GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 28, 2020

Marcia Curtiss
Homestead Management
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #:	AL410007144
Investigation #:	2020A0356039
	Addington Place at East Paris #6

Dear Mrs. Curtiss:

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.

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410007144
Investigation #:	2020A0356039
Complaint Receipt Date:	05/19/2020
Investigation Initiation Date:	05/19/2020
Report Due Date:	07/18/2020
Licensee Name:	Homestead Management
Licensee Address:	Suite 115, 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(616) 949-9500
Administrator:	Kat Hartley
Licensee Designee:	Marcia Curtiss
Name of Facility:	Addington Place at East Paris #6
Facility Address:	3962 Whispering Way Grand Rapids, MI 49546-5804
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	07/07/1988
License Status:	REGULAR
Effective Date:	01/30/2020
Expiration Date:	01/29/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED ALZHEIMERS

II. ALLEGATION(S)

Allegation	Violation Established?
Staff do not administer medication as prescribed and staff failed to provide care requested by Resident A.	Yes
Staff do not supervise Residents A & B taking their medications.	Yes
Staff do not provide personal care to Residents A & B per their assessed needs.	Yes

III. METHODOLOGY

Date	Contact
05/19/2020	Special Investigation Intake 2020A0356039
05/19/2020	Special Investigation Initiated - Telephone Resident A.
05/19/2020	Contact - Document Received Information from Resident A.
05/19/2020	Contact - Document Received Resident A care plan.
05/22/2020	Contact - Document Sent Request for GRPD police report.
05/26/2020	Contact - Document Received GRPD report received.
05/27/2020	Contact - Telephone call received Resident B.
05/29/2020	Contact - Telephone call made Kat Hartley, Audra Rein and Marcia Curtiss.
06/22/2020	Contact - Document Received Resident A.
07/13/2020	Contact - Document Received Resident A and B facility documents.
07/16/2020	Contact-Telephone Call Made Dee Orr and Shartrice Hines

07/21/2020	Contact-Telephone Call Made Shiniece Horton, LaToya Hurley, Tiona Lyons & Sierra Trevino. Anita Smith (did not return call)
07/30/2020	Exit Conference-Licensee Designee, Marcia Curtiss.

ALLEGATION: Staff do not administer medication as prescribed and staff failed to provide care requested by Resident A.

INVESTIGATION: On 05/19/2020, I received a complaint via email and followed up by a telephone call from Resident A. Resident A reported on 05/10/2020, around 4:30PM, she put her call light on to request an enema. Resident A stated the supervisor, Dee Orr said she would let the Med Tech, LaToya Turley know that Resident A needed an enema. At 5:40PM, Resident A stated when the med tech, Ms. Turley came in to administer medications, Resident A asked Ms. Turley, if she would give her (Resident A) an enema. Resident A stated she was in so much pain by this time but Ms. Turley, would not answer her, did not administer the enema and walked out of the room. Resident A stated she asked Direct Care Worker (DCW), Sierra Trevino if she would give her the enema and she said no, she had to make a telephone call and that she was unable to administer an enema. Resident A stated she told the DCW's on duty Ms. Turley, Ms. Trevino and Anita Smith that one of three options were about to happen, "give me an enema, if not, I might puke all over the place or I (Resident A) will call the police and let them know that all three caregivers are neglecting my care." Resident A stated none of the staff responded or seemed to care so she called the police. Resident A stated the police arrived and another DCW, Shartrice Hines AKA: Care Bear came from another building and administered the enema at 6:00PM. Resident A stated once she felt better, she spoke to the police who were at the facility and the police inquired about her well-being. Resident A stated she told the police that she was ok now but that she is neglected by staff at the facility. Resident A stated Audra Rein, facility nurse met with her on 05/12/2020 to develop a care plan but the care plan they established really did not accomplish anything and did not improve the quality of care she was getting from the staff.

