GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 24, 2021

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS630405663
Investigation #: 2021A0993022
Seymour Home

Dear Ms. Ott:

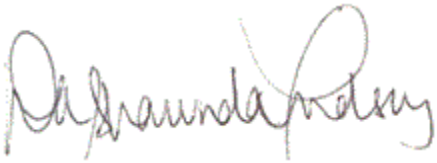
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630405663
Investigation #:	2021A0993022
Complaint Receipt Date:	04/26/2021
Investigation Initiation Date:	04/27/2021
Report Due Date:	06/25/2021
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Brittany Johnson
Licensee Designee:	Paula Ott
Name of Facility:	Seymour Home
Facility Address:	241 Cheltenham Oxford, MI 48371
Facility Telephone #:	(248) 572-6040
Original Issuance Date:	03/04/2021
License Status:	REGULAR
Effective Date:	03/04/2021
Expiration Date:	09/03/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 04/19/2021, Resident T asked for her medications early. Staff Angela Allen yell at her and told her to wait. Resident T and Ms. Allen began to verbally fight. Ms. Allen grabbed Resident T's hair and pushed and kicked her. Resident T told Ms. Allen to "cut it out" while Resident T grabbed onto Ms. Allen's legs. Assistant manager Jeffrey Brand also yell at Resident T and pushed her wheelchair causing her to hit the bathroom door.	Yes
• On 04/20/2021 at 8pm staff made Resident T sit with a full brief. An unknown staff threw her medications in the trash. Staff did not administer Resident T her medications. • Resident T asked assistant home manager Jeffrey Brand for assistance with getting into bed around 8/8:30pm and staff did not assist her into bed until 11:45pm. • On 05/02/2021, assistant home manager Jeffrey Brand ignored Resident T and did not give her food. • Staff turned off the WiFi in the facility.	Yes

III. METHODOLOGY

04/26/2021	Special Investigation Intake 2021A0993022
04/26/2021	Referral - Recipient Rights Received allegations from recipient rights advocate Rishon Kimble
04/27/2021	Special Investigation Initiated - Letter Emailed recipient rights advocate Rishon Kimble
04/28/2021	APS Referral Received allegations from adult protective services (APS). The assigned APS specialist is Nina Higgins.
05/06/2021	Inspection Completed On-site Conducted an unannounced onsite investigation
05/24/2021	Contact - Telephone call made Telephone call made to facility. Spoke with assistant home manager Jeffrey Brand

05/25/2021	Contact - Telephone call made Telephone call made to home manager Dionne Thomas. Left a message.
06/02/2021	Contact - Telephone call made Telephone call made to home manager Dionne Thomas. Left a message.
06/14/2021	Contact - Telephone call made Telephone call made to home manager Dionne Thomas. Left a message.
06/14/2021	Contact - Document Sent Emailed licensee designee Paula Ott and home manager Dionne Thomas
06/14/2021	Contact - Telephone call made Telephone call made to assistant home manager Jeffrey Brand. Left a message.
06/15/2021	Contact - Telephone call made Telephone call made to home manager Dionne Thomas. Left a message.
06/15/2021	Contact - Telephone call made Telephone call made to APS specialist Nina Higgins. Left a message.
06/15/2021	Contact - Telephone call made Telephone call made to recipient rights specialist Rishon Kimble. Left a message.
06/16/2021	Contact - Telephone call made Telephone call made to Sign Language Services. They agreed to call me back.
06/16/2021	Contact - Telephone call made Telephone call made to recipient rights specialist Rishon Kimble
06/16/2021	Contact - Telephone call made Telephone call made to APS specialist Nina Higgins
06/16/2021	Contact - Telephone call made APS specialist Nina Higgins and I contacted staff Angela Allen. Left a message. Sent a text message.

