STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

May 27, 2021

Stephanie Hildebrant
Cliffside Company
910 S. Washington Av
Royal Oak, MI 48067

RE: License #: AL110077441
Investigation #: 2021A0579019
Caretel Inns Of Royalton Arlington

Dear Stephanie Hildebrant:

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:

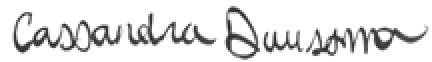
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and contact me with any questions. 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,



Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW, 7th Floor- Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110077441
Investigation #:	2021A0579019
Complaint Receipt Date:	03/12/2021
Investigation Initiation Date:	03/12/2021
Report Due Date:	05/11/2021
Licensee Name:	Cliffside Company
Licensee Address:	910 S. Washington Av Royal Oak, MI 48067
Licensee Telephone #:	(248) 330-9598
Administrator:	Stephanie Hildebrant
Licensee Designee:	Stephanie Hildebrant
Name of Facility:	Caretel Inns Of Royalton Arlington
Facility Address:	3905 Lorraine Path Saint Joseph, MI 49085
Facility Telephone #:	(269) 428-1111
Original Issuance Date:	07/17/1998
License Status:	REGULAR
Effective Date:	05/06/2020
Expiration Date:	05/05/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
The facility staffing level is insufficient.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/12/2021	Special Investigation Intake 2021A0579020
03/12/2021	Special Investigation Initiated - Letter Stephanie Hildebrant, Licensee Designee
03/12/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, with staff contact information.
03/16/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
03/20/2021	Contact- Document Received Text message from Direct Care Worker J
03/22/2021	Contact- Document Received Email response received from Stephanie Hildebrant, Licensee Designee, agreeing to coordinate for an on-site investigation.
03/22/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
03/23/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
03/31/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
04/08/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
04/09/2021	Contact- Telephone call made

	Direct Care Worker A
04/09/2021	Contact- Telephone call made Direct Care Worker B
04/09/2021	Contact- Telephone call made Direct Care Worker E
04/09/2021	Contact- Telephone call made Direct Care Worker F
04/09/2021	Contact- Telephone call made Direct Care Worker G
04/09/2021	Contact- Telephone call made Direct Care Worker C
04/09/2021	Contact- Telephone call made Direct Care Worker H
04/09/2021	Contact- Telephone call made Direct Care Worker I
04/09/2021	Contact- Telephone call made Direct Care Worker D
04/09/2021	Contact- Document Received Email response received from Stephanie Hildebrant, Licensee Designee, agreeing to be present for the on-site investigation 04/12/2021.
04/12/2021	Contact- Face to Face Stephanie Hildebrant (Licensee Designee), Candice Bearden (Direct Care Worker), Megan Aukerman (Licensing Consultant), Direct Care Worker V, Direct Care Worker W, and Resident A, B, and C.
04/12/2021	Contact- Document Received Additional allegations received from the Bureau of Community Health On-Line Complaint System
04/14/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, inquiring about staff clock-ins.
04/15/2021	Contact- Document Received

	Email response from Ms. Hildebrant reporting it would take additional time to receive staff clock-ins.
04/30/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, inquiring about staff clock-ins.
05/03/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, summarizing her review of staff clock-ins.
05/03/2021	Additional allegations received from the Bureau of Community Health On-Line Complaint System
05/03/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, providing information relating to the allegations received today.
05/06/2021	Contact- Telephone call made Direct Care Worker O
05/06/2021	Contact- Telephone call made Direct Care Worker P
05/11/2021	Contact- Telephone call made Direct Care Worker Y
05/11/2021	Contact- Telephone call made Direct Care Worker Z
05/26/2021	Exit Conference Stephanie Hildebrant, Licensee Designee

ALLEGATION: The facility staffing level is insufficient.

INVESTIGATION: On 03/12/2021, I entered this referral into the Bureau of Community Health System Bureau Information Tracking System after completing an on-site investigation at a connected facility where staff addressed concerns regarding insufficient staffing.

On 03/12/2021, I exchanged emails with Ms. Hildebrant obtaining the contact information for all Direct Care Workers (DCWs).

