GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2021

Destiny Saucedo-Al Jallad
Turning Leaf Res Rehab Svcs., Inc.
P.O. Box 23218
Lansing, MI 48909

RE: License #: AL390392504
Investigation #: 2021A0581051
Birch Cottage II

Dear Mrs. Saucedo-Al Jallad:

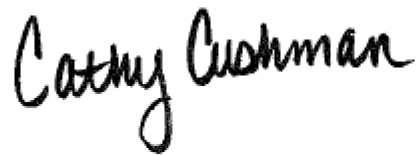
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9730.

Sincerely,



Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390392504
Investigation #:	2021A0581051
Complaint Receipt Date:	08/27/2021
Investigation Initiation Date:	08/27/2021
Report Due Date:	10/26/2021
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Zeta Francosky
Licensee Designee:	Destiny Saucedo-Al Jallad and Sami Al Jallad
Name of Facility:	Birch Cottage II
Facility Address:	13326 N. Boulevard St. Vicksburg, MI 49097
Facility Telephone #:	(269) 585-8762
Original Issuance Date:	11/14/2019
License Status:	REGULAR
Effective Date:	05/14/2020
Expiration Date:	05/13/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with supervision while out in the community.	Yes
The licensee did not provide transportation to Resident A when required to do so.	Yes
The Administrator, Zeta Francosky, swore and threw chairs at Resident A. Ms. Francosky threatens other residents in the facility and acts inappropriately.	Yes

III. METHODOLOGY

08/27/2021	Special Investigation Intake 2021A0581051
08/27/2021	Special Investigation Initiated - Letter Sent a referral to Macomb Co. CMH.
08/27/2021	Referral - Recipient Rights Macomb Co. Office of Recipient Rights.
08/31/2021	Inspection Completed On-site Interviewed Administrator, Activity's Director, staff and obtained documentation.
09/21/2021	Contact - Telephone call made Interview with direct care staff, Stephanie Lamb
09/23/2021	Contact - Document Received Received additional allegations from intake #182182
09/23/2021	APS Referral APS received allegations but denied them for investigation.
09/23/2021	Contact - Telephone call made Interview with direct care staff, Kayla Jackson
09/24/2021	Contact - Telephone call made Interviews with Ms. Jackson and Ms. Lamb.
09/27/2021	Contact – Document Sent Requested Resident A's *Resident Care Agreement* and received via email.

09/28/2021	Contact – Document Sent Email correspondence with Kendra Casper, Macomb RRO.
09/29/2021	Contact – Document Sent Email correspondence with Kendra Casper, Macomb RRO.
09/30/2021	Contact – Document Sent Email correspondence with Kendra Casper, Macomb RRO.
10/06/2021	Inspection Completed On-site Interviewed staff and residents.
10/07/2021	Contact – Document Received Email containing resident assessment plans and staff schedules.
10/12/2021	Contact – Document Received 30 day discharge notice for Resident A.
10/20/2021	Exit conference with licensee designee, Destiny Saucedo-Al Jallad.

ALLEGATION:

Resident A was not provided with supervision while out in the community.

INVESTIGATION:

On 08/26/2021, I received an email from the facility's Administrator, Zeta Francosky, stating a resident attempted to strangle herself with shoelaces. Her email indicated the resident reported the incident to her friend who picked her up and transported her to a hospital in Kalamazoo to be assessed. Ms. Francosky stated in her email the hospital was looking for an inpatient psychiatric facility for Resident A. Attached to Ms. Francosky's email was an *AFC Licensing Division Incident / Accident Report* (IR).

The IR indicated on 08/25/2021, at approximately 9:30 pm, the facility's program manager was notified by 3rd shift staff Resident A had gone to her friend's house after work. The IR indicated Resident A told her friend she tried strangling herself with shoestrings and stood on train tracks waiting for a train to come. The IR indicated Resident A's friend transported Resident A to the hospital for help. The IR also indicated Resident A's friend contacted the facility's 3rd shift staff again to report Resident A had been dropped off at the hospital. The IR further indicated the facility's program manager contacted the hospital in the morning to follow up and was informed the hospital was awaiting an open bed for psychiatric treatment.

