GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2024

Debra Krajewski
SouthWest AFC, L.L.C.
#296
6026 Kalamazoo Ave., SE
Kentwood, MI 49508

RE: License #: AM410285333
Investigation #: 2025A0583002
SouthWest AFC

Dear Ms. Krajewski:

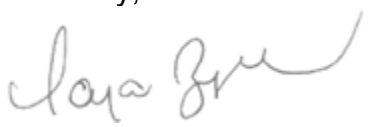
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	AM410285333
Investigation #:	2025A0583002
Complaint Receipt Date:	10/23/2024
Investigation Initiation Date:	10/24/2024
Report Due Date:	11/22/2024
Licensee Name:	SouthWest AFC, L.L.C.
Licensee Address:	#296 6026 Kalamazoo Ave., SE Kentwood, MI 49508
Licensee Telephone #:	(616) 698-6681
Administrator:	Debra Krajewski
Licensee Designee:	Debra Krajewski
Name of Facility:	SouthWest AFC
Facility Address:	212 56th St. SW Wyoming, MI 49548
Facility Telephone #:	(616) 534-5870
Original Issuance Date:	05/01/2007
License Status:	REGULAR
Effective Date:	10/18/2023
Expiration Date:	10/17/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED, AGED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Rose Thompson verbally mistreats the residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/23/2024	Special Investigation Intake 2025A0583002
10/24/2024	Special Investigation Initiated - On Site
10/24/2024	APS Referral
10/24/2024	Contact - Telephone call made Public Guardian Holly Momber
10/24/2024	Contact - Telephone call made Licensee Designee Debra Krajewski
10/31/2024	Exit Conference Licensee Designee Debra Krajewski

ALLEGATION: Staff Rose Thompson verbally mistreats the residents.

INVESTIGATION: On 10/23/2024 complaint allegations were received from the LARA-BCHS-Complaints online reporting system. The complaint alleged that staff Rose Thompson verbally mistreated Resident A and Resident B. The complaint alleged the following allegations: *'Rose had confiscated and hidden (Resident A's) "Mrs. Beasley" doll. Rose stated that it was because (Resident A) was "giving her an attitude. Rose had not allowed (Resident A) to attend her day program at Care Resources. Rose stated that it was because (Resident A) was "giving her an attitude". Rose will frequently speak rudely to (Resident B), saying things such as "Don't get an attitude with me", etc. Rose became very frustrated with (Resident B) and made the statement, "I'm bigger and stronger than you, I could take you and beat you up if you really wanna go [fight]". Rose became frustrated with (Resident B) for requesting a second pop and tossed the pop at (Resident B) across the kitchen table. (Resident B) reported that it "almost hit me".'*

On 10/24/2024 I completed an unannounced onsite investigation at the facility and interviewed staff Joyce Smith, Resident B, and Resident C.

Ms. Smith stated that she does not work with Ms. Thompson. Ms. Smith stated that Ms. Thompson works "Fridays". I informed Ms. Smith that I would be interviewing residents of the facility and Ms. Smith stated, "I don't think you can interview

residents without their guardians present". I informed Ms. Smith that it is routine to interview residents privately and without their guardians present.

I observed that Resident B and Resident C were outside on the front porch smoking cigarettes together. I asked Resident B and Resident C if I could speak with them and both residents stated that they were not allowed to speak to licensing staff without their guardians present. I informed Resident B and Resident C that it was appropriate to speak to licensing staff however both residents refused. I left my card with Resident B and requested that Resident B call me after speaking with her guardian, Holly Momber.

On 10/24/2024 I interviewed Resident B's public guardian, Holly Momber, via telephone. Ms. Momber stated that Resident B is truthful in her testimony. Ms. Momber stated that she has never expressed to Resident B that Resident B must have Ms. Momber present to speak with licensing staff. Ms. Momber stated that she is comfortable with Resident B speaking privately with licensing staff.