On 04/09/2021, I completed a telephone interview with DCW A. DCW A reported she has worked for CareTel for numerous years. She stated she has worked various

shift times at the facility but primarily works third shift. She stated she has worked alone at the facility during first, second, and third shift. She stated when she works alone, especially when residents are awake, she cannot provide adequate care to all the residents in the facility due to their care needs, such as transferring or toileting due to multiple residents needing the assistance of two DCWs to safely complete these tasks.

On 04/09/2021, I completed a telephone interview with DCW B. DCW B stated she works various shifts at the facility but primarily works second shift. She stated she has worked alone at this facility due to the facility being “short-staffed”. She stated she could not provide adequate care for all of the residents when working alone at the facility because multiple residents require the assistance of two DCWs.

On 04/09/2021, I completed a telephone interview with DCW F. DCW F works various shifts but primarily works first and second shift at this facility. She stated she has worked alone during her shifts. She stated residents do not receive adequate care with only one person on duty and are unsafe should there be a fire because multiple residents require the assistance of two DCWs with transferring or toileting.

On 04/12/2021, I completed an on-site investigation with the assistance of Licensing Consultant, Ms. Aukerman. Interviews were completed with Ms. Hildebrant, DCW X, and Residents A, B and D. Interviews were attempted with Resident P, Resident G and Resident H but they were not present in their rooms.

Resident A was interviewed privately. Resident A expressed frustration with third shift staff. She stated she has to push her call light multiple times during the night before any staff come to her aid. Resident A stated she feels third shift staff never come into her room to change her adult brief. Resident A stated the staff during first shift always provide adequate care.

Resident B was interviewed privately. Resident B stated she is very pleased with the care she receives at the facility. She stated staff always respond immediately when she uses her call light. Resident B stated staff, including third shift, always check on her during the day and night. Resident B denied having any concerns regarding the facility.

Resident C was interviewed privately. Resident C stated she enjoys residing at the facility and does not have any concerns. She stated all the staff are “fabulous”. Resident C stated she is very mobile and does not require a lot of staff assistance.

DCW X was interviewed privately and stated she has worked at the facility since October 2020. DCW X stated she typically works first shift. She stated she is aware that third shift do not appropriately toilet or transfer residents. She stated she and other staff who work first shift come in after third shift, and find residents in urine saturated briefs. She stated she feels first shift has adequate staffing to meet resident care needs.

While on-site I reviewed the written assessment plan for Resident A, B, C, D, E, F, H, I, J, L, M, N, O and P. Resident G, H and I did not have written assessment plans completed. Resident K and B were listed as transferring and ambulating independently. Resident E, C, J, L, N and O were listed as needing “limited” assistance from one DCW with transferring and/or ambulating. Resident D was listed as needing “extensive” assistance from two DCWs with transferring and/or ambulating. Resident A, F and P were listed as needing “total” assistance from two DCWs with transferring and/or ambulating, indicating they are not weight bearing.

I also reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules noted there were two DCW on 03/24/2021, 03/31/2021, and 04/09/2021 from 7:00 AM to 3:00 PM. There were two DCW on 03/24/2021 and 04/09/2021 from 3:00 PM to 11:00 PM. There were three DCW on 03/31/2021 from 3:00 PM to 11:00 PM. There was one DCW on 03/24/2021, 03/31/2021, and 04/09/2021 from 11:00 PM to 7:00 AM. The schedule also listed a section for a “Float” staff, the position was not filled on 03/24/2021, 03/31/2021, and 04/09/2021.

On 05/04/2021, I received an email from Relative Q1 who stated when she visited Resident Q on 04/04/2021, she was unable to find any Direct Care Workers on the floor of the facility. She stated it was common when she came to visit that DCWs were not readily available. She stated a worker from the attached skilled nursing facility was at Arlington handing out candy to residents and that worker had to yell down a hallway adjacent from the facility for assistance from a DCW. She stated when the DCW arrived, the DCW stated hospice needed to be contacted immediately as Resident Q needed medical treatment.

On 05/06/2021, DCW P stated she primarily works third shift, on her own, at this facility. She stated she is able to provide adequate care for residents on her own.