I requested Ms. Francosky send me Resident A's *Assessment Plan for AFC Residents* (assessment plan) and any other Community Mental Health plans (i.e., treatment, behavior support, person center plan, etc.) for my review, which Ms. Francosky sent via email.

According to Resident A's assessment plan, dated 03/24/2021, the box on the assessment was checked "yes" to the question of whether or not she is able to move independently within the community; however, in the corresponding comment section it stated the following:

> "[Resident A] is monitored by staff in the community for health and safety. Staff transport, provide skill coaching, advocacy, and model appropriate interaction with the community."

Her assessment plan also indicated Resident A "has a history of self-injurious behavior including cutting and non-lethal suicide attempts. [Resident A] engages in DBT therapy at the DBT Inst. of MI. Staff prompt skill use."

I also reviewed Resident A's Macomb County Community Mental Health's Annual Assessment, dated 08/09/2021, which did not address what was required of the facility in terms of her supervision while in the community.

On 08/31/2021, I conducted an unannounced on-site inspection at the facility, as part of my investigation. I interviewed the facility's Administrator, Zeta Francosky, the facility's identified Community Integration Coordinator, Jeff Ostrawski, and the facility's identified interim Program Manager, Angie Bloesma, who had also been on call the night of 08/25/2021. I did not interview Resident A during the on-site as she was still hospitalized and unavailable.

According to Ms. Francosky, Resident A was admitted to the facility on 09/28/2020. She stated Resident A obtained employment the end of April 2021 at a local store after having an interview with them the beginning of April 2021. She stated Resident A then graduated from a local alternative school on 06/10/2021.

Ms. Francosky stated the store where Resident A is employed is within walking distance to the facility. She stated Resident A gets to and from work from in a variety of ways such as Resident A's friends who work with her, staff from the facility or Resident A walks. Ms. Francosky stated Resident A can be independent out in the community without staff supervision.

Though Ms. Francosky was not working on 08/25/2021, she indicated after talking to the staff working that day, staff who had contact with Resident A and Resident A's friend, she deduced Resident A signed herself out of the facility for a walk at approximately 7 pm and then came back to the facility at 10:03 pm with her friend.

Ms. Francosky indicated the IR sent to Licensing had therefore been incorrect as the IR indicated Resident A had been at work on the evening of 08/25/2021. Ms. Francosky provided me with sign out sheets initialed by Resident A. Though the sign in/sign out sheet did not indicate the date or am/pm, there was a “Community Sign out/in log” for Resident A, which indicated she signed out at 7:09 (am/pm not provided) for a walk and checked back into the facility at 10:03 (am/pm not provided). The sign in/sign out sheet also indicated Resident A then signed back out at 10:10 (am/pm not provided) to go to the hospital.

Ms. Francosky stated Resident A’s coworker and friend, Witness1, is also an acquaintance of 3rd shift direct care staff, Stephanie Lamb. Ms. Francosky stated Resident A contacted Witness1 while she was working at the store and indicated to her that she was feeling suicidal. Due to Witness1 working, she contacted Witness2, another friend, who went and picked up Resident A and took her to Witness1’s apartment until Witness1 got out of work. Ms. Francosky stated when Witness1 got out of work she went and picked up Resident A and brought her to the facility. At the facility, Resident A told staff she was getting her clothes and then going back to Witness1’s apartment to spend the night but indicated on her sign out sheet she was going to the hospital.

