GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 26, 2024

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

RE: License #: AM460008927
Investigation #: 2024A1032021
McAnallys AFC Facility

Dear Vicki Cates:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	2024A1032021
Complaint Receipt Date:	02/06/2024
Investigation Initiation Date:	02/06/2024
Report Due Date:	04/06/2024
Licensee Name:	McAnally AFC Facility, Inc.
Licensee Address:	325 E. Hunt, Adrian, MI 49221
Licensee Telephone #:	(517) 263-8745
Administrator:	Vicky Cates
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?
The home did not take steps to improve Resident A's functioning.	No
Resident A was not afforded the opportunities for proper hygiene.	No
Additional Findings	No

III. METHODOLOGY

02/06/2024	Special Investigation Intake 2024A1032021
02/06/2024	Special Investigation Initiated - On Site
02/06/2024	Contact - Face to Face
02/15/2024	Contact - Telephone call made Telephone call with Adult Protective Services Specialist Melissa Auld
03/08/2024	Exit Conference

ALLEGATION:

The home did not take steps to improve Resident A's functioning.

INVESTIGATION:

On 2/6/24, I interviewed Resident A at Lymwood Manor. Resident A stated that he wants to return to the home because he misses his friends. He was asked why he was initially hospitalized. He stated that he did not know why he was hospitalized. I asked Resident A if he was able to recall his medication list, and if he was taking his medications as prescribed. He provided the names of at least two medications,

Seroquel and Insulin, claiming that he took them as prescribed. Resident A stated that he attended to his hygiene often. I asked Resident A if he used marijuana or marijuana gummies at the home and he denied doing so. Resident A was unable to tell me the date or the year.

I interviewed social worker Jonathan Richardson at Lynwood Manor. Mr. Richardson stated that Resident A appears to be in cognitive decline as evidenced by poor memory and orientation to place and time. Mr. Richardson advised that he has provided Resident A's Community Mental Health case manager with some additional resources through Region II Area on Ageing.

I interviewed employee Amanda Cilley in the home. Ms. Cilley stated that leading up to Resident A's hospitalization, he had been exhibiting some bizarre behaviors. She described him walking around the home naked, being very agitated when asked to take a shower, and difficulty forming sentences. Ms. Cilley reported that the home was making a concerted effort to provide Resident A with prompts, since it was noted that he seemed to be in cognitive decline. She reported that coordination with Community Mental Health had improved.

Ms. Cilley stated that to her knowledge, no one in the home provided Resident A with any marijuana or marijuana gummies. She stated that Resident A did have a frequent visitor, who stayed in the porch area, that could have been a point of contact.

I interviewed Resident B in the home. Resident B stated that he was Resident A's roommate. Resident B denied seeing anyone in the home provide Resident A with marijuana or marijuana gummies.

During the onsite inspection, I observed the room shared by Residents A and B to be clean and orderly in appearance. There were several articles of clothing folded on Resident A's bed.

On 2/15/24, I interviewed Adult Protective Services Specialist Melissa Auld via telephone. Ms. Auld stated that she plans to file a petition for guardianship due to Resident A's cognitive decline.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and

	normalization.
ANALYSIS:	Based on my interviews with the staff and a resident, Resident A has demonstrated a significant decline cognitively. While it is suggestive that he could have been under the influence of marijuana that remains unknown. However, staff modified his routine to include prompting, communicated with his CMH caseworker and APS worker, and encouraged visitors.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not afforded the opportunities for proper hygiene.

INVESTIGATION:

On 2/6/24, Ms. Cilley stated that the day before emergency medical services were called, she attempted to assist Resident A with showering; at first, he agreed to take one, but as she assisted him to the bathroom, he grew agitated and stormed off inexplicably. She advised that it was later discovered that Resident A had a groin infection.

During the onsite inspection, I observed the room shared by Residents A and B to be clean and orderly in appearance. There were several articles of clothing folded on Resident A's bed.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on my interview with Ms. Cilley, and my observation of Resident A's room, there is insufficient evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 3/8/24, I conducted an exit conference with licensee designee Vicky Cates. I shared my findings with Ms. Cates and she agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

3/26/24

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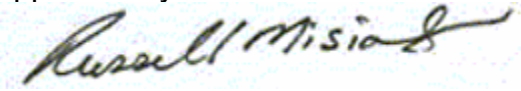
Dwight Forde Date
Licensing Consultant

Approved By:



3/26/24

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Russell B. Misiak Date
Area Manager