06/16/2021	Contact - Telephone call made Telephone call made to Central State Community Services Inc program coordinator Brittany Johnson
06/16/2021	Contact - Telephone call made Telephone call made to home manager Dionne Thomas. Left a message. Sent a text message.
06/16/2021	Contact - Document Sent Requested documentation
06/16/2021	Contact - Telephone call made Telephone call made to Open Arms support coordinator Elizabeth Culberson
06/16/2021	Contact - Telephone call made Telephone call made to Open Arms support coordinator assistant Nicholas Tait. Left a message.
06/16/2021	Contact - Telephone call made Telephone call made to behavioral psychologist Judy Frei. Left a message.
06/16/2021	Contact - Document Sent Requested a police report from Oakland County Sheriff's Department
06/17/2021	Contact - Document Received Received documentation from Oakland County Sheriff's Department
06/21/2021	Contact - Document Sent Requested documentation
06/22/2021	Contact - Document Received Received documentation
06/23/2021	Contact - Telephone call made Telephone call made to Open Arms support coordinator assistant Nicholas Tait. Left a message.
06/23/2021	Contact - Telephone call made Telephone call made to staff Angela Allen. "Number not in service"
06/23/2021	Contact - Telephone call made Telephone call made to staff Danique Draper

06/23/2021	Contact - Telephone call made Telephone call made to staff Nahbria Thompson
06/23/2021	Contact - Telephone call made Telephone call made to home manager Dionne Thompson
06/23/2021	Contact - Telephone call made Telephone call made to staff Dana Hudson. "Not accepting calls at this time"
06/23/2021	Contact - Telephone call made Telephone call made to recipient rights advocate Rishon Kimble
06/23/2021	Inspection Completed On-site Conducted an unannounced onsite inspection
06/23/2021	Contact - Telephone call made Interviewed Resident T via Sorenson Video Relay Services for the hearing impaired
06/24/2021	Exit Conference Exit conference held with licensee designee Paula Ott

ALLEGATION:

On 04/19/2021, Resident T asked for her medications early. Staff Angela Allen yell at her and told her to wait. Resident T and Ms. Allen began to verbally fight. Ms. Allen grabbed Resident T's hair and pushed and kicked her. Resident T told Ms. Allen to "cut it out" while Resident T grabbed onto Ms. Allen's legs. Assistant manager Jeffrey Brand also yell at Resident T and pushed her wheelchair causing her to hit the bathroom door.

INVESTIGATION:

On 04/26/2021, I received the allegations from recipient rights advocate Rishon Kimble.

On 04/28/2021, I received the allegations from adult protective services (APS). The assigned APS specialist is Nina Higgins.

On 05/06/2021, I conducted an unannounced onsite investigation. I interviewed assistant home manager Jeffrey Brand. Mr. Brand stated the facility is owned by a new company and he has worked with the new company for about seven months. He worked for the old company for about 21-22 years. Mr. Brand works second shift (from 3:30pm to 11:30pm) and sometimes midnight shift (from 11:30pm to 7:30am). Mr. Brand verified he worked in the facility on or around 04/19/2021 with staff Angela Allen. Per Mr. Brand, Resident T attacked Ms. Allen in the living room. Resident T had Ms. Allen in

the corner, with one hand on her shirt and the other hand in Ms. Allen's hair. This occurred around 7-7:30pm that day. Prior to the incident, Resident T asked Ms. Allen for her medications. Ms. Allen informed Resident T that the medication time was 9 o'clock in the evening. Resident T became upset and attacked Ms. Allen. Mr. Brand stated he separated Resident T and Ms. Allen. At the time, Resident T was in her wheelchair. Mr. Brand grabbed Resident T's hands away from Ms. Allen and turned her wheelchair around. Resident T wheeled herself into her bedroom and locked herself in there. Staff Danique Draper arrived at the facility later that day to work the midnight shift. When she arrived, Resident T talked to Ms, Draper. Ms. Draper called 911. Resident T told the police Ms. Allen kicked her in the stomach. Resident T was taken to the hospital.

Mr. Brand stated he caught the end of the altercation between Ms. Allen and Resident T. He denied hearing Ms. Allen yell at Resident T. He denied observing Ms. Allen pushed or kicked Resident T and/or pull Resident T's hair. He denied hearing Resident T tell Ms. Allen to "stop" or "cut it out". He denied observing Resident grabbing Ms. Allen's legs. Mr. Brand denied pushing Resident T in her wheelchair causing her to hit the bathroom door. He also denied yelling at Resident T.