Ms. Francosky stated prior to Witness1 coming to the facility with Resident A at approximately 10 pm on 08/25/2021, Witness1 had contacted Ms. Lamb via a social media application to inform her of Resident A suicidal ideation. Ms. Francosky stated Ms. Lamb, who was not working at the time, contacted interim program manager, Ms. Bloesma, who was on call at the time. Ms. Francosky stated while Resident A was at the hospital awaiting a bed for inpatient psychiatric care staff neither accompanied her to the hospital nor provided supervision at the hospital while she was awaiting inpatient treatment. She stated Ms. Bloesma contacted the hospital at approximately 6 am and hospital staff indicated Resident A would be admitted, which she was at approximately 7 am.

Ms. Francosky stated Resident A is her own guardian and therefore, her community access cannot be restricted.

I interviewed Ms. Bloesma who confirmed being contacted by Ms. Lamb about Resident A on 08/25/2021. She stated Ms. Lamb told her Witness1 would transport Resident A to the hospital that evening due Resident A expressing suicidal ideation. Ms. Bloesma also stated direct care staff, Kayla Jackson, had been informed by Resident A she was staying the night at a friend’s house indicating Resident A was telling staff different stories.

Ms. Bloesma stated it was normal behavior for Resident A to be out in the community by herself without staff supervision. She stated Resident A often went to Witness1’s apartment. Ms. Bloesma confirmed there was no staff at the hospital with Resident A while she awaited admission.

On 09/21/2021, I interviewed direct care staff, Stephanie Lamb, via telephone. Ms. Lamb confirmed she received a message via a social media application from Witness1 on 08/25/2021 at approximately 9 or 9:30 pm regarding Resident A expressing suicidal ideation. Ms. Lamb stated she contacted Ms. Bloesma who told her since the situation with Resident A was a "dire emergency" then Resident A could be transported by one her friends to the hospital.

Ms. Lamb stated Resident A is her own guardian and can sign herself in and out of the facility. She confirmed Resident A's employment, as well. She stated Mr. Ostrowski or other available staff would provide transportation for Resident A, Resident A's friends would pick her up or drop her off or Resident A would walk.

On 09/23/2021, I interviewed direct care staff, Kayla Jackson, via telephone. Ms. Jackson stated on 08/25/2021 she worked from 3 pm until 11 pm. Ms. Jackson could not recall if Resident A was at the facility when she got into work that day. She stated Resident A often spends time with Witness1 and can be out in the community independently, but she is expected to sign herself in and out of the facility. Ms. Jackson stated she did not realize Resident A went to the hospital until her manager informed her later. Ms. Jackson stated she believed Resident A had spent the night at Witness1's apartment.

On 09/28/2021, I contacted Macomb County Recipient Rights Officer, Kendra Casper, via email. Ms. Casper stated in her email she was not opening a special investigation due to reviewing Resident A's current Individual Plan of Service (IPOS) not having any conflicting directions on Resident A's supervision within the community. Ms. Casper provided the following excerpt from Resident A's IPOS:

> "[Resident A] indicated that she enjoys her current job and desires to keep working at that location. She stated that she requires transportation due to the weather but the location of the job is within walking distance. [Resident A] enjoys walking and many days she also makes plans for friends to transport. [Resident A] has agreed to provide her schedule to that TL staff so that there is open communication between [Resident A] and staff. When she does so she will also indicate to staff on which days she is requesting transportation. Staff will indicate the days for transport on the VB calendar.
>
> [Resident A] will sign in and out of the community binder indicating the following information: date, time leaving, expected time of return, location to where she is going. If [Resident A] does not return by the time she has indicated on the sign in/out sheet then staff have been directed to call 911 and provide the last identifying information; along with her planned location. This is part

> of a new safety plan due to Lucy's recent increase in suicidal ideation and urges to self-harm. [Resident A] is able to move independently within the community; this includes being at the hospital without staff. If [Resident A] goes to the hospital without staff, then TL staff will monitor [Resident A's] whereabouts and maintain communication with hospital at all times until admitted or discharged."

Ms. Casper indicated in her email the IPOS meeting took place on 05/25/2021.

