GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 18, 2024

Vicky Cates
3960 Sharp Rd.
Adrian, MI 49256

RE: License #: AM460064217
Investigation #: 2024A1032042
On The Hill AFC Home

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.
- 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.

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

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

I. IDENTIFYING INFORMATION

License #:	AM460064217
Investigation #:	2024A1032042
Complaint Receipt Date:	07/25/2024
Investigation Initiation Date:	07/25/2024
Report Due Date:	09/23/2024
Licensee Name:	Vicky Cates
Licensee Address:	3960 Sharp Rd. Adrian, MI 49256
Licensee Telephone #:	(517) 902-3950
Administrator:	Vicky Cates
Name of Facility:	On The Hill AFC Home
Facility Address:	3446 East US 223 Adrian, MI 49221
Facility Telephone #:	(517) 264-2203
Original Issuance Date:	05/15/1996
License Status:	REGULAR
Effective Date:	03/21/2024
Expiration Date:	03/20/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly physically managed.	Yes
Resident C's medical needs were not properly managed.	No
Resident C was not given an accounting of her resident funds.	No
The upstairs restroom is not clean.	No
Additional Findings	No

III. METHODOLOGY

07/25/2024	Special Investigation Intake 2024A1032042
07/25/2024	Special Investigation Initiated - Telephone
07/25/2024	APS Referral
07/26/2024	Inspection Completed On-site
07/29/2024	Contact - Telephone call received New information about Resident C having a medical crisis that was not properly tended to.
08/05/2024	Contact - Telephone call received More information about Resident C
08/07/2024	Inspection Completed On-site
08/12/2024	Contact - Telephone call received Interview with LCMHA case manager Sheila Sears
09/04/2024	Contact - Telephone call received Phone call from complainant with new allegations
09/05/2024	Inspection Completed On-site
09/17/2024	Contact - Document Received Resident Funds II was reviewed

09/17/2024	Exit Conference

ALLEGATION:

Resident A was improperly physically managed.

INVESTIGATION:

On 7/25/24, I interviewed Adult Protective Services specialist Randy Walch via telephone. Mr. Walch stated that he had made a law enforcement notification. He advised that Resident A did have bruises, but that he also has frequent falls. He shared being told that a minor had retrained Resident A after he supposedly made threatening moves toward his roommate.

On 7/26/24, I interviewed employee Amanda Cilley in the home. Ms. Cilley stated that she was giving another resident her medications when she heard a commotion coming from Resident A's room. She chanced upon her son on his back using his arms to restrain Resident A. Her son reported to her that Resident A and Resident B were trading threats, but Resident A appeared to attack Resident B physically. She stated that once her son and Resident A were no longer entangled, she told her son that under no circumstances was he to restrain a resident.

I interviewed Resident A in the home. Resident A advised that he was resting when all of a sudden, a minor started attacking him, causing a bruise on his left arm. He also showed me a small scab on his head. He stated that this happened on a Monday, earlier in the week.

I interviewed Resident B in the home. Resident B stated that he was watching a movie on his computer when the minor came into his room to ask a question. He asked the minor to leave then heard a commotion, saw the minor start hitting Resident A with pillows which turned into the minor throwing punches at Resident A. He stated that he started shouting at the minor to stop hitting Resident A.

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:	Based on interviews with employee Amanda Cilley, Resident A and Resident B, there was a physical interaction involving Ms. Cilley's son and Resident A that should not have occurred, per Ms. Cilley's report.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C's medical needs were not properly managed.

INVESTIGATION:

On 7/29/24, I received information that Resident C had struggled with blood pressure issues as well as pain from a dental infection. I was advised that employee Amanda Cilley had provided licensee Vicky Cates with information about Resident C's deteriorating health, but that Ms. Cates wanted to contact a dentist rather than send Resident C to the emergency department.

On 8/7/24, I interviewed employee Amanda Cilley in the facility. Ms. Cilley stated that Resident C had missed a dentist appointment and had been complaining about gum pain, because she had dry sockets from where her teeth were removed. Ms. Cilley stated that licensee Vicky Cates had contacted Resident C's dentist to see if an appointment could be scheduled. Ms. Cilley stated that Resident C checks her blood pressure twice a day and that on the day in question, the diastolic number for Resident C's blood pressure reading was 41. Ms. Cilley advised that there is a protocol that if the number sits at 40, that Resident C is to be referred to Emergency Medical Services. Ms. Cilley stated that Resident C usually arranges transport with her CMH case worker or peer support specialist.
Ms. Cilley stated that she communicated with other staff that Resident C had an appointment on August 5th 2024, but that the message may have been missed, since the employee who typically does medical transports was scheduled to work in another facility.
Ms. Cilley stated that Resident C sees her own physician, but recently asked for some medical advice when the visiting doctor from Harmony Cares came to the facility. This doctor put in a note to discontinue two of Resident C's medications, with the rationale being that these medications were negatively impacting her blood pressure.
Ms. Cilley provided a tour of Resident C's bedroom. The temperature was mild, and the window above Resident C's bed was open. Ms. Cilley stated that Resident C will typically open the window for circulation despite the central air conditioning running.
I interviewed Resident C in the home. Resident C stated that as far as she knew, her case manager and peer support specialist were providing transport to appointments. She stated that she has missed two dentist appointments, due in part to the home not providing transport.