During the onsite investigation, I attempted to interview Resident T with no success. Resident T is deaf. I was also unable to interview Resident P, Resident Q, Resident R, and Resident S due to their very cognitive abilities.

On 05/24/2021, I conducted a follow up interview with Mr. Brand. He stated Resident T was hospitalized about one week ago due to mental health concerns. He was unsure of her discharge date.

On 06/16/2021, I conducted a telephone interview with recipient rights advocate Rishon Kimble. Ms. Kimble stated her investigation was pending.

On 06/16/2021, I conducted a telephone interview with APS specialist Nina Higgins. Ms. Higgins stated Resident T has a history of making false allegations. Resident T tends to be "manipulative" and "attention-seeking" when she does not get her way. She has called the police numerous times. The police stated if she contacts their department again, they will arrest her. Ms. Higgins stated the investigation is pending, but as of now, she does not plan to substantiate the allegations.

On 06/16/2021, I conducted a telephone interview with Central State Community Services Inc program coordinator Brittany Johnson. Ms. Johnson stated she was not in the facility when the alleged incident occurred. Ms. Allen called her and saidd Resident T hit her, kick her, and tore her sweatshirt. When Ms. Johnson visited the facility, Resident T informed her Ms. Allen hit her, kick her, and tore her sweatshirt. Ms. Johnson denied observing any marks, bruises of injuries on Resident T. Ms. Johnson did not have knowledge of Mr. Brand or any other staff pushing Resident T's wheelchair, causing her to hit the bathroom door.

On 06/16/2021, I conducted a telephone interview with Open Arms support coordinator Elizabeth Culberson. Ms. Culberson stated Resident T informed her that she asked for her medications early. Ms. Allen yelled at her. Ms. Allen and Resident T began arguing. Resident T stated she grabbed Ms. Allen's foot and Ms. Allen grabbed Resident T's hair. Resident T stated Ms. Allen was tipping her wheelchair over while they were arguing. Mr. Brand observed them arguing and grabbed Resident T's wheelchair aggressively and made her hit her toe on the door frame. Per Ms. Culberson, it is common for Resident T to think someone is mad at her or arguing/yelling at her when that person is just simply talking to her.

Ms. Culberson stated staff are not communicating well with Resident T. To address this, she scheduled a training for staff with Deaf Can Interpreting Services on 06/30/2021. In the training, staff will learn the best way to communicate with Resident T.

On 06/17/2021, I received a log from Oakland County Sheriff's Department. Per the long, Ms. Draper contacted 911 on 04/20/2021 a little after midnight because Resident T was having stomach pain from someone kicking her in the stomach. Resident T stated she was assaulted. The log did not document who assaulted Resident T.

On 06/21/2021, I reviewed an incident report. Per the incident report, on 04/19/2021, Resident T asked for her 9pm medications. Staff Angela Allen told her she had to wait. Resident T started screaming for about 10 minutes. Ms. Allen went into the garage to see if Resident T would calm down. Resident T followed Ms. Allen into the garage, screaming the entire way. Resident T grabbed a broom and started hitting Ms. Allen with the handle. Ms. Allen walked out of the garage, around the front of the facility, and reentered the facility through the living room. When Resident T saw Ms. Allen, she grabbed a drink out of Ms. Allen's hand and threw it at her. She also grabbed Ms. Allen and started hitting her multiple times. Resident T grabbed Ms. Allen's hand and dug her nails into them, causing them to bleed. Resident T reached into Ms. Allen's pocket, grabbed Ms. Allen's cellphone, and slammed it on the ground. She also ripped Ms. Allen's cellphone pocket. Resident T continued to hit and bite Ms. Allen. Mr. Brand came in and got Resident T off Ms. Allen.

On 06/23/2021, I conducted a telephone interview with staff Danique Draper. Ms. Draper stated she has worked in the facility for almost two years. She works all shifts. Ms. Draper denied ever witnessing Ms. Allen, Mr. Brand or any other staff yell at Resident T, pull her hair, or do anything else inappropriate to her. Ms. Draper stated one day when she arrived at the facility Resident T was not in bed. Resident T looked distraught, and her eyes were puffy. Resident T informed her that Ms. Allen had kicked her three times in her stomach area and pulled her hair. Ms. Draper stated Resident T showed her a chunk of her hair in the trash. Resident T stated she was in too much pain to sleep. Ms. Draper called 911 and Resident T was transported to the hospital. Ms. Draper stated when she arrived at the facility, Ms. Allen was gone. She never discussed the incident with Ms. Allen. She also did not talk to Mr. Brand about the incident.