On 10/06/2021, I interviewed Resident A at the facility. Resident A stated she's allowed out in the community without staff supervision; however, she indicated she's supposed to receive rides from facility staff to and from work, but this is not consistent. Resident A did not provide additional information regarding the incident where she went to the hospital on or around 08/25/2021.

On 10/07/2021, I received *Assessment Plans for AFC Residents* (assessment plan) for the nine residents within the facility from Ms. Francosky. Per the resident's assessment plans, none of them required additional assistance within the facility or with any type of transferring or self-care. As part of the assessment plans, Ms. Francosky sent me an updated assessment plan for Resident A, dated 09/10/2021, and signed by only the licensee designee, Destiny Saucedo – Al Jallad. According to this assessment plan, Resident A can be out in the community independently. It indicated Resident A should sign herself in and out of the facility and staff should contact 911 if she doesn't return as indicated on the sign in/sign out sheet. Additionally, the assessment plan indicated Resident A is able to be in the hospital without direct care staff, but facility staff will maintain communication with hospital staff.

I reviewed the facility's file, which indicated this is a repeat violation of AFC licensing rule R 400.15303(2). According to special investigation report # 2021A1030023, on 07/14/2021, a resident left the facility without direct care staff, Kayla Jackson's knowledge, and without signing out or telling Ms. Jackson where she was going or when she would be back. Further, Ms. Jackson did not take additional steps to assure the alarmed gate in the courtyard was fully secured after it was opened by another resident thus allowing the resident an undetected means of leaving the facility. Additionally, the resident's Person Centered Plan indicated staff would have the resident sign and out and know when she would sign back in. The resident's assessment plan also documented she was highly delusional and would leave without notifying staff. Consequently, the investigation determined the licensee did not provide the resident with the supervision as outlined in her Person Centered Plan, which the licensee agreed to provide. The licensee provided a corrective action plan, dated 09/16/2021, which indicated the facility's Administrator and Licensee Designees contacted EPS Security, the facility's gate/alarm servicer, to ensure all the mechanics of the alarmed gate were working properly. Additionally,

the corrective action plan indicated the Administrator and Licensee Designees would ensure all sign in/sign out procedure were updated, and staff have been trained at a staff meeting. The corrective action plan indicated staff are expected to know when residents are expected to be back to the facility and if they did not return then the police were to be contacted.

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 assessment plan.
Definitions.	**Rule 102. (1) As used in these rules:** **(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well being and the methods of providing the care and services, taking into account the preferences and competency of the individual.**

ANALYSIS:	Based on my investigation, which included interviews with direct care staff, Resident A, and a review of Resident A's *Assessment Plan for AFC Residents*, dated 03/24/2021 (the assessment plan provided to me at the start of the investigation) her assessment plan was not updated to reflect Resident A's *current status* for her level of supervision in the community. Though the licensee marked "yes" under the assessment plan section of independent community access; the licensee also provided written instruction within the assessment plan for Resident A to be monitored and supervised while in the community thus creating conflicting instruction within her assessment plan. There was no indication Resident A's assessment plan, dated 03/24/2021, had been updated to reflect Resident A's current level of supervision while out in the community and current employment status until the facility's Administrator, Zeta Francosky, sent me an updated assessment plan, dated 09/10/2021, on 10/07/2021. Additionally, this assessment was only signed by the licensee designee; not by Resident A, who is her own guardian, or Resident A's responsible agency. Despite the licensee updating Resident A's assessment plan in September 2021, my investigation indicates it was only completed *after* an investigation started whereas the licensee was aware of Resident A's employment and ability to be within the community back in May 2021. This information further indicates the licensee did not update Resident A's assessment plan to reflect her *current status*. Consequently, Resident A was not provided with supervision per her assessment plan at the time of the incident.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR 2021A1030023, DATED 09/09/2021 AND CAP DATED, 09/16/2021]**

ALLEGATION:

The licensee did not provide transportation to Resident A when required to do so.