Resident C stated that she had a medical issue where her blood pressure diastolic number was 39. She stated that her peer support specialist took her to the hospital. Resident C stated that she is not supposed to live on the second floor and that her room gets too hot when she uses her oxygen.

On 8/12/24, I interviewed LCMHA case manager Sheila Sears via telephone. Ms. Sears indicated that there may have been a mix up with scheduling Resident C's dentist appointment, but that the last one that was missed was a miscommunication between employees at the home. She stated that Resident C's physician is the house doctor, and that Resident C was claiming that a pulmonary specialist was the primary care physician. Ms. Sears stated that she was able to clarify with the pulmonary specialist that they were not the primary care physician. In regard to Resident C's recent trip to the ER, Ms. Sears stated that the ER team did not consider Resident C's blood pressure as an emergency. Ms. Sears advised that efforts were being made to get an understanding of when to send Resident C to the ER for blood pressure issues. Ms. Sears advised that there were no restrictions about Resident C living on the second floor or having difficulty walking up and down steps

On 8/27/24, I interviewed employee Amanda Wright at the home. Ms. Wright reported that she will typically transport residents to medical appointments, if need be, on Tuesdays and Thursdays. She stated that Resident C has been told to avoid scheduling appointments on days that she is not available, but that if she does, to alert other staff so that alternate arrangements can be made. She stated that Resident C made an appointment on a Monday, a day that she is not scheduled for medical runs. She further advised that Resident C refused to go to a dentist appointment earlier this month.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	There appeared to be a miscommunication about Resident C's appointments, because Resident C scheduled the appointment on a day that transportation was not available through the home. Resident C acknowledged that CMH was the primary method of transport to medical appointments. CMH also followed up with the hospital and it was determined that Resident C's blood pressure issues did not require emergency treatment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C was not given an accounting of her resident funds.

INVESTIGATION:

On 9/4/24, Resident C stated that she asked for an audit of her account. She tried to buy a wall unit air conditioner but was reportedly told that she did not have enough funds. She stated that she questioned this, and wanted to get an account balance.

On 9/16/24, licensee Vicky Cates provided a copy of Resident C's Resident Funds II form for review.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(13) A licensee shall provide a complete accounting, on an annual basis and upon request, of all resident funds and valuables which are held in trust and in bank accounts or which are paid to the home, to the resident, or to his or her designated representative. The accounting of a resident's funds and valuables which are held in trust or which are paid to the home shall also be provided, upon the resident's or designated representative's request, not more than 5 banking days after the request and at the time of the resident's discharge from the home.
ANALYSIS:	Licensee Vicky Cates provided a copy of Resident C's Resident Funds II form.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The upstairs restroom is not clean.

INVESTIGATION:

On 9/4/24, I interviewed a complainant, who added that the home has bedbugs, ad that the spray used to treat the infestation has also been applied to Resident C's

medical equipment. As a result, Resident C was unable to use her equipment for four days.

On 9/5/24, I interviewed employee Amanda Cilley in the facility. Ms. Cilley advised that while there is no infestation, a few bedbugs were sighted. As a result, all the residents' clothes were laundered, and treatments were applied to the rooms. Ms. Cilley stated that she sprayed around the edges of the rooms, around the bed frames, and the space between the mattresses and the box-springs. Ms. Cilley denied spraying any chemical into Resident C's breathing machine. Ms. Cilley advised that Resident C has been caught smoking in the room, as there was a faint marijuana smell detected. Ms. Cilley discussed the clothing arrangements, saying that Resident A has a filing cabinet to store her clothing, but chooses to leave her garments in bags on the floor, because she stores her tubing and other breathing machine attachments in the filing cabinet. Ms. Cilley stated that Resident C was offered a wood dresser but declined.

Ms. Cilley allowed me to take pictures in the second-floor bathroom. It was relatively clean, but there were signs of rust left by hard water. I observed a commode near the toilet, that was similarly stained. There was a square outline on the bottom of the commode that Ms. Cilley stated was a dissolved Brillo pad. She advised that the commode had not been in use for some time. I did not smell any odor of feces.
I interviewed Resident C in the facility. Resident C stated that while no chemicals were sprayed into her breathing machine, she could smell the spray when using the device and surmised that the chemical may have entered through the filter on her machine.

Resident C stated that her clothing was laundered but that she was told that she could only have 10 outfits. Resident C advised that she sternly told the staff that this was not going to happen. She stated that she was not in fact restricted from having her clothing. She reported that a conversation did occur about having a wooded dresser replace the filing cabinet, but she declined the offer. Resident C stated that since she moved into the home, the commode in the second-floor bathroom has had remnants of feces.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on my observation of the upstairs bathroom, as well as resident bedrooms, there is insufficient evidence to establish a violation of poorly maintained premises. I observed the bathrooms to be relatively clean and there was no foul odor

	usually associated with feces. In addition, the home had taken steps to address a possible pest infestation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/17/24, I conducted an exit conference with licensee Vicky Cates, who agreed to furnish a corrective action plan to address the violation established.

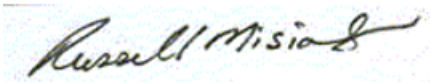
IV. RECOMMENDATION

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

9/18/24

Dwight Forde Date
Licensing Consultant

Approved By:



9/19/24

Russell B. Misiak Date
Area Manager