On 06/23/2021, I conducted a telephone interview with staff Nahbria Thompson. Ms. Thompson stated she has worked in the facility since October 2020. She mainly works first shift (from 7:30am to 3:30pm), but sometimes she works midnight shift (from 11:30pm to 7:30am). Ms. Thompson stated she did not have knowledge of the alleged incident between Ms. Allen and Resident T. When she arrived at the facility, Resident T was crying and stated she wanted to speak with the manager. Ms. Thompson stated Resident T never discussed the incident with her. Ms. Thompson denied hearing staff yell at Resident T or talk inappropriately to her.

On 06/23/2021, I conducted a telephone interview with home manager Dionne Thompson. Ms. Thompson stated she was on vacation when the alleged incident occurred between Ms. Allen and Resident T. Per Ms. Thompson, staff Nahbria Thompson Facetime her and said Resident T wanted to talk to her. Ms. Thompson stated although Resident T is deaf, she can understand Resident T. Also, sometimes, she writes notes to communicate with Resident T. Ms. Thompson stated Resident T was crying and said Ms. Allen pulled her hair and kicked or pushed her in the stomach. Ms. Thompson was not sure if Resident T said Ms. Allen kicked her in the stomach or pushed her in the stomach. Ms. Thompson stated Resident T has a history of exaggerating and making false allegations, but the way Resident T was crying, she knew there was some truth to what Resident T was saying. Ms. Thompson stated Ms. Allen was suspended pending the investigation. Ms. Allen eventually terminated her employment with the facility. Regarding staff yelling at Resident T, Ms. Thompson stated Resident T tends to think staff are yelling at her when staff are just speaking with her.

On 06/23/2021, I conducted a telephone interview with Resident T via Sorenson Video Relay Services for the hearing impaired. Resident T stated Ms. Allen screamed at her. Ms. Allen shook her by her hair. Ms. Allen grabbed her hair, shook her, and hit her in the stomach. The other residents were sleep when this occurred. Initially, Resident T stated no staff was present, but she later stated Mr. Brand was present and did not step in to help. Resident T stated Mr. Brand pushed her wheelchair, causing her to hit the bathroom door. She had to go the emergency room as a result. Resident T stated she thinks Mr. Brand did it on purpose. Resident T stated the staff yell and scream at her every day. At this point, she just ignores them. Resident T stated staff do not realize that she does not communicate the same way they do because she is deaf. Resident T stated staff need to be more culturally sensitive.

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:	Mr. Brand denied yelling at Resident T and pushing her wheelchair causing her to hit the bathroom door. Mr. Brand caught the end of the altercation between Ms. Allen and Resident T. According to Resident T, Ms. Allen kicked her in her stomach and pulled her hair. In addition, Mr. Brand pushed her wheelchair causing her to hit the door. Ms. Draper did not observe the incident, but Resident T showed her a chunk of her hair in the trash after the incident. Ms. Thompson said that Resident T has a history of exaggerating and making false allegations, but the way Resident T was crying, she knew there was some truth to what Resident T was saying. According to Ms. Culberson, it is common for Resident T to think someone is mad at her or arguing/yelling at her when that person is just simply talking to her. Ms. Culberson said staff are not communicating well with Resident T. To address this, she scheduled a training for staff with Deaf Can Interpreting Services on 06/30/2021. In the training, staff will learn the best way to communicate with Resident T.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **On 04/20/2021 at 8pm staff made Resident T sit with a full brief. An unknown staff threw her medications in the trash. Staff did not administer Resident T her medications.**
- **Resident T asked assistant home manager Jeffrey Brand for assistance with getting into bed around 8/8:30pm and staff did not assist her into bed until 11:45pm.**
- **On 05/02/2021, assistant home manager Jeffrey Brand ignored Resident T and did not give her food.**
- **Staff turned off the wifi in the facility.**