INVESTIGATION:

The additional allegations received on 09/22/2021 alleged Resident A is supposed to be picked up and dropped off to work, but the facility is understaffed and cannot provide transportation causing Resident A to walk to and from her employer. The complaint alleged Resident A is sometimes able to get rides, but other times she has to walk to and from work alone.

During my on-site at the facility, both Ms. Francosky and Mr. Ostrowski stated Resident A may get rides into work from facility staff, if available, friends, or she may walk. Mr. Ostrowski stated Resident A does not work more than 24 hours a week due to also receiving social security. He indicated Resident A needs to provide her schedule to him in advance in order for the facility to arrange transportation.

I reviewed Resident A's last two *Resident Care Agreements (RCA)*, dated 10/02/2020, and 08/23/2021. According to the RCA dated, 10/02/2020, which was signed by Resident A and the licensee designee, Destiny Saucedo-Al Jallad, Resident A agreed to pay the basic fee of $896.50. The RCA indicated the basic fee includes the following basic services: "All utilities including water, electric, heat. 3 balanced meals per day plus 2 snacks. Transportation to and from medical appointments as well as legal appointments. Basic hygiene supplies".

Additionally, the RCA indicated Resident A and the licensee designee were in agreement the basic fees included the following transportation services: "All medical, psychological, and court appointments. Community integration outings."

The RCA dated 08/23/2021, was signed by both Resident A and the licensee designee, Destiny Saucedo-Al Jallad. The RCA indicated Resident A agreed to pay the basic fee of $862.50 a month to the licensee. The RCA indicated the basic fee includes the following basic services: "ROOM AND BOARD; UTILITIES; FOOD; TRANSPORATION; PERSONAL SUPPLIES; CABLE TV; SCHEDULING OF APPOINTMENTS; COORDINATION OF CARE".

Additionally, the RCA indicated Resident A and the licensee designee were in agreement the basic fees included the following transportation services: "CMH RELATED ACTIVITIES; COMMUNITY BASED: MEDICAL/OPTICAL/DENTAL/THERAPEUTIC APPTS; LOAs; COMMUNITY BASED OUTINGS AND ACTIVITIES; CHURCH; EMPLOYMENT AND VOCATIONAL ACTIVITIES".

Resident A’s assessment plan, dated 03/24/2021, indicated Resident A was to be monitored by staff in the community and staff transport within the community. There was no additional information in the assessment further describing transportation services for Resident A.

I also interviewed direct care staff, Ms. Jackson, who’s statement to me was consistent with Mr. Ostrowski’s statement to me. Ms. Jackson stated there had been incidences where Resident A needed a ride, but staff were not available to transport her. Ms. Jackson indicated when these situations would arise, Resident A either had to walk or find a ride from her friend/coworker.

I interviewed Resident A who confirmed her employment was within walking distance to the facility. She stated even if she gives her schedule to staff, they aren’t always able to provide transportation due to them not having enough staff. She indicated they should still have to provide her with transportation due to safety reasons.

I reviewed the facility’s staff schedules for July, August, and September 2021, which indicated the facility was appropriately staffed with at least one direct care staff for nine residents. Additionally, per the staff schedules the identified Community Integration Coordinator, Jeff Ostrowski, provided transportation for Resident A to work on the following days:

- 07/02/2021
- 07/06/2021
- 08/17/2021

The schedules indicated direct care staff provided transportation for Resident A to and/or from work on the following days:

- 07/04/2021
- 07/12/2021

On 10/21/2021, I contacted Ms. Francosky requesting any additional documentation the facility would have indicating direct care staff provided transportation for Resident A to and from work. Ms. Francosky indicated Mr. Ostrowski would obtain Resident A’s work schedule via text message but would delete the text messages after putting the transportation requirements on the schedule. Ms. Francosky indicated direct care staff may have completed Community Integration sheets indicating if Resident A was taken to work as well. She stated she would review these sheets and if any indicated staff transported Resident A to or from work then she would send them for my review.