On 05/19//2020, I received a copy of a handwritten care plan dated 05/12/2020, signed by Resident A and Ms. Rein. The care plan documented the following information. *'Enema's-Audra will give me an enema when I need one. If I need one on the weekend I will look at my calendar and see if Keyauna or Deeishere, both of them stated they will help me. I will reach out to one of the three people listed. This alleviates the med tech from being uncomfortable giving it to me. It also prevents me from having to bother someone to give me one.'*

On 05/19/2020, I received a video taken in the facility by Resident A. The video is dated 05/08/2020 at 2:09 PM and staff in the video are difficult to see but can be easily heard. The video shows two staff sitting on a couch talking and Resident A asks staff if someone can give her an enema, and staff answer by saying "Ok, well

she's on break so you are going to have to wait." Resident A stated the three staff involved are Shiniece Horton, LaToya Turley and Tiona Lyons, Ms. Turley was the person on break. I discussed the video with Resident A who stated Ms. Horton was the staff talking in the video. Resident A stated she used the call light to summon staff to her room and when Ms. Horton came in, she asked her for an enema, and Ms. Horton said, "I can't believe you asked for that" and then laughed all the way down the hallway. Resident A stated all three staff sat on the couch and laughed. Finally, "Care Bear" (Shartrice Hines) came about an hour later from building #5 and administered the enema.

On 05/26/2020, I received the Grand Rapids Police Report dated 05/10/2020 at 19:54 hrs. (7:54PM). The reporting officer is Wayne Hill, Officer Hill documented the following information, *'We were dispatched to the Addington Place facilities located at 3956 Whispering Way building #6 in reference to caller: Was able to reach (*Resident A*) 30 yr. old-says that her caretakers gave her some medication to help her go to the bathroom and that everything was fine (was not able to speak to any of the caretakers) medical declined. No answer at the TX (telephone number) listed. I arrived and spoke to one of the workers who advised that (*Resident A*) was not being abused or neglected. She took us to see (*Resident A*), (*Resident A*) said that she called 911 because she had not received her enema at 5PM.* (Resident A*) advised that she had since received it and she no longer needed medical or police assistance. Orr (*Resident Care Supervisor, Dee Orr*) advised (*Resident A*) to call her instead of 911 for future conflicts of not getting her medicine or other procedures done. GRPD was not needed and we cleared.'*

On 05/29/2020, I interviewed Ms. Curtiss, Ms. Rein and Ms. Hartley. Ms. Rein stated if Resident A does not like staff, she will set them up to make it appear as though they are not providing the care she needs. Ms. Rein stated Resident A's enemas are PRN (as needed) so she requests them when she wants/needs one and then staff are to administer it but, on this particular day, Ms. Rein stated Resident A did not ask staff for an enema and then called the police. Ms. Rein stated staff in this building typically work in other buildings on this campus so they are not used to dealing with Resident A and she (Resident A) can be very difficult to deal with. Ms. Rein stated she received and viewed the video dated 05/08/2020 and staff in the video were disciplined and written up. Ms. Curtiss stated she, Ms. Rein and Ms. Hartley will talk to staff and residents and ask that they report issues to Ms. Rein so she can discuss the problems with Ms. Curtiss and Ms. Hartley and take steps to remedy it without police involvement and complaints.

On 07/13/2020, I received and reviewed the Medication Administration Records (MARs) for Resident A for the months of May and June 2020. The MARs have a prescription for Enemeez mini enema, use 1-2 enemas once daily as needed for constipation. The prescriber is Lisa Smith, Nurse Practitioner and originated on 08/23/2019. In May 2020, there are no signatures on any date throughout the entire month showing that an enema was administered to Resident A. This includes no signatures that an enema was administered on 05/08/2020 or 05/10/2020 as

reported in this complaint. June 2020 shows no signatures that an enema was administered on any of the dates during the month.

On 07/13/2020, I reviewed the ADL (activities of daily living) logs for Resident A for the months of May and June 2020. The ADL logs document Resident A's bowel movements every day and every shift. The ADL log for 05/08/2020 documents no BM for 1st shift signed by DCW Whitney Hodges, no BM for 3rd shift signed by DCW Whitney Hodges and on 2nd shift there is documentation of a bowl movement, medium in size and of normal consistency, signed by DCW LaToya Turley. On 05/10/2020, 1st shift DCW, Anita Smith documents no BM, 2nd shift DCW, LaToya Turley documents no BM and 3rd shift DCW, Anita Smith documents no BM.

On 07/13/2020, I received and reviewed the Resident A's Assessment Plan for AFC Residents dated 08/22/2019, signed by Kat Hartley, administrator, Audra Rein, nurse and Resident A. The assessment plan documents Resident A as needing help with toileting and describes her as requiring a one-person assist but does not document her need for the use of enema's to assist with her toileting needs.