INVESTIGATION:

On 05/06/2021, I conducted an unannounced onsite investigation. I interviewed assistant home manager Jeffrey Brand. Mr. Brand denied he refused to give Resident T food on 05/02/2021 or any other day. Per Mr. Brand, he prepared food for Resident T and attempted to give it to her. Resident T stated she was full and did not want it. Mr. Brand stated he placed Resident T's plate on the stove. About two hours later, Resident T told staff Dana Hudson he did not give her any food. Ms. Hudson gave Resident T her plate and Resident T threw the food in the trash. Mr. Brand stated Resident T has been refusing food for "quite a while". Mr. Brand did not have knowledge of staff throwing Resident T's medications in the trash. Mr. Brand stated he does not administer medications. He did not have knowledge of staff not administering medications to

Resident T as prescribed. He stated all staff who administer medications are trained to do so. Mr. Brand stated Resident T does not want to be bothered with him or talk to him. He was instructed to avoid any confrontation with her or do anything that would get her upset. Mr. Brand stated Resident T does not want him to assist her with getting in bed. He has not put her in bed in months as a result. Mr. Brand stated he does not provide personal care (i.e., changing briefs, showering/bathing, assisting with dressing, etc.) to any of the residents. He denied observing staff refusing to change Resident T and making her sit in a full brief. Mr. Brand denied turning off the wifi in the facility.

On 06/16/2021, I conducted at telephone interview with Central State Community Services Inc program coordinator Brittany Johnson. Ms. Johnson denied ever observing Resident T in a full brief. She denied knowledge of staff refusing to change Resident T and forcing her to sit in a full brief. She denied knowledge of staff throwing Resident T's medications in the trash. She stated staff completed medication administration training, and they administer medications as prescribed. She denied knowledge of staff refusing to assist her with getting into her bed. She denied knowledge of staff not giving Resident T food and/or ignoring her.

On 06/16/2021, I conducted a telephone interview with Open Arms support coordinator Elizabeth Culberson. Ms. Culberson stated Resident T has reported to her that Mr. Brand does not give her food and ignores her. Per Ms. Culberson, Resident T tends to fixate on one staff in the facility. Right now, it is Mr. Brand. Resident T does not like Mr. Brand's cooking. When he offers her food, she refuses it and orders her something else to eat. Ms. Culberson denied knowledge of staff refusing to change Resident T and making her sit in a full brief. Ms. Culberson stated staff has not always administered Resident T's medications as prescribed. Sometimes, Resident T refuses her medications. Ms. Culberson stated Resident T informed her one day she asked Mr. Brand for assistance with getting into bed at 8:30pm and was not assisted until 11:45pm.

On 06/22/2021, I verified staff Angela Allen, Daniqua Draper, Nahbria Thompson as well as assistant home manager Jeffrey Brand and home manager Dionne Thompson completed medication administration training.

I observed Resident T's assessment plan. Per the plan, Resident T needs help with toileting (changing her briefs as needed) and dressing. Resident T can put on her shirt, but she needs help with putting on her pants. Resident T can push herself in the wheelchair.

I observed Resident T's weight chart from January 2021 to May 2021. I did not observe any weight loss concerns.

I reviewed several incidents reports (IRs). The following was documented:

- On 04/06/2021, Resident T refused a shower, dinner and her 9pm medications. She also refused to allow staff to change her brief.

- On 04/20/2021, Ms. Allen went into Resident T's bedroom to see if she wanted to change into her pajamas and change her briefs. Resident T started yelling at Ms. Allen and told her to get out of her room. Ms. Allen asked Resident T to call her back into her bedroom if she changed her mind. Resident T refused her 5pm medications that day. She also refused to eat dinner.
- On 04/21/2021, Resident T came into the kitchen at 9pm. Ms. Allen assumed Resident T wanted her medications. Ms. Allen got Resident T's medications ready and handed them to her. Resident T threw the medications to the ground and told Ms. Allen either "fuck you" or "fuck off". The incident report documented Ms. Allen was unsure exactly what Resident T said. On this day, Mr. Brand went into Resident T's bedroom and asked if she wanted assistance with getting into bed. Resident T stated, "no I'm waiting on 3rd shift". Resident T refused her 5pm medications on this day as well.