On 10/24/2024 I interviewed licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that she and staff Joyce Smith did have a conversation at the facility in which both individuals expressed that residents "might want" their respective guardians present during licensing investigations because residents have expressed being uncomfortable with licensing staff "twisting their words". Ms. Krajewski stated that residents "may have overheard" her conversation with Ms. Smith but denied directing residents not to speak with licensing staff without their respective guardians present. Ms. Krajewski stated that she has no knowledge regarding the current allegations of verbal mistreatment of Resident A and Resident B by staff Rose Thompson. Ms. Krajewski stated that Resident A does not have a behavioral plan in place and staff should not be confiscating residents' personal items or restricting their day programming as a consequence of poor behavior.

On 10/24/2024 I emailed the complaint allegations to Adult Protective Services Centralized Intake.

On 10/24/2024 I interviewed staff Rose Thompson via telephone. Ms. Thompson stated that she worked at the facility on 10/21/2024 "to make sure that the residents didn't bite each other's heads off". Ms. Thompson stated that Resident A woke up just before 7:00 AM and "stormed out of her bedroom". Ms. Thompson stated that Resident A immediately began displaying angry and agitated behaviors because Resident A could not locate cereal which was placed on top of the refrigerator. Ms. Thompson stated that she assisted Resident A with obtaining the cereal from the top of the refrigerator however Resident A continued to have "attitude problems" as evidenced by cursing at other residents and biting her shirt sleeve. Ms. Thompson stated that in response to Resident A's "attitude problems," Ms. Thompson entered Resident A's bedroom and took Resident A's "Ms. Beasley doll" off Resident A's bed. Ms. Thompson stated that she placed the doll on a different bed in the same bedroom that Ms. Thompson identified as Ms. Thompson's personal bed. Ms.

Thompson stated that Ms. Thompson sleeps in her own bed located in Resident A's bedroom. Ms. Thompson stated that she informed Resident A that Resident A could have the doll back after her behaviors improved. Ms. Thompson stated that she allowed Resident A to retrieve her doll after approximately five minutes. Ms. Thompson stated that Resident A's behaviors continued to escalate later into the morning and as a result Ms. Thompson "cancelled" Resident A's day programing at Care Resources and did not allow Resident A to attend. Ms. Thompson stated that she "cancelled" Resident A's day programming as a "consequence" for Resident A's "attitude". Ms. Thompson stated that she has never verbally mistreated Resident B.

On 10/24/2024 I interviewed staff Charleen Thompson via telephone. Ms. Charleen Thompson stated that she worked at the facility on 10/21/2024 and did not observe Ms. Rose Thompson confiscate Resident A's "Ms. Beasley doll" because Ms. Charleen Thompson was out of a facility for approximately 30 minutes running an arrand while the incident occurred. Ms. Charleen Thompson stated that when she arrived back to the facility, she observed Resident A stomping and cursing. Ms. Charleen Thompson stated that she observed Rose Thompson tell Resident A that Resident A could not attend her day program at Care Resources due to Resident A's acting out behaviors. Ms. Charleen Thompson stated that she has never observed Rose Thompson verbally mistreat any resident of the facility.

On 10/25/2024 I completed an unannounced onsite investigation at the facility. I privately interviewed Resident A. Resident A stated that on 10/21/2024 staff Rose Thompson was working. Resident A stated that, "I wasn't acting my age" and therefore, Ms. Thompson took her "Ms. Beasley doll" and placed the doll on Ms. Thompson's personal bed located in Resident A's bedroom. Resident A stated that Ms. Thompson gave Resident A her doll back after Resident A "acted my age". Resident A stated that on that same date of 10/21/2024, Ms. Thompson would not allow Resident A to attend her day program because Resident A was "talking mean" to Ms. Thomspon.

While onsite I attempted to interview Resident B. Resident B stated that she was playing a card game and refused to participate in the interview.