On 05/11/2021, I completed a face-to-face interview with DCW Z who stated she has worked alone at this facility during first shift on one occasion. She stated she does not recall the exact date. She stated it is not possible for one DCW to provide adequate care for all the residents in this facility when working alone during first shift. She stated residents require the assistance from more than one staff person when they are awake to ensure their personal care needs are met.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	The written assessment plan for Resident D noted she needs “extensive assistance” with transferring and/or ambulating from two Direct Care Workers. The written assessment plan for Resident A, F and P noted they need “total assistance” with transferring and/or ambulating from two Direct Care Workers. Direct Care Worker A, B, F, P and Z noted they have worked alone during their shifts at Arlington House. Due to the findings summarized above there is sufficient evidence to indicate the facility is not sufficiently staffed at all times to provide supervision, personal care, and protection of residents and to provide the services specified in the residents’ assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 04/09/2021, I completed a telephone interview with DCW A. DCW A reported she has worked for CareTel for numerous years. She stated she has worked various shift at the facility but primarily works third shift. She stated she has worked alone at the facility during first, second and third shift. She stated when she works alone, especially when residents are awake, she cannot provide adequate care to all the residents due to their care needs, such as transferring or toileting due to multiple residents needing the assistance of two DCWs to safely complete these tasks.

On 04/09/2021, I completed a telephone interview with DCW B. DCW B stated she works various shifts at the facility but primarily works second shift. She stated she has worked alone at this facility due to the facility being short-staffed. She stated she could not provide adequate care for all residents when working alone at the facility because multiple residents require the assistance of two DCWs.

On 04/09/2021, I completed a telephone interview with DCW F. DCW F works various shifts but primarily works first and second shift at this facility. She stated she has worked alone during her shifts. She stated residents do not receive adequate care with only one person on duty and are unsafe should there be a fire because multiple residents require the assistance of two DCWs with transferring or toileting.

On 04/12/2021, Resident A expressed frustration with third shift staff. She stated she has to push her call light multiple times during the night before any staff come to her aid. She stated she feels third shift staff never come into her room to change her adult brief. She stated the staff during first shift always provide adequate care.

Resident B stated she is very pleased with the care she receives at the facility and denied any concerns regarding any shift.

Resident C stated she enjoys residing at the facility and does not have any concerns. Resident C stated she is very mobile and does not require a lot of staff assistance.

While on-site I reviewed the written assessment plan for Resident A, B, C, D, E, F, H, I, J, L, M, N, O and P. Resident G, H and I did not have written assessment plans completed. Resident K and B were listed as transferring and ambulating independently. Resident E, C, J, L, N and O were listed as needing “limited” assistance from one DCW with transferring and/or ambulating. Resident D was listed as needing “extensive” assistance from two DCW with transferring and/or ambulating. Resident A, F, and P were listed as needing “total” assistance from two DCW with transferring and/or ambulating, indicating they are not weight bearing.

I also reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules noted there were two DCW on 03/24/2021, 03/31/2021, and 04/09/2021 from 7:00 AM to 3:00 PM. There were two DCW on 03/24/2021 and 04/09/2021 from 3:00 PM to 11:00 PM. There were three DCW on 03/31/2021 from 3:00 PM to 11:00 PM. There was one DCW on 03/24/2021, 03/31/2021, and 04/09/2021 from 11:00 PM to 7:00 AM. The schedule also listed a section for a “Float” staff, the position was not filled on 03/24/2021, 03/31/2021, and 04/09/2021.

On 05/06/2021, DCW P stated she worked alone at this facility during third shift. She stated she is able to provide adequate care for residents when working alone.

On 05/11/2021, I completed a face-to-face interview with DCW Z who stated she regularly arrives for her shift to find residents left in urine and feces saturated briefs so soiled that it is apparent that they were not toileted appropriately overnight. She stated there used to be numerous DCWs who did not complete their resident care duties on third shift, but most no longer work at the facility. She stated there is still one DCW working third shift, DCW M, who regularly leaves residents in saturated briefs. She stated it is known the DCW M does not toilet residents because when the third shift DCW who regularly works at this facility, DCW P is on duty, residents' briefs are not found to be excessively saturated or soiled.

On 05/11/2021, I completed a face-to-face interview with DCW Y who stated she regularly arrives for her shift to find residents left in urine and feces saturated briefs so soiled that it is apparent that they were not toileted appropriately overnight. She stated there is still one DCW working third shift, DCW M, who regularly leaves residents in saturated briefs. She stated it appears from how saturated the briefs are that residents were not appropriately toileted overnight.