Additionally, she indicated direct care staff complete transportation logs for the facility’s van indicating the names of staff, resident names, and location of transport.

Ms. Francosky stated she would also send this documentation over if it showed additional transports for Resident A.

Ms. Francosky sent me via email 16 Community Integration logs pertaining to Resident A and transportation provided for outings involving her. According to these logs, staff provided transportation to Resident A's place of employer on the following days:

- 09/20/2021
- 09/01/2021
- 08/17/2021
- 07/19/2021
- 06/15/2021
- 06/11/2021
- 05/31/2021
- 05/29/2021

An additional two Community Integration sheets indicated Resident A was taken to work; however, there were no dates on them. A third sheet indicated Resident A was taken on an outing, dated 06/15/2021; however, there was no indication the type of outing that took place.

Ms. Francosky provided the van log sheets as well. According to these logs, Resident A was transported to her place of employment on the following days:

- September: 09/21/2021, 09/20/2021, 09/01/2021
- August: 08/24/2021, 08/17/2021
- July: 07/19/2021, 07/15/2021, 07/12/2021, 07/10/2021, 07/09/2021, 07/05/2021, 07/04/2021, 07/01/2021
- June: 06/30/2021, 06/29/2021, 06/15/2021, 06/12/2021, 06/11/2021, 06/09/2021, 06/05/2021, 06/04/2021, 06/03/2021, 06/01/2021
- May: 05/14/2021

The van log also included an unidentifiable date in July 2021 indicating Resident A was transported to work.

I asked Ms. Francosky the reason for the decline in transports for August and September 2021. She indicated Resident A wasn't providing her work schedule to Mr. Ostrowski and Resident A would obtain rides from her friends.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(3) A licensee shall assure the availability of transportation services as provided for in the resident care agreement.

ANALYSIS:	Based on Resident A's *Resident Care Agreement*, dated 08/23/2021, the licensee designee and Resident A agreed Resident A would pay the basic fee of $862.50 to the licensee, which included transportation to employment. Additionally, Resident A's *Assessment Plan for AFC Residents*, dated 03/24/2021, did not provide any description of transportation to and from Resident A's employment. Based on my interviews with direct care staff, Kayla Jackson, and Resident A, there had been incidences where Resident A needed transportation from direct care staff to or from her employment, but it wasn't available. Subsequently, the licensee is responsible for assuring transportation services specified in the Resident Care Agreement. Regardless of how transportation is provided or paid for, the licensee must assure transportation is available if it is needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The Administrator, Zeta Francosky, swore and threw chairs at Resident A. Ms. Francosky threatens other residents in the facility and acts inappropriately.

INVESTIGATION:

The additional complaint received on 09/23/2021 alleged the facility's Administrator, Zeta Francosky, has thrown chairs, sworn at, and called Resident A names.

On 09/24/2021, I re-interviewed Ms. Lamb and Ms. Jackson via telephone. Ms. Lamb stated due to her working third shift, she wasn't around Resident A and Ms. Francosky; therefore, she had no direct knowledge of their interactions. Ms. Jackson stated Resident A does not like Ms. Francosky as she has observed Resident A swear at and call Ms. Francosky names, but not vice versa. She denied ever seeing Ms. Francosky throw a chair at Resident A.

On 10/06/2021, I conducted a follow-up unannounced on-site inspection at the facility. I interviewed Resident A regarding the allegations. Resident A stated Ms. Francosky became aggressive towards Resident B, who no longer resides in the facility, back in February 2021 when Ms. Francosky was frustrated by Resident B's behaviors. She stated Ms. Francosky threw a chair towards Resident B, who was emotionally dysregulated, after Resident B returned to the facility from an elopement. Resident A stated no other residents were around when the incident

occurred; however, she shared a video Resident B had taken when Ms. Francosky allegedly yelling at her. Ms. Francosky was not observed in the video; however, I was able to identify her by her voice. I heard Ms. Francosky raising her voice at Resident B while explaining to Resident B how her behavior was inappropriate and causing disruption to the other residents. Based on my review of the video, Ms. Francosky raised her voice at Resident B indicating she was frustrated with Resident B, but Ms. Francosky did not appear to be mistreating Resident B or calling her names. Additionally, there was no information from the video as to what occurred prior to Ms. Francosky raising her voice at Resident B.