On 10/28/2024 I completed a LARA file review for facility AM410285333. I observed that Special Investigation 2024A0583001 (completed 11/01/2023) indicated that this facility was found to be in violation of R 400.14305 (3) due to staff Joyce Smith verbally mistreating residents. The approved Corrective Action Plan stated that the licensee designee, Debra Krajewski, would provide staff with continual training and monitor monthly for compliance. I observed Special Investigation 2024A0583018 (completed 02/16/2024) indicated that this facility was found to be in violation of R 400.14305 (3) due to staff Joyce Smith verbally mistreating residents. The approved Corrective Action Plan stated that the licensee designee, Debra Krajewski, would have staff sign a document indicating that residents must be treated with dignity and respect, receive additional training as needed, and that the licensee designee would monitor for compliance.

On 10/31/2024 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that she had no knowledge of the 10/21/2024 incident until after the licensing complaint was investigated. Ms. Krajewski stated that it was her understanding that staff Rose Thompson attempted to deescalate Resident A and had contacted "someone from Care Resources" requesting assistance with de-escalation. Ms. Krajewski stated that she was unsure if Ms. Thompson left a message with anyone from Care Resources or had spoken to a staff member. Ms. Krajewski stated that it is difficult to monitor how staff are providing care and interacting with residents because Ms. Krajeski cannot always be at the facility. Ms. Krajewski stated that she would accept the issuance of a Provisional License and submit an acceptable Corrective Action Plan.

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:	Resident A stated that on 10/21/2024 staff Rose Thompson "took" Resident A's "Ms. Beasley doll" and would not allow Resident A to attend her day program because Resident A was "talking mean" to Ms. Thomspon. Staff Rose Thompson stated that she worked at the facility on 10/21/2024 and entered Resident A's bedroom, confiscated Resident A's "Ms. Beasley doll", and "cancelled" Resident A's day programing at Care Resources as a "consequence" for Resident A's "attitude". A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Staff Rose Thompson did not treat Resident A with dignity and respect as evidenced by confiscating Resident A's doll and denying Resident A from attending her day program on 10/21/2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2024A0583018 02/16/2024** **Special Investigation 2024A0583001 11/01/2023**

ADDITIONAL FINDING: Staff Rose Thompson sleeps in Resident A's bedroom.

INVESTIGATION: On 10/25/2024 I completed an unannounced onsite investigation at the facility and interviewed Resident A, staff Rose Thompson, and staff Charleen Thompson.

Resident A stated that staff Rose Thompson sleeps on a separate bed located in Resident A's bedroom. Resident A explained that the bedroom houses four residents and there are currently three residents residing in the bedroom. Resident A stated that Ms. Thompson sleeps in the empty resident bed.

Staff Rose Thompson stated that the main floor bedroom is approved to accommodate four residents however the bedroom currently has three residents residing in it. Ms. Thompson stated that she sleeps in the empty bed while working at the facility and stated that licensee designee Debra Krajewski is aware that she was sleeping in the bed.

Staff Charlene Thompson stated that she sleeps in the empty bed located in Resident A's bedroom when she is working. Ms. Thompson stated that licensee designee Debra Krajewski has approved of Ms. Thompson sleeping in Resident A's bedroom in the empty bed.

On 10/25/2024 I interviewed licensee designee Debra Krajeski via telephone. Ms. Krajewski stated that Resident A's bedroom is approved to accommodate four residents. Ms. Krajewski stated that the bedroom currently houses three residents which leaves one empty bed. Ms. Krajewski stated that she is aware that staff Rose Thompson and Charleen Thompson were sleeping in the empty bed located in Resident A's bedroom. Ms. Krajewski stated she is in the process of securing new sleeping arrangements for staff Rose Thompson and Charleen Thompson at the facility.

On 10/31/2024 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that staff are no longer sleeping in resident bedrooms. Ms. Krajewski stated that she would accept the issuance of a Provisional License and submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of 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. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A stated that staff Rose Thompson sleeps on a separate bed located in Resident A's bedroom. Staff Rose Thompson stated that she sleeps in the empty bed located in Resident A's bedroom while working at the facility. Staff Charlene Thompson stated that she sleeps in the empty bed located in Resident A's bedroom when she is working. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Staff Rose Thompson sleeps in Resident A's bedroom impacting Resident A's privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Medications were left unsecured in Resident A's bedroom.