04/12/2021, I received additional information, through the Bureau of Community Health Systems on-line complaint system, relating to the complaint. It was reported Resident J was in her room with Relative J1 when she began choking on candy. Relative J1 pushed Resident J's call light for help and encouraged Resident J to cough while waiting. No staff arrived, but Resident J settled down without staff

assistance. Relative J1 later saw Direct Care Worker Z and asked why no one came to assist Resident J. Direct Care Worker Z stated she could not respond because "someone took the pager home from third shift" and reported there was not another one. Relative J1 expressed concern that Resident J could have choked to death.

On 05/11/2021, Ms. Bearden stated the choking incident Resident J had was brought to her attention by relatives after it had occurred. She stated there were two DCWs working but one was without a call light pager because third shift had accidentally brought one home that morning. She stated in response to those concerns, there are now three pagers mounted in the facility so they can be heard throughout the facility, in addition to the pagers each DCW wears during their shift.

On 05/11/2021, DCW Z confirmed there were two DCWs on duty when Resident J had her reported choking incident, but there was only one pager available because third shift accidentally brought a pager home. She stated there are now three pagers mounted to the walls of the facility in addition to the pagers each DCW wears on their shift.

On 05/11/2021, DCW Z stated she was working when Relative J1 reported Resident J had choked. She stated she was coming in from emptying the trash at the end of her shift and she was stopped by Relative J1 who inquired why no one came when she had pressed Resident J's call light and that Resident J waited 30 minutes for assistance. She stated she reported there were call light pagers that staff wear but only one staff person had a pager because the third shift staff had taken the second pager home. She stated she checked Resident J and found her to be fine. She stated the worker with the pager did not respond because she was busy tending to other residents and did not arrive to the room prior to Relative J1 stopping her. She expressed concern that relatives knew Resident J choked at Easter dinner and later in April 2021, but still brought her a steak that they fed her in her room and reported to staff she also started choking on. She inquired why if there were multiple relatives in Resident J's room, why none of them left the room to seek help from staff.

On 05/11/2021, DCW Y stated relatives reported Resident J choked at home on Easter in April 2021. She stated she was also aware of an incident where relatives brought Resident J a steak to eat in her room while relatives were present, and they reported she choked on that as well. She expressed concern that relatives continue to say that staff are not appropriately supervising Resident J to prevent her from choking but continue to bring Resident J things she can choke on in a snack basket in her room. She stated relatives bring Resident J dry muffins, dry cupcakes, and other items that are easy to choke on.

On 05/11/2021, I completed a face-to-face interview with Resident J. She denied ever choking. She was observed eating snacks including chocolate and Oreo cookies in her room while a private aide, not associated with CareTel, assisted her.

05/03/2021, I received an additional complaint, through the Bureau of Community Health Systems on-line complaint system, it was reported Resident Q was a resident of Arlington prior to her death. She was unwell due to a Urinary Tract Infect (UTI). She was put in a wheelchair and taken to breakfast. She could typically sit and feed herself but was weak due to her UTI. She fell from her wheelchair, hit her head, and died four days later due to her head injury. Resident Q's cause of death was listed as Accidental Death Due to Blunt Trauma to the Head. The complaint indicated that no one associated with the facility explained Resident Q's injuries and did not communicate following Resident Q's hospitalization and a review of the video footage of the incident was requested.

On 05/03/2021, I emailed Ms. Hildebrant to request documentation relating to Resident Q's fall and death. I requested to view video footage of the incident if it was available. Ms. Hildebrant responded there are cameras in the common areas but they are "written over" since the incident was so long ago, so the footage may not be available. She agreed to provide documentation for Resident Q and video footage if it was available.