On 07/16/2020, I interviewed Resident A via telephone. Resident A stated 12 enemas are in the medication cart at the facility each month for use when she needs them. Resident A stated she used 7-8 enemas (each month) in May and June 2020 and uses 7-8 enemas every month. Resident A explained that when she feels the urge to have a bowel movement, sometimes she is unable to and requires an enema to assist. Resident A stated it's painful when she has to wait for long periods of time to get the enema.

On 07/16/2020, I interviewed Resident Care Supervisor, Dee Orr via telephone. Ms. Orr stated she is the 1st shift supervisor in another building on the campus and went over to this facility on 05/10/2020 to "see what was going on." Ms. Orr stated police came to the building to check on Resident A's well-being, and Resident A told her (Ms. Orr) that she was upset because staff were laughing at her. Ms. Orr stated someone administered Resident A's enema to her and everything was ok. Ms. Orr stated she doesn't remember who administered the enema or anything else about the events of the evening.

On 07/16/2020 I interviewed DCW Shartrice Hines, AKA: Care Bear via telephone. Ms. Hines stated she is a 2nd shift supervisor in another building on campus. Ms. Hines stated on 05/10/2020, she administered an enema to Resident A because "nobody wanted to do it" in this facility. Ms. Hines stated Resident A told her how to administer the enema and she did it for her. Ms. Hines stated she told Ms. Rein about this because she was not comfortable with administering the enema to Resident A but no one else in the building would do it. Ms. Hines stated this all occurred late afternoon, possibly close to dinner which is 5:00PM and Ms. Hines stated there was a commotion or something going on in that building, so she went over to see what was going on. Ms. Hines stated she asked the Med Tech, Ms. Turley to open the medication cart and she administered Resident A's enema. Ms.

Hines stated apparently when Resident A couldn't get staff to give her the enema, Resident A called the police. Ms. Hines stated she does not recall if she's ever given Resident A an enema on any other date(s) due to staff in the building's unwillingness to administer the medication.

On 07/21/2020 I interviewed DCW, Shiniece Horton via telephone. Ms. Horton stated she does know how to administer Resident A's enema, and that some staff do not know how. Ms. Horton acknowledged that staff are responsible to give Resident A her enema when she requests it. Ms. Horton stated she has heard and known other staff to refuse to give Resident A her enema and admits that she has refused to give Resident A an enema because of the way Resident A talks to her. Ms. Horton explained that Resident A talks badly to staff and complains about staff all the time, but she never includes all the things she does to staff. Ms. Horton stated Resident A never goes without her medications and will get still get the enema when she requests it, just from another staff. Ms. Horton acknowledged that she was one of the staff in the video taken on 05/08/2020. Ms. Horton stated Resident A wanted an enema and she told her she had to wait until Ms. Turley, who was the acting Med Tech on this date, was back from break. Ms. Horton stated she did not administer the enema, even though she is trained and knowledgeable about administering Resident A's enema. Ms. Horton stated the video was given to Ms. Rein, and Ms. Rein addressed it with Ms. Horton, and she was written up for it.

On 07/21/2020, I interviewed DCW LaToya Turley via telephone. Ms. Turley stated she is able to administer Resident A's enemas and acknowledged that she was working on 05/08/2020 and 05/10/2020. Ms. Turley also acknowledged that Resident A's enema's are PRNs (as needed) and when they are administered, they are documented on the MAR. Ms. Turley stated on 05/08/2020 she was not involved in the video, but she was the staff person mentioned in the video who was out on break. Ms. Turley stated when she came back from break, Resident A got an enema and that Resident A only waited an hour max for the enema. Ms. Turley stated on 05/10/2020, Resident A had diarrhea and did not need an enema. Ms. Turley stated she was told by Ms. Rein and Resident A's mother that Resident A could not have an enema because of the diarrhea. Ms. Turley stated she assisted and wiped Resident A 5x during her shift with diarrhea. Ms. Turley stated that Ms. Trevino wiped Resident A 4x between 3:00-5:00PM due to diarrhea. Ms. Turley explained the enemas help Resident A go BM and on this particular date, she didn't need an enema. Ms. Turley stated she called Ms. Rein who instructed her not to give Resident A an enema and DCW Sierra Trevino called Resident A's mom who instructed her not to administer an enema. Ms. Turley then stated the police showed up and checked on Resident A's well-being and left stating there was nothing else that needed to be done because Resident A was being taken care of.