On 06/23/2021, I conducted a telephone interview with staff Danique Draper. Ms. Draper stated Mr. Brand and Resident T bump heads a lot. Resident T does not like what Mr. Brand cooks. She often refuses to eat. Resident T is a picky eater and orders outside food a lot. Ms. Draper stated she has witnessed Mr. Brand offer Resident T food and Resident T refused it. Ms. Draper stated she completed medication administration training and administers Resident T's medications to her as prescribed. Ms. Draper stated there has been several times where she observed Resident T in her wheelchair when she arrived at the facility at 11:30pm and had to put Resident T in bed. Ms. Draper did not know why Resident T was not in bed. Resident T has not stated to her that Mr. Brand refused to put her in bed. Ms. Draper denied turning off the wifi in the facility.

On 06/23/2021, I conducted a telephone interview with staff Nahbria Thompson. Ms. Thompson denied knowledge of staff not administering medications to Resident T as prescribed. She stated Resident T refuses her medications a lot. Ms. Thompson stated she completed medication administration training and administers medications as prescribed. Ms. Thompson denied ever witnessing staff not giving food to Resident T. Resident T often says she does not want the food staff prepare. Ms. Thompson stated often she has observed Resident T in her wheelchair when she arrived at the facility and had to put Resident T in bed. Ms. Thompson did not know why Resident T was not in bed. Resident T has not stated to her that Mr. Brand refused to put her in bed. Ms. Thompson denied turning off the wifi in the facility.

On 06/23/2021, I conducted a telephone interview with home manager Dionne Thompson. Ms. Thompson stated Resident T refuses her medications a lot. If she has an attitude with one of the staff, Resident T will refuse to take her medication as a way of getting back with that staff. Per Ms. Thompson, staff completed medication administration training and administer medications as prescribed. Ms. Thompson stated there was an incident where Mr. Brand offered Resident T food while she was on a Zoom call. Resident T did not want the meal at that time. Later, Resident T came out and asked for the meal. Mr. Brand ignored her. Staff Dana Hudson tried to give Resident T something to eat, and Resident T threw it in the trash. Per Ms. Thompson,

Resident T has told her that Mr. Brand has refused to put her in bed. In addition, staff has told her that Resident T was not in bed when they arrived at the facility and had to put Resident T in bed. Ms. Thompson stated Mr. Brand is not allowed to change and/or clean the female residents. If Resident T sees one of the female staff caring for another resident, Resident T will say she needs help at that very moment. Ms. Thompson denied that staff refuse to change Resident T and make her sit in a full brief. Ms. Thompson denied that staff turn off the wifi in the facility.

On 06/23/2021, I conducted an announced onsite investigation. I observed Resident T's medications and medication administration record (MAR) for June 2021. I observed the following:

- Staff did not initial the MAR to show administration of Resident T's medications at 7am on 06/07/2021.
- Staff did not initial the MAR to show administration of Pantoptazole SOD DR 40mg and DOK 100mg softgel at 5pm on 06/07/2021.
- Staff did not initial the MAR to show administration of Nystatin 100,000 unit/GM and Lorazepan 1mg at 9pm on 06/07/2021.
- Staff did not initial the MAR to show administration of Furosemide 40mg, Pantoprazole SOD DR 40mg, Potassium CL ER MEQ TA, Vitamin B-1 100mg and Aspirin EC 81mg at 7am on 06/22/2021.
- Staff did not initial the MAR to show administration of Pantoprazole SD DR 40mg and DOK 100mg softgel at 5pm on 06/22/2021.
- Staff did not administer Trintellix 10mg at 7am on 06/22/2021. I observed the pill still in the bubble pack.
- Staff did not initial the MAR to show administration of Vitamin D2 1.25mg (50,000) on 06/07/2021, 06/14/2021 and 06/21/2021. In addition, the time the medication was administered was not documented. I was able to verify the medication was given by observing the bubble pack.
- Staff did not initial the MAR to show administration of Metformin HCL 500mg daily at 7am and 5pm. I was able to verify the medication was given by observing the bubble pack.
- Staff did not initial the MAR to show administration of Trintellix 20mg, Trazadone 100mg, Melatonin 10mg, Montelukast SOD 10mg and Lorazepam 1mg at 9pm on 06/09/2021.
- Staff did not initial the MAR to show administration of Lorazepam 1mg at 9pm on 06/14/2021.
- Resident T refused all her medications at 9pm on 06/13/2021.