On 05/04/2021, Ms. Hildebrant responded via email with Resident Q's medical records and a written summary Resident Q's care and fall. Ms. Hildebrant reported Resident Q was admitted on 03/15/2019 from hospice care. She was 97 years old with a diagnosis of dementia, in additional to multiple other health diagnosis. She stated a psychiatric note from 03/3/2021 shows Resident Q's dementia progression with agitation and disorientation. She stated a psychiatric note from December 2020 could verify significant cognitive decline from December 2020 to March 2021 which is when Resident Q fell. Ms. Hildebrant stated, *'On 3/30/2021 she was sent to the emergency room for change in mental status. She became very aggressive and combative (more so than usual) and actually got a skin tear to her arm and would not keep the dressing on it. The hospital did CT, CXR and labs - believes she had a UTI and daughter asked she be sent back. CT, CXR and labs didn't show anything significant. On 4/2/2021 - she did have a witnessed fall in the dining room when finishing breakfast around 9am. She did hit the left side of her head and was sent back to the emergency room for medical treatment. There the family decided not to do any further testing or intervention so an additional CT was not ordered. She was sent back to the facility for end of life care because she continued to decline. She could not be admitted to hospice because she did not have insurance that would cover it (she was foreign born). She had been hospice appropriate for some time.'* She stated Resident Q died on 04/06/2021. She stated it was not Resident Q's fall that resulted in her death, rather the fall was a symptom of her decline in functioning prior to her death. She stated DCW L and DCW Y were witnesses to the incident but DCW L is no longer employed at the facility.

On 05/04/2021, I reviewed the documentation provided by Ms. Hildebrant. Resident Q's psychiatric notes from 12/04/2020 and 03/03/2021. It was noted in March 2021, Resident Q presented with increased confusion and disorientation with her thoughts being incoherent at times. It was noted staff reported Resident Q as increasingly

anxious and agitated. It was noted in December 2020, that Resident Q was not presenting with increased behavioral/emotional disturbances.

On 05/11/2021, Ms. Bearden also stated she was aware Resident Q did have a fall prior to her death. She stated Resident Q was rapidly declining and became more confused in March 2021 prior to her fall. She stated after the fall, Resident Q returned to the facility because she was not eligible for hospice services due to her insurance. She stated it was expected when she returned that Resident Q would be receiving end of life care.

On 05/11/2021, DCW Z confirmed there were two Direct Care Workers present when Resident Q fell.

On 05/11/2021, DCW Z stated she also worked with Resident Q prior to her death. She stated prior to her going on vacation for one week in March 2021, Resident Q began to decline. She stated Resident Q was not eating as much, although she usually had a good appetite, and was confused. She stated she returned from vacation and Resident Q was bed-bound and appeared to be nearing end of life. She stated Resident Q's decline prior to her death began before Resident Q had her fall.

DCW Y stated she was working when Resident Q fell. She stated she was preparing medication in the medication room when another resident yelled, "She's falling." She stated she ran to the dining room and she heard Resident Q fall as she turned the corner to go to the dining room. She stated DCW L was sitting approximately three feet away from Resident Q, with her back to her, when this happened. She stated she looked Resident Q over, assisted her back into her wheelchair, and determined it was necessary to call 911 since Resident Q had a laceration on her head from the fall.

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:	The written assessment plan for Resident B, F, H, J and O noted they needed assistance from two Direct Care Workers with transferring and/or ambulating. The schedule for 03/24/2021, 03/31/2021, and 04/09/2021 noted there was one DCW from 11:00 to 7:00 AM each day. DCW A, B, F and O reported working alone at the facility and expressed concern for resident care and/or safety when working alone due to residents requiring the assistance of two DCWs.

	DCW Y and DCW Z reported they regularly arrive for their shift to find residents left in urine and/or feces soiled briefs that are so saturated it is apparent that residents were not toileted appropriately overnight. Based on the interviews completed and documentation observed, there is sufficient evidence to support the allegation that residents did not receive sufficient supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 03/20/2021, DCW J sent me a text message stating DCW Z is *'trying to fill [staff] sign in sheets with people they know are not going to show up and are not even in town just so [Licensing] think[s] that [the home] is fully staffed.'* DCW Z is a Direct Care Worker with the title of who also has the title of Facility Director and oversees all the facilities located at this address.

On 04/09/2021, DCW A stated employee schedules are intentionally falsified by DCW Z to make it appear as if there are sufficient staff on duty although the facility is "severely short-staffed." She stated she knows the schedules are intentionally falsified because on multiple occasions staff names have been placed on the schedule even though it is a shift they do not work. She stated staff are not notified they were placed on the schedule and therefore they do not show up to work. She stated there were multiple occasions where she had to call someone whose name was on the schedule, only to find out they would not be coming in because they did not know they were on the schedule and no one had contacted them. She stated staff who are known to have ended their employment will continue to be written on the schedule as well. She stated it is well known the employee has quit but their name will continue to be written down as if they were working. She stated any written or printed schedule would not be accurate. She stated the only accurate way to confirm who worked, would be to review staff clock-ins because anything managed by DCW Z would be falsified.