On 07/21/2020, I interviewed DCW Tiona Lyons via telephone. Ms. Lyons stated she was present in the building on 05/08/2020 when the video was taken. Ms. Lyons stated Resident A requested an enema and Ms. Horton told Resident A she would have to wait as the med tech (Ms. Turley) was on break. Ms. Lyons stated things

escalated after that between staff and Resident A but Resident A got an enema when Ms. Turley was done with her break. Ms. Lyons stated some staff avoid Resident A and avoid giving her enemas because she picks and picks at staff and likes who she likes and not others. Ms. Lyons stated Resident A does not go without her medications or special medical procedures because staff in this building will always get someone else like a supervisor or a staff from another building to come over and do it for them. Ms. Lyons stated Resident A's enema is a PRN so whenever she asks for it, she gets it, but it is not documented on the MAR.

On 07/21/2020, I interviewed DCW Sierra Trevino via telephone. Ms. Trevino stated on 05/10/2020, she worked a double shift and it was Mother's Day, so she took a break to call her mother and that's when Resident A asked for an enema. Ms. Trevino stated she asked Resident A to wait a minute because she was on break and Resident A said that she (Ms. Trevino) was "always on break" and that she was going to call the police on her. Ms. Trevino stated she told Resident A if that's what she needed to do, go ahead but that she would give her an enema as soon as she was done on break. Ms. Trevino stated she never refused to administer the enema to Resident A but that she was an aide on this particular day and not the med tech so even though she was trained and able to administer Resident A's medications, it was really up to the med tech to administer the enema. Ms. Trevino stated Ms. Orr was the supervisor in the building that day and she ended up giving Resident A the enema. When I further questioned Ms. Trevino about Resident A having diarrhea on 05/10/2020 as reported to me by Ms. Turley, Ms. Trevino stated that Resident A did have diarrhea on 05/10/2020 and staff were told by the supervisor, Ms. Orr not to give Resident A an enema due to the diarrhea. Ms. stated she was going to give Resident A an enema anyway after her break because Resident A requested one. Ms. Trevino stated she never called Resident A's mother to inquire about whether or not to administer an enema on 05/10/2020 because of Resident A's diarrhea. Ms. Trevino added the way that Resident A treats staff causes staff to not want to do things for her but, she doesn't want to neglect Resident A's care so she will provide what Resident A needs. Ms. Trevino stated Resident A picks and picks at staff and that's why staff don't want to do things for Resident A. Ms. Trevino stated that Resident A's enemas are not documented on the MAR when they are administered.

On 07/30/2020, I conducted and Exit Conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she was aware of some of the issues in this facility and actively making changes in staff, staff training and the overall environment of this facility. Ms. Curtiss will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15312	**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 §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A's MARs document a prescription for enemas and for May and June 2020, there are no signatures on any date throughout either month showing that an enema was administered to Resident A. Based on the investigative findings, it is clear that staff at the facility are not following Resident A's individual special medical procedures nor are they administering Resident A's medications as prescribed by the doctor by their lack of documentation on the MAR and their admitted delay and/or refusal to administer Resident A's enema when requested. Therefore, a violation of this applicable rule is established. *Repeat Violation, SI 2020A0356037, Report date 07/13/2020, CAP due 07/30/2020. In this complaint, Rule R 400.15312 was cited after a preponderance of evidence showed that staff did not document a resident's blood glucose levels on several dates during April 2020. The blood glucose level would have determined if the resident required the prescribed Novolog medication or not.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**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 reported that on 05/08/2020 and on 05/10/2020 she requested a PRN enema and staff told her she had to wait, on 05/10/2020, Resident A called the police because staff would not administer an enema.

