GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 9, 2023

Vicky Cates
McAnally AFC Facility, Inc.
3960 Sharp Road
Adrian, MI 49221

RE: License #: AM460008927
Investigation #: 2024A1032003
McAnallys AFC Facility

Dear Vicky Cates:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM460008927
Investigation #:	2024A1032003
Complaint Receipt Date:	10/11/2023
Investigation Initiation Date:	10/12/2023
Report Due Date:	12/10/2023
Licensee Name:	McAnally AFC Facility, Inc.
Licensee Address:	325 E. Hunt Adrian, MI 49221
Licensee Telephone #:	(517) 263-8745
Licensee Designee:	Vicky Cates
Name of Facility:	McAnallys AFC Facility
Facility Address:	325 E. Hunt Adrian, MI 49221
Facility Telephone #:	(517) 263-8745
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	05/06/2022
Expiration Date:	05/05/2024
Capacity:	11
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
An employee used illicit drugs on shift and provided Resident A with drugs.	No
Employees did not properly dispense medication to Residents A and B.	No
Bedrooms were not properly cleaned.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/11/2023	Special Investigation Intake 2024A1032003
10/12/2023	Special Investigation Initiated - Telephone
10/16/2023	Inspection Completed On-site
10/16/2023	Contact - Document Received Interview with Guardian A1
10/16/2023	Contact - Telephone call received Interview with LCMHA Case manager Logan Chapman
10/17/2023	Contact - Document Received More information received for intake 198024
10/26/2023	Contact - Face to Face I reviewed MARs for Residents A and B
11/02/2023	Contact - Document Received Exclusion notice

11/07/2023	Exit Conference

ALLEGATION:

An employee used illicit drugs on shift and provided Resident A with drugs.

INVESTIGATION:

On 10/12/23, I reviewed the complaint information with the source. It was reported that Resident A and staff member Kerry Vancoppenolle had denied the allegations.

On 10/16/23, I interviewed Resident A in the home. Resident A denied that he was under the influence of any illicit drugs. He denied taking medication that does not belong to him. He denied that there is an inappropriate interaction between him and a staff member at the home named Kerry Vancoppenolle. He denied that Ms. Vancoppenolle supplies him with medications that are not prescribed to him. Resident A was asked to list his medications. He was able to do so and described his regimen as well. Resident A stated that he likes living in the home and that his guardian was being intrusive.

I interviewed Guardian A1 via telephone. Guardian A1 stated that she was advised that staff member Kerry Vancoppenolle had possibly supplied Resident A with drugs, but acknowledged that no one had direct knowledge of these incidents. She reported that Ms. Vancoppenolle had also given Resident A too many Depakote.

On 10/26/23, I interviewed licensee Vicky Cates at the home. Ms. Cates reported that she had to terminate Ms. Vancoppenolle's employment after receiving an exclusion notice. Ms. Cates stated that to her knowledge, Ms. Vancoppenolle was not using drugs while working.

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.**
	(1) A licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household shall be in such physical and mental health so as not to negatively affect

	either the health of the resident or the quality of his or her care.
ANALYSIS:	Resident A denied using illicit drugs, and rejected the notion that he was given drugs or unprescribed medication from staff member Kerry Vancoppenolle. There was insufficient evidence to conclude that the employee was responsible for getting Resident A intoxicated or in an altered state. Ms. Vancoppenolle was terminated before I was able to interview her.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees did not properly dispense medication to Residents A and B.

INVESTIGATION:

On 10/16/23, I interviewed Lenawee Community Mental Health Authority case manager Logan Chapman via telephone. Ms. Chapman stated that she had received information from the home that Ms. Vancoppenolle had mismanaged Resident B's medication over the weekend, and that the licensee Vicky Cates had been notified.

On 10/17/23, I received new information that Resident B had not received his medication the previous week, and that he had reported this on 10/13/23.

On 10/26/23, I reviewed the medication administration (MAR) records for Residents A and B. The MAR reflected that Resident A's medication was changed from two pills at night to liquid form. I was advised that this was done because the levels were too high, and there was also an issue with Resident A possibly diverting his medication, then crushing it and snorting it.

Resident B's MAR showed that his medication was administered during the period that he claimed not to have received it. The medication supply did not reveal any reporting errors.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	I reviewed MARs for Resident A and B. There did not appear to be any discrepancies between the document, and the medication supply.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Bedrooms were not properly cleaned.

INVESTIGATION:

On 10/16/23, Resident B stated that he does not like his food choices, and as such will decline meals. He was asked if he was aware of the menu for the day and he stated that the home will likely prepare hotdogs, but he does not like hotdogs. Resident B denied that there was a time recently when someone in the room soiled the sheets. He denied that there was a time when a staff member was approached to assist with housekeeping, and the staff member declined. I asked Resident B about the room cleaning schedule, and he stated that the rooms are supposed to be cleaned once a week. Resident B was also in line to have his clothing laundered, and his clothes were in a pile in a hamper. Resident B stated that his roommate sometimes has problems with bowel control.

I observed a bed in the bedroom, to have soiled sheets.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable/, clean, and orderly appearance.
ANALYSIS:	I observed Resident A and Resident B's room. The room was cluttered with clothing on the floor and one of the beds had soiled sheets.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 10/16/23, I asked Resident A if he had a hamper for his clothing. He stated that he did not, nor did he have a dresser. I asked him what he does with his clothing after it was cleaned and he stated that he folds it up and puts it in a bag.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(1) The bedroom furnishings in each bedroom shall include all of the following: **(a) An adequate closet or wardrobe.**
ANALYSIS:	During an onsite inspection, I noted that Resident A had no dresser. As a result, there was no adequate space to place his clothing.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/7/23, I conducted an exit conference with licensee Vicky Cates. Ms. Cates agreed with the conclusions reached and made a commitment to furnish an acceptable corrective action plan.

IV. RECOMMENDATION

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

11/9/23

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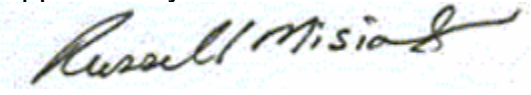
Dwight Forde Date
Licensing Consultant

Approved By:



11/16/23

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Russell B. Misiak Date
Area Manager