On 04/09/2021, DCW B stated staff schedules are intentionally falsified by DCW Z. She gave the example of DCW Q, whose name has been written on the schedule during weekdays to make it appear the schedule is full. She stated DCW Q only works two weekends a month and is not notified when she is placed on the schedule outside of those two weekends, so she does not arrive to work although her name is written on the schedule. She stated people who are no longer employed by the facility are written on the schedule as well.

On 04/09/2021, DCW H reported staff schedules are intentionally falsified. She stated names of employees are just written down, even if they are not notified that they were placed on the schedule or if they had ended their employment. She stated she knows this because it happened to her on one occasion. She stated she is "contingent" which means she only works two weekends a month. She stated one weekday, she was contacted by someone inquiring why she was not present for her shift. She stated her name was on the schedule, but she was not informed by anyone that she was assigned to work. She stated she has another job and was working that job. She stated she believes she was written in as a "no call, no show" but it is unfair because she was not notified that she was scheduled, nor is that a schedule she typically works.

On 04/09/2021, DCW C stated she has witnessed staff schedules being intentionally falsified by DCW Z. She stated that employee names are frequently just written down without notifying the employee or with knowledge that the employee no longer works at the facility. She stated although there is a name on the schedule, the person does not show up. She stated this happens "all the time."

On 04/09/2021, DCW I reported staff schedules are intentionally falsified. She stated "names are just put down" to make it appear there is sufficient staffing. She stated names of people who do not typically work that shift and are not notified that they were scheduled, are written in. She stated names of people who are known to have quit also continue to be written in to make the facility appear fully staffed.

On 04/09/2021, DCW F staff schedules are intentionally falsified by DCW Z. She stated names are written down for shifts or days employees typically do not work. She stated the written and printed staff schedules do not accurately reflect who is present for the shift.

On 04/09/2021, DCW G stated the staff schedule is not accurate. She stated often, names are written down and employees are unaware they are expected to be working because they were not notified. She stated this is done intentionally to make the schedule appear sufficiently staffed.

On 04/12/2021, I reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules appeared to note schedule changes, the hours worked, the names of staff on duty, the job titles of staff on duty, and the date and hours worked.

On 04/12/2021, Ms. Hildebrant stated she was not aware of the allegation that staff schedules were being falsified. I reported that I had sufficient evidence to support that staff schedules were intentionally being falsified. She stated that she would review the record of employee clock-ins and provide that information to me.

On 04/14/2021, I inquired of Ms. Hildebrant via email if the record of employee clock-ins were available for my review. Ms. Hildebrant responded that it would take additional time for her to receive and review the employee clock-in record.

On 04/30/2021, I inquired again via email to Ms. Hildebrant if employee clock-in records were available for my review.

On 05/03/2021, Ms. Hildebrant responded to my email from 04/30/2021, that she had gone through timecards and realized there were primarily concerns with adequate staffing on the midnight shift. She stated they have started having management supervision on the midnight shift. She stated the evening supervision has been replaced and staff with problematic behavior were released from duty. Ms. Hildebrant did not include any mention of providing me with the employee "clock-in" record in her 05/03/2021 email.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(c) Hours or shifts worked.** **(e) Any scheduling changes.**
ANALYSIS:	I reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules appeared to note schedule changes, the hours worked, the names of staff on duty, the job titles of staff on duty, and the date and hours worked. DCW A, DCW B, DCW H, DCW C, DCW I, DCW F and DCW G reported staff schedules are falsified to make the facility appear sufficiently staffed. Each reported that the names of individuals who do not typically work certain shifts, certain days, or have knowingly ended their employment continue to be written down on the schedule without informing the individual they are scheduled. I asked Ms. Hildebrant multiple times to provide employee clock-in forms. Ms. Hildebrant did not provide those forms and instead summarized her findings from her own review of the clock-in forms noting there were primarily concerns with the staffing on third shift.