	Ms. Rein stated on 05/10/2020, Resident A did not ask staff for an enema and then called the police on staff. The care plan for Resident A as written by Ms. Rein, documented Ms. Rein or two other specific staff will administer Resident A’s enema to alleviate the med tech from being uncomfortable administering the enema and to prevent Resident A from having to bother someone to administer an enema. I viewed a video dated 05/08/2020. The video shows staff telling Resident A she will have to wait to receive an enema until the med tech is back from break. I reviewed a Grand Rapids Police Department report dated 05/10/2020 at 7:54PM documents Resident A’s call stating staff were neglecting her by refusing to administer an enema to her as requested at 4:30PM. Ms. Hines stated on 05/10/2020, she administered an enema to Resident A because “nobody wanted to do it” in the facility. Ms. Horton stated she knows other staff refuse to give Resident A her enema and admits that she has refused to give Resident A an enema because of the way Resident A talks to her. Ms. Turley stated on 05/08/2020, when she came back from break, Resident A got an enema and that Resident A only waited an hour at the most for the enema. Ms. Turley stated on 05/10/2020, Resident A had diarrhea and did not need an enema. Resident A’s ADL logs for the months of May and June 2020 do not document Resident A having diarrhea on 05/08/2020 or on 05/10/2020 causing her to not need the enema she requested. Ms. Orr stated police came to the building to check on Resident A’s well-being, but someone had already administered Resident A’s enema. Ms. Lyons stated Resident A requested an enema on 05/08/2020 and when Ms. Turley was done with her break, Resident A got her requested enema. Ms. Lyons stated some staff avoid Resident A and avoid giving Resident A enemas because she (Resident A) picks at staff.

	Ms. Trevino stated she never refused to administer the enema to Resident A on 05/10/2020 but that she was an aide on this particular day and not the med tech so even though she was trained and able to administer Resident A's medications, it was up to the med tech to administer the enema. Based on investigative findings, staff at the facility did not tend to Resident A's personal needs nor did they treat Resident A with dignity. Staff admitted to delaying and/or refusing to administer Resident A's enema when requested and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff do not supervise Resident A & B taking their medications.

INVESTIGATION: On 05/19/2020, I received a complaint via email and followed up with a telephone call from Resident A. Resident A reported that staff enter her room and leave a cup of medications on her bedside table, staff then leave the room and do not watch her take her medications. Resident A stated she has a history of attempted suicide by overdose and worries that having the ability to take medications on her own could create an opportunity to overdose again.

On 05/19//2020, I received a copy of a handwritten care plan dated 05/12/2020 and signed by Resident A and Ms. Rein. The care plan documented the following information, *'Audra will in service the staff to watch me take my meds. I will consent to an oral cavity check if asked to prove I took my meds. I have paranoia about saving up my meds. So, I don't want to risk it. I want to be watched.'*

On 05/27/2020, I interviewed Resident B via telephone. Resident B stated some of the staff watch her take her medications and some leave the medications on the table and let her take them on her own without any staff supervision.

On 06/03/2020, I received a video taken in the facility by Resident A. The video is dated 06/03/2020 and shows DCW LaToya Turley dropping a cup of medications off to Resident A, leaving it on a table and walking out of the room with the door shutting behind her.

On 06/03/2020, I interviewed Ms. Curtiss, Ms. Rein and Ms. Hartley via telephone. I informed Ms. Curtiss, Ms. Rein and Ms. Hartley of the video. Ms. Rein stated the staff was probably watching Resident A take her medications but possibly out of sight of the video. Ms. Rein explained that these are the types of things that Resident A does to get staff in trouble. Ms. Rein stated she has addressed this with staff and will in-service all staff on the correct way to administer resident

medications. Ms. Curtiss stated if staff are continuing to leave medications in resident(s) rooms and letting resident(s) take them on their own, we cannot allow that to continue happening. Ms. Curtiss stated the issue will be addressed immediately.

On 07/13/2020, I received and reviewed Resident A's Assessment Plan for AFC Residents dated 08/22/2019, signed by Kat Hartley, administrator, Audra Rein, nurse and Resident A. The assessment plan documents Resident A requires staff to administer all medications.

On 07/13/2020, I received and reviewed Resident B's Assessment Plan for AFC Residents dated 09/11/2020, signed by Ms. Hartley, Ms. Rein and Resident B. The assessment plan documents Resident B requires staff to administer all medications.

On 07/21/2020 I interviewed Ms. Horton via telephone. Ms. Horton stated her method of administering resident medications is that she pops the pills, brings a cup of water and watches the residents take their medications. When asked if she leaves the medications for the residents to take on their own or if she has seen any of the other DCW's leaving medications for residents to take unsupervised, Ms. Horton responded by saying, "no, not really."

