Dorothy Thompson leaving residents alone at the facility on 11/09/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A's Resident Care Agreement does not include a fee for services.

INVESTIGATION: Resident A's Resident Care Agreement, signed 05/04/2023, states Relative 1 agreed to pay the basic fee of "SSI Rate monthly". The document does not specify an exact rate for the fee for services.

On 11/27/2023 I completed an Exit Conference with licensee designee Laura Esese via telephone. Ms. Esese stated she agreed with the findings and would submit an acceptable Corrective Action Plan

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(b) A description of services to be provided and the fee for the service.**
ANALYSIS:	While onsite 11/14/2023, I observed Resident A's Resident Care Agreement, signed 05/04/2023, states Relative 1 agreed to pay the basic fee of "SSI Rate monthly". I observed that said document does not specify an exact rate for the fee for services. A preponderance of evidence supports violation of the applicable rule occurred as a result of Resident A's Resident Care Agreement not specifying Resident A's fee for service.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

11/27/2023

Toya Zylstra Date
Licensing Consultant

Approved By:

11/27/2023

Jerry Hendrick Date
Area Manager