	Based on the interviews of staff who reported schedules are falsified, there is sufficient evidence to indicate that staff schedules do not accurately include the names of all staff on duty, hours and shifts worked, and any scheduling changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 03/20/2021, I received a text message from Direct Care Worker J that stated, *'[DCW Z] is telling us [Licensing] are not our friend and we need to tell you guys that we never work alone.'* She also stated, *'DCW Z is trying to fill [staff] sign in sheets with people they know are not going to show up and are not even in town just so [Licensing] think[s] that [the home] is fully staffed.'*

On 04/08/2021, I exchanged emails with Ms. Hildebrant coordinating an on-site investigation. I requested DCW Z not participate in the scheduled on-site investigations as I had concerns regarding her being intentionally deceitful and obstructive with the investigative process after completing an on-site investigation for a facility DCW Z also oversees on 03/09/2021.

On 04/09/2021, DCW B denied that DCW Z recently told her to give false information to licensing. She stated, however, that the staff schedules are intentionally falsified by DCW Z.

On 04/09/2021, DCW A stated DCW Z "lies about everything" and "falsifies paperwork to cover up concerns" within the facility. She stated the staff schedule is falsified because names of employees who do not work a certain shift, a certain day, or have knowingly ended their employment will continue to be placed on the schedule without notifying the scheduled individual. She stated the written schedule does not accurately note who worked, rather it makes it appear the facility is sufficiently staffed when it is not.

On 04/09/2021, DCW H reported staff schedules are intentionally falsified and she witnessed it firsthand when her name was put down for a day she does not work. She stated she found this out when staff called and asked why she was not at work. She stated the staff schedules are approved by DCW Z.

On 04/09/2021, DCW C stated she has witnessed staff schedules being intentionally falsified by DCW Z. She stated that employee names "are frequently just written down" without notifying the employee or with knowledge that the employee no longer works at the facility.

On 04/09/2021, DCW I reported staff schedules are intentionally falsified. She stated "names are just put down" to make it appear there is sufficient staffing and DCW Z is aware.

On 04/09/2021, DCW F stated staff schedules are intentionally falsified by DCW Z. She stated names are intentionally written down for people on shifts or days employees typically do not work without notifying the employee to make it appear the facility is adequately staffed. She stated when she and other staff members bring concerns to DCW Z, DCW Z does not address them, rather DCW Z "covers everything up."

On 04/09/2021, DCW G stated often, names are written down and employees are unaware they are expected to be working because they were not notified. She stated this is done intentionally to make the schedule appear sufficiently staffed and DCW Z is aware.

On 04/20/2021, DCW B inquired why I had completed my investigation without any changes being made within the facility and implored me to investigate further. I inquired what she meant and reported that my investigation was not completed. She stated DCW Z held a "threatening meeting" on 04/19/2021, stating she "was aware of what staff had said" and that "all concerns have been addressed" and "licensing said everything was fine." DCW B was advised that was not accurate and that my investigation was ongoing.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	DCW J reported DCW Z advised staff not to cooperate with licensing. DCW B reported DCW Z held a "threatening meeting" on 04/19/2021 where she told staff she was "was aware of what staff had said" and that "licensing said everything was fine." DCW A noted DCW Z "lies about everything." DCW B stated DCW Z "lies all of the time." DCW F stated DCW Z "covers everything up." DCW J, DCW A, DCW B, DCW F, DCW H, DCW C, DCW G, and DCW I reported staff schedules are intentionally falsified with DCW Z's knowledge. Based on the interviews completed, there is sufficient evidence to indicate that not all employees who are under the direction of

	the licensee, primarily DCW Z, are suitable to assure the welfare of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 04/12/2021, I observed the assessment plan for each resident at Arlington House. Resident G moved into the facility on 03/19/2021 and did not have a written assessment plan. Resident H moved into the facility on 03/19/2021 and did not have a written assessment plan. Resident I moved into the facility on 03/29/2021 and did not have a written assessment plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.** **(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.**
ANALYSIS:	Assessment Plan were not completed for Resident G, H and I. Based on my review of documentation, Resident G, H and I were accepted for care without written determination that they were suitable for the personal care, supervision, and personal

	care available, nor that the services, skills, and physical accommodations required were available, nor that residents are compatible with other residents. Additionally, a written assessment plan was not completed at the time of the resident admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 04/12/2021, I received allegations that Resident J's bathroom was observed to have feces on the floor and toilet. Relative J1 requested the room be cleaned. The following day, feces was again found in Resident J's bathroom.