On 07/21/2020, I interviewed Ms. Turley via telephone. Ms. Turley stated if the resident asks her to leave their medications on the table, she does it, if a resident is independent and in charge of themselves, Ms. Rein has told staff that they can leave the medications on the residents table for self-administration. Ms. Turley stated Resident A asked her to leave her medications on the table and then took a video of it. Ms. Turley stated she was disciplined by Ms. Rein due to the video showing her leaving Resident A's medications on the table in her room. Ms. Turley stated she no longer leaves resident medications unattended for residents to self-administer.

On 07/21/2020, I interviewed Ms. Lyons and Ms. Trevino individually via telephone. Ms. Lyons and Ms. Trevino stated they administer medications at the facility and always supervise residents when they take their medications, they do not leave the medications in residents room unattended. Ms. Trevino stated some of the DCWs passing medications will leave the medications unsupervised for residents to take on their own and she has seen pills in cups in residents room unattended. Ms. Trevino and Ms. Lyons stated Ms. Rein does not agree with leaving resident medications unattended in resident rooms, she tells staff not to do this.

On 07/30/2020, I conducted and Exit Conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she was aware of some of the issues in this facility and actively making changes in staff, staff training and the overall environment of this facility. Ms. Curtiss will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Based on investigative findings, there is a preponderance of evidence to show that resident medications are being left unattended in resident rooms by direct care staff at the facility. The taking of medications is not being supervised by staff at the facility and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff do not provide personal care to Resident's A & B per their assessed needs.

INVESTIGATION: On 05/19/2020, I received a complaint via email and followed up by a telephone call from Resident A. Resident A reported her scheduled shower dates are Monday, Wednesday and Fridays before lunch. Resident A stated on 05/11/2020, she waited all day for a shower and never got a shower. Resident A stated on 05/18/2020, she waited all day for a shower and asked staff, Lexie Mann twice for a shower and no one ever came to get her. Resident A stated LaToya Turley and Kamesha Spencer were also working but neither would give her a shower. Resident A stated this is not the first-time staff refused to give her a shower.

On 05/19/2020, I received a copy of a handwritten care plan dated 05/12/2020 and signed by Resident A and Ms. Rein. The care plan documented the following information. *'Showers-My (*showers*) are Mon-Wed-Fri on day shift before lunch. DaJane or Audra will be doing my showers if my choice of caregiver is unavailable.'*

On 05/27/2020, I interviewed Resident B via telephone. Resident B stated she has not had a shower in 3 weeks, only a bed bath. Resident B stated staff wash her body but not her hair. Resident B stated her scheduled baths are on 2nd shift on Tuesdays and Fridays. Resident B stated she requires the use of a Hoyer lift and a two-person assist and this building is a busy building for resident cares, so staff do not get around to showering her per her schedule.

On 05/29/2020, I interviewed Ms. Curtiss, Ms. Rein and Ms. Hartley. Ms. Rein stated Resident B requested bed baths, staff does not refuse to give her baths, she requested them. Ms. Rein stated sometimes staff get busy and when they go back to give Resident B her bath, it might be late and then Resident B tells staff she does not want a shower. Ms. Rein stated Resident A only wants her (Ms. Rein) or another

staff, DaJane to do her showers and refuses to allow other staff to assist her and this is not part of her care plan. Ms. Rein stated Resident A treats staff terrible, takes videos of them and reports their every move. Ms. Rein stated staff try to give Resident A showers but if she doesn't like them, she will refuse the shower.

On 07/13/2020, I reviewed the ADL (activities of daily living) logs for Resident A for the months of May and June 2020. The ADL logs document Resident A's showers for the month of May 2020 were signed by staff as administered on Monday, Wednesday and Friday's all month except on Monday, May 11 when staff Keyauna Caston documented at 3:05PM *'Resident refused AM shower.'* Resident A's June ADL log documents Resident A received showers on Monday, Wednesday and Fridays up until June 10th, from June 10th through the end of June, Resident A's shower ADL log is not signed by staff showing showers given and the AM shower ADL log shows they are DC'd (discharged).

On 07/13/2020, I received and reviewed Resident A's Assessment Plan for AFC Residents dated 08/22/2020, signed by Kat Hartley, administrator, Audra Rein, nurse and Resident A. The assessment plan documents Resident A requires assistance with bathing and documents she requires one staff to assist.

