GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 16, 2022

Jason Schmidt
New Life Services Inc
36022 Five Mile Road
Livonia, MI 48154

RE: License #: AS630012619
Investigation #: 2022A0605017
Alta Vista

Dear Mr. Schmidt:

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012619
Investigation #:	2022A0605017
Complaint Receipt Date:	12/29/2021
Investigation Initiation Date:	12/29/2021
Report Due Date:	02/27/2022
Licensee Name:	New Life Services Inc
Licensee Address:	36022 Five Mile Road Livonia, MI 48154
Licensee Telephone #:	(734) 744-7334
Administrator/Licensee Designee:	Jason Schmidt
Name of Facility:	Alta Vista
Facility Address:	3361 Alta Vista Milford, MI 48380
Facility Telephone #:	(248) 685-8216
Original Issuance Date:	02/21/1990
License Status:	REGULAR
Effective Date:	06/25/2021
Expiration Date:	06/24/2023
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Alta Vista direct care staff (DCS) Shirley Wilson yelled at Resident A and would not allow Resident A in the kitchen.	Yes
Resident A has been receiving his medications late and not as prescribed.	Yes
Resident A was left unsupervised in the van on 10/02/2021 while the home manager Shurlean Blount-Douglas went grocery shopping.	Yes
Alta Vista's van used for transporting was in the repair shop for two weeks and there were no other forms of transportation available to the residents.	Yes

III. METHODOLOGY

12/29/2021	Special Investigation Intake 2022A0605017
12/29/2021	Special Investigation Initiated - Telephone I contacted Office of Recipient Rights (ORR) Marilyn Minnick who stated ORR is investigating these allegations. ORR stated she also made a referral to Adult Protective Services (APS) regarding these allegations.
12/29/2021	APS Referral Adult Protective Services (APS) referral made by ORR.
12/29/2021	Contact - Document Received ORR Marilyn Minnick emailed me the incident report (IR) and Resident A's crisis plan and individual plan of service (IPOS) completed by Macomb-Oakland Regional Center (MORC) for my review.
12/29/2021	Contact - Telephone call made I interviewed Resident A's guardian regarding the allegations.
12/29/2021	Contact - Document Sent I submitted a request to Oakland County Sheriff's Department requesting police calls/contacts at Alta Vista.

12/29/2021	Contact - Document Sent APS sent email denying their referral.
01/05/2022	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed Resident A, Resident B, Resident C, and direct care staff (DCS) Siani Price regarding the allegations. I reviewed Resident A's medications and medication logs.
01/27/2022	Contact - Telephone call made I left a voice mail message for the home manager Shurlean Douglas.
01/31/2022	Contact - Telephone call made I left a message for DCS Shurlean Douglas and Resident A's case manager Keturah Bell with Macomb-Oakland Regional Center (MORC) to return my call.
01/31/2022	Contact - Telephone call made I interviewed the area supervisor Lori Mitchell regarding the allegations.
02/02/2022	Contact - Telephone call received I received a voice mail message from Resident A's MORC case manager Keturah Bell.
02/03/2022	Contact - Telephone call made I interviewed the home manager Shurlean Blount-Douglas and Resident A's case manager Keturah Bell regarding the allegations.
02/07/2022	Contact - Telephone call received The home manager Shurlean Blount-Douglas called to report that after Resident A was discharged back to Alta Vista from the hospital, Resident A's mother brought garbage bags full of linens. Ms. Blount-Douglas stated then Resident A complained of bed bugs biting him.
02/08/2022	Contact - Telephone call made I contacted DCS Shirley Wilson to discuss the allegations, but she stated she will have to call me back.
02/08/2022	Contact - Telephone call received I interviewed DCS Shirley Wilson regarding the allegations.

02/09/2022	Contact – Document sent I emailed ORR Kathleen Garcia regarding the status of her case. Ms. Garcia emailed back stating she is still actively investigating these allegations.
02/09/2022	Exit Conference I conducted the exit conference with licensee designee Jason Schmidt's wife, Cheryl Schmidt, the vice president of New Life Services, Inc. regarding my findings.

ALLEGATION:

Alta Vista direct care staff (DCS) Shirley Wilson yelled at Resident A and would not allow Resident A in the kitchen.

INVESTIGATION:

On 12/29/2021, intake #184214 was referred by Office of Recipient Rights (ORR) regarding the staff at Alta Vista direct care staff (DCS) yelling, laughing, mocking, and not allowing Resident A into the kitchen on 12/16/2021. Also, staff are passing Resident A's medications late.

On 12/29/2021, I contacted ORR Marilyn Minnick who stated that ORR is investigating these allegations and has made a referral to Adult Protective Services (APS).

On 12/29/2021, I received an email from APS stating they will not be investigating these allegations.

On 12/29/2021, I interviewed Resident A's guardian regarding the allegations. The guardian stated there have been issues with Alta Vista since August 2021 regarding how staff treat Resident A. The guardian stated staff "tease, agitate and do not allow Resident A to put his groceries away in the kitchen." Resident A is tall and large in stature, so staff call police instead of trying to redirect Resident A because staff say, "We're afraid of him (Resident A)." On 12/16/2021, the guardian received a call from Resident A telling the guardian that staff Shirley was not allowing Resident A in the kitchen to put away his groceries. The guardian stated she could hear Shirley yell at Resident A. Resident A told the guardian "Shirley is recording me (Resident A) with her cell phone. I told her to stop, but she (Shirley) was laughing and mocking me." The guardian stated these issues have been reported to the area supervisor Lori Mitchell, but they continue to happen.

On 12/29/2021, I requested police records from Oakland County Sheriff's Office regarding any contact police had with Resident A within the last six months. I received two incident reports that had the following summary:

Incident report dated 12/14/2021 regarding DCS Shirley Wilson contacting police due to Resident A “acting aggressive and caller (Shirley Wilson) states if she doesn’t give him (Resident A) another pill, he will take all the pills. Resident A has a history of tampering with medications. Resident A is also getting in caller’s (Shirley Wilson) face.” Police contacted Resident A at the home and Resident A’s mother/guardian and police were able to figure everything out regarding Resident A’s medications to make Resident A compliant.

Incident report dated 11/02/2021 was regarding Resident A’s mother/guardian contacting police advising police that Resident A had Covid-19 and the staff were denying Resident A medication and would not allow Resident A to leave his bedroom. Police contacted Lori Mitchell, the area supervisor who told police that the staff gave Resident A the things Resident A’s mother/guardian bought for Resident A.

On 01/05/2022, I conducted an unannounced on