On 05/11/2021, DCW Y reported Relative J1 requested that DCW Y scrub Resident J's toilet because there was an approximately dime sized amount of feces left inside Resident J's toilet bowl. She denied there ever being feces on the outside of Resident J's toilet or on her floor.

On 05/11/2021, DCW Z stated Resident J's family has high expectations for cleanliness for Resident J's room. She stated staff work hard to keep Resident J's room well-kept or otherwise the family will make complaints about the condition of Resident J's room.

On 05/11/2021, I observed the rooms and bedrooms of Resident B, F, M, P and R. I found Resident F, M, P and R to have clean rooms and bathrooms. I observed Resident B's room had dried food ground into her carpet surrounding her recliner and bed. I observed Resident M's toilet seat was soiled with dried urine and feces. There were also patches of dried feces on the floor surrounding his toilet.

On 05/11/2021, Relative B1 was observed visiting with Resident B. He stated he has concerns regarding the dried food embedded in the carpet of Resident B's room by her recliner and bed. He stated it has been there for several days. He stated previously there was a vacuum in the hallway, but staff recently moved it. He stated he intended to vacuum the carpet himself for Resident B. He stated he brought the food to staff's attention and they reported it was from Resident B choosing to eat meals in her room recently. He stated aside from that, he has no concerns regarding the condition of Resident B's room.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	I observed Resident M's toilet seat and the floor surrounding his toilet was soiled with dried urine and feces. I observed Resident B's room had dried food ground into the carpet surrounding her recliner and bed. Relative B1 reported there has been dried, ground food on the floor of Resident B's room for several days. Based on my summarized observations and interview, there is sufficient evidence to indicate the facility is not maintained to provide adequately for the health, safety, and wellbeing of residents due to dried urine and feces being found on a resident toilet and dried, ground food found in another resident bedroom that was reported to have been there for several days.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

05/03/2021, I received additional information, through the Bureau of Community Health Systems on-line complaint system, relating to the complaint. It was reported Resident Q's weight was found to be 70 pounds when she was hospitalized in March 2021. The facility reported she weighed 84 pounds at that time.

On 05/11/2021, Ms. Bearden reported that Resident Q was always very petite for the entire time she resided at Arlington House. She stated she does not believe Resident Q had any significant weight loss or weight gain.

On 05/11/2021, DCW Y stated Resident Q was "always very tiny" even though "she always had a good appetite and usually ate 100% of her meals." She stated Resident Q did start to eat less prior to her fall but she does not believe Resident Q had any significant weight loss.

On 05/11/2021, DCW Z stated Resident Q was very thin. She stated Resident Q ate very well but did not gain weight. She stated around the time Resident Q began to decline before her fall in March 2021, Resident Q began to eat less. She stated she does not believe Resident Q had any significant weight loss while residing at the facility.
On 05/11/2021, I reviewed the weight records for Resident Q from 03/15/2019 when she was admitted to 02/08/2021. Resident Q's weight consistently remained around 80 pounds. Her weight at admission was noted as 83 pounds. Her highest weight was noted as 90 pounds in June 2019. Her lowest weight was noted as 78 pounds in July 2019, April 2020, and February 2021 which was the last weigh in recorded prior to her death.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	I reviewed Resident Q's weight records from March 2019 to February 2021. Resident Q did not experience documented significant weight loss and remain near approximately 80 pounds. Ms. Bearden, DCW Y, and DCW Z reported that Resident Q was thin throughout her stay at Arlington House. Based on the interviews and documentation summarized above, there is insufficient evidence to support allegations that Resident Q's weight records were not maintained.
CONCLUSION:	VIOLATION NOT ESTABLISHED

05/26/2021, I completed an exit conference with Licensee Designee, Stephanie Hildebrant, who reported she disputes my findings pending further review of the written report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license be modified to a provisional license.

Cassandra Duursma 05/26/2021

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 05/27/2021

Jerry Hendrick Date
Area Manager