On 07/13/2020, I reviewed the ADL logs for Resident B for the months of May and June 2020. Resident B's showers are scheduled for afternoon between 3:30-5:30PM. Resident B's showers are documented as given every Tuesday and Friday throughout the month of May and June 2020. There are no notes to indicate whether the shower was a bed bath or an actual shower.

On 07/13/2020, I reviewed Resident B's assessment plan for AFC residents dated 09/11/2020 and signed by Ms. Hartley, Ms. Rein and Resident B. The assessment plan documents Resident B requires assistance from staff with showering. The assessment plan documents Resident B requires the use of a Hoyer Lift as an assistive device.

On 07/16/2020, I interviewed Resident A via telephone. Resident A stated her shower schedule was changed to 3rd shift in June, so she gets up at 4:30AM and gets her showers on a regular basis 3x each week. Resident A stated she loves it and there are no longer issues with her showers.

On 07/16/2020, I interviewed Resident B via telephone. Resident B stated she is getting showers regularly now because another person has been hired to assist with showers and she is getting them as scheduled.

On 07/21/2020 I interviewed DCW, Shiniece Horton via telephone. Ms. Horton stated Resident A's shower schedule has changed and it's going much better. Ms. Horton stated she has refused to provide showers and care for Resident A because of the way Resident A talks to her but someone else will get her shower done. Ms. Horton stated Resident A is disrespectful to her and pushes a lot of buttons with

many of the DCWs. Ms. Horton stated Resident B requires two staff to transfer her and sometimes staff are so busy caring for other residents in the building that they require assistance from staff in another one of the buildings to shower Resident B. Ms. Horton stated both Resident A and B get their showers as scheduled.

On 07/21/2020, I interviewed DCW LaToya Turley via telephone. Ms. Turley stated she has showered Resident A one-time and that a lot of the DCWs don't like to deal with Resident A, they don't feel comfortable with her because she tries to get them into trouble all the time. Ms. Turley stated she doesn't know anything more about Resident A's showers and if she gets them as scheduled or not. Ms. Turley stated Resident B was getting bed baths a lot because the shower chair in the shower room was broken and could not hold Resident B. Ms. Turley stated she does not know if Resident A or B were getting their showers as scheduled.

On 07/21/2020, A review of Resident A's ADL logs shows that Ms. Turley signed as showering Resident A 9 times out of the documented 12 showers given during the month of May and one time during the first 10 days of June 2020. After 06/10/2020, Resident A's shower scheduled was changed so Resident A began getting showers during third shift.

On 07/21/2020, I interviewed DCW Tiona Lyons via telephone. Ms. Lyons stated Resident B would often get bed baths and sometimes actual showers in the shower room. Ms. Lyons stated bathing Resident B can be rough because she often has spasms and loose bowels so showering ends up being a lot to clean up. Ms. Lyons stated she never denies Resident B a shower, but staff do try to avoid having to clean up a large mess after a shower by giving Resident B a bed bath instead of an actual shower. Ms. Lyons stated that Resident A's showering schedule is followed.

On 07/21/2020, I interviewed DCW Sierra Trevino via telephone. Ms. Trevino stated Resident B wants a shower when she wants it and if staff aren't able to give her a shower when she wants it, she will refuse and won't want it at all. Ms. Trevino stated Resident B will request to go to bed and refuse the shower so instead, staff give her bed baths so at least she is cleaned up. Ms. Trevino stated Resident A picks at staff constantly and then when she needs something, none of the staff want to touch her. Ms. Trevino stated Resident A will refuse a shower until staff take a break and then she will be ready and request care or her shower. Ms. Trevino stated Resident A still gets her showers, but it might not be right at the time she (Resident A) requests it.

On 07/30/2020, I conducted and Exit Conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she was aware of some of the issues in this facility and actively making changes in staff, staff training and the overall environment of this facility. Ms. Curtiss will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on investigative findings that include staff and resident interviews along with a review of resident ADL logs, there is a preponderance of evidence to show that Resident A & B's personal care in the way of showers are not provided as documented in the resident assessment plans and ADL logs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/28/2020

Elizabeth Elliott Date
Licensing Consultant

Approved By:

07/28/2020

Jerry Hendrick Date
Area Manager