Resident A was unable to provide concrete examples of Ms. Francosky mistreating her other than Ms. Francosky following her to her room while asking Resident A questions and telling her she would call Resident A's family regarding her behavior.

I interviewed Ms. Francosky who denied mistreating any of the residents, including Resident A. She acknowledged the incident referenced by Resident A involving her getting upset with Resident B. Ms. Francosky stated Resident B had returned from an elopement and was throwing chairs and breaking items within the facility. Ms. Francosky stated she tried redirecting and talking to Resident B; however, nothing worked in getting Resident B to calm down or act appropriately, which caused Ms. Francosky to become frustrated. She acknowledged kicking over a chair, but denied it was at Resident B. She stated after she kicked the chair, which she indicated was a move to get Resident B's attention, she then posed the question to Resident B of what throwing chairs around even proved. She stated she raised her voice to get Resident B's attention but denied calling her names. Ms. Francosky stated Resident B caused great disruption to the facility and the other residents. She stated there were no other residents who observed the incident between her and Resident B.

I interviewed Resident C and Resident D who both denied Ms. Francosky acting inappropriately with residents or talking inappropriately to them. They both denied ever seeing Ms. Francosky throw a chair at Resident A or Resident B. Resident C stated Ms. Francosky can use a "stern tone."

During the on-site inspection, I also interviewed direct care staff, Benjamin Hamrick. Mr. Hamrick denied ever observing Ms. Francosky acting inappropriately or talking inappropriately to residents. He also stated Ms. Francosky can use a "stern voice, at most".

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or

	omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my investigation, which included interviews with direct care staff, Stephanie Lamb, Kayla Jackson, Benjamin Hamrick, Administrator, Zeta Francosky, Resident A, Resident C, and Resident D, and my review of a video involving Ms. Francosky, there is no definitive evidence indicating Ms. Francosky mistreated Resident A or Resident B, by speaking to either resident inappropriately or throwing chairs them in a threatening manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

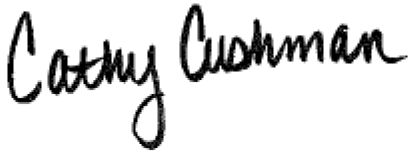
APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	The Administrator, Zeta Francosky, acknowledged an incident involving Resident B where she kicked over a chair while in the presence of Resident B after she became frustrated with Resident B's behavior. Consequently, Ms. Francosky was not treating Resident B with consideration and respect, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/20/2021, I conducted an exit conference with the licensee designee, Destiny Saucedo-Al Jallad, via telephone to explain my findings and provide an opportunity for questions or comments. Mrs. Saucedo-Al Jallad acknowledged an understanding of needing to update assessment plans to reflect a resident's current status. She disagreed with my finding of not providing transportation for Resident A's employment as agreed upon in the RCA. Mrs. Saucedo-Al Jallad indicated Resident A may choose to walk to her employment or not provide ample notice to facility staff, which

causes difficulty in providing transportation. I informed Mrs. Saucedo-Al Jallad resident documents should all be updated whenever is there is a change in a resident's current status and the documents should be consistent with one another.

IV. RECOMMENDATION

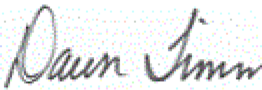
Upon receipt of an acceptable plan of correction, I recommend no changes in the current license status.



10/20/2021

Cathy Cushman Date
Licensing Consultant

Approved By:



10/21/2021

Dawn N. Timm Date
Area Manager