INVESTIGATION: On 10/25/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Resident A, staff Joyce Smith, and staff Charleen Thompson.

While interviewing Resident A in her personal bedroom, I observed two Advair Diskus 100 mcg-50 mcg/dose powder for inhalation located on the bedroom floor and one small plastic container of acetaminophen 325 mg and acetaminophen 500 mg located on a dresser. Resident A stated that she did not know who the medications belonged to.

Staff Joyce Smith stated that she did not know who the medications belonged to. Ms. Smith stated that no resident of the facility is prescribed Advair and she did not know who the acetaminophen belonged to.

Staff Charlene Thompson stated that the container of acetaminophen belonged to her and that she had left the pills in Resident A's bedroom on 10/21/2024. Ms. Thompson stated that she did not know who the Advair belonged to.

On 10/28/2024 I completed a LARA file review for facility AM410285333. I observed that renewal inspection 10/02/2023 indicated that this facility was found to be in violation of R 400.14312 (1) due to staff Joyce Smith documenting the administration

of a residents' medication that she later acknowledged she did not actually administer. Furthermore, it was discovered that the medication Ms. Smith documented administering was not in the facility because the facility was out of stock of that medication. The approved Corrective Action Plan stated that the facility's compliance coordinator would monitor Medication Administration records monthly for compliance.

On 10/31/2024 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that all medications are now secured and not accessible to residents. Ms. Krajewski stated that she would accept the issuance of a Provisional License and submit an acceptable Corrective Action Plan.

APPLICABLE RULE.	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. (2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	I observed two Advair Diskus 100 mcg-50 mcg/dose located on Resident A's bedroom floor and one small plastic container of acetaminophen 325 mg and acetaminophen 500 mg located on a dresser. Resident A stated that she did not know who the medications belonged to. Staff Charlene Thompson stated that the container of acetaminophen belonged to her and that she had left the pills in Resident A's bedroom on 10/21/2024. Ms. Thompson stated that she did not know who the Advair belonged to. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Staff Charlene Thompson left a plastic container of acetaminophen unsecured in Resident A's bedroom. Additionally, two Advair diskus' were observed unsecured in Resident A's bedroom, and it is unknown whom the Advair diskus' belong to.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal 10/02/2023**

ADDITIONAL FINDING: Reasonable precautions were not taken to insure that prescription medication is not used by a person other than whom the medications are prescribed for.

INVESTIGATION: On 10/25/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Resident A, staff Joyce Smith, and staff Charleen Thompson.

While interviewing Resident A in her personal bedroom, I observed two Advair Diskus 100 mcg-50 mcg/dose powder for inhalation located on the bedroom floor and one small plastic container of acetaminophen 325 mg and acetaminophen 500 mg located on a dresser. Resident A stated that she did not know who the medications belonged to.

Staff Joyce Smith stated that she did not know who the medications belonged to. Ms. Smith stated that no resident of the facility is prescribed Advair and she did not know who the acetaminophen belonged to.

Staff Charlene Thompson stated that the container of acetaminophen belonged to her and that she had left the pills unsecured in Resident A's bedroom on 10/21/2024. Ms. Thompson stated that she did not know who the Advair belonged to.

On 10/31/2024 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that all medications are now secured and not accessible to residents. Ms. Krajewski stated that she would accept the issuance of a Provisional License and submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	I observed two Advair Diskus 100 mcg-50 mcg/dose located on Resident A's bedroom floor and one small plastic container of acetaminophen 325 mg and acetaminophen 500 mg located on a dresser. Said medications were unsecured and accessible to residents.

	Staff Charlene Thompson stated that the container of acetaminophen belonged to her and that she had left the pills unsecured in Resident A's bedroom on 10/21/2024. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Staff Charlene Thompson left a plastic container of acetaminophen unsecured in Resident A's bedroom. Two Advair diskus' were observed unsecured in Resident A's bedroom, and it is unknown whom the Advair diskus' belong to. Reasonable precautions were not taken to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the license be modified to Provisional Status as a result of the above cited quality of care violations.

10/31/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

10/31/2024

Jerry Hendrick Date
Area Manager