I also reviewed Resident T's MAR from April 2021. I observed the following:

- Resident T refused 5pm medications on 04/06/2021.
- Resident T refused 9pm medications on from 04/19/2021 to 04/21/2021.
- Staff did not initial the MAR to show administration of Metaformin HCL 500mg and Pantoprazole SOD DR 40mg at 5pm on 04/27/2021 or at 7am and 5pm from 04/28/2021 to 04/30/2021.
- Staff did not initial the MAR to show administration of Furosemide 40mg at 7am from 04/28/2021 to 04/30/2021.

- Staff did not initial the MAR to show administration of Trintellix 20mg, Trarzadone 100mg, Mealtonin 10mg, Montelukast SOD 10mg and Advair 250-50 Diskus at 9pm from 04/28/2021 to 04/30/2021.
- Staff did not initial the MAR to show administration of Advair 250-50 Diskus at noon from 04/28/2021 to 04/30/2021.

While at the facility, I observed menus posted and an adequate food supply.

On 06/23/2021, I conducted a telephone interview with Resident T via Sorenson Video Relay Services for the hearing impaired. Resident T stated Mr. Brand seem to be in a bad mood. He refused to give her food. He gave everyone food except for her. She stated it was another staff present that day, but she could not recall the staff's name. According to Resident T, staff quite regularly refuse to change her. Mr. Brand ignores her all the time. He does not give her medications to her either. Resident T stated there is nothing wrong with the wifi. It is working.

On 06/24/2021, I conducted an exit conference with licensee designee Paula Ott. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14303	**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:	According to Ms. Thompson, Mr. Brand is not allowed to change and/or clean the female residents. If Resident T sees one of the female staff caring for another resident, Resident T will say she needs help at that very moment. Ms. Thompson denied that staff refuse to change Resident T and make her sit in a full brief. Other staff interviewed also denied refusing to change Resident T's briefs and making her sit in a full brief. According to Mr. Brand, Resident T does not want him to assist her with getting in bed. He has not put her in bed in months as a result. Ms. Draper and Ms. Thompson acknowledged often they have observed Resident T in her wheelchair when she arrived at the facility and had to put Resident T in bed. They did not know why Resident T was not in bed. Resident T has not said to them that Mr. Brand refused to put her in bed. Per an IR, Mr. Brand went into Resident T's bedroom and asked if she wanted assistance with getting into bed. Resident T stated, "no I'm waiting on 3rd shift".
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Staff interviewed denied turning off the WiFi in the facility. Resident T stated there is nothing wrong with the WiFi. It is working.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff did not administer Trintellix 10mg at 7am on 06/22/2021During the onsite, I observed the pill still in the bubble pack.
CONCLUSION:	**VIOLATION ESTABLISHED**

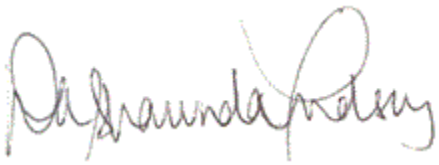
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medications of procedures.**

ANALYSIS:	On several days and at different times in April 2021 as well as in June 2021, staff failed to initial the MAR to show administration of medications as documented above.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Staff interviewed stated Resident T is offered food, but often she refuses it and orders something else to eat. During the onsite investigation on 06/23/2021, I observed an adequate food supply in the facility. I also reviewed Resident T's weight chart and did not observe any weight loss concerns.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

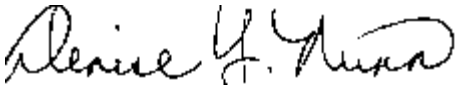
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



06/24/2021

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



06/24/2021

Denise Y. Nunn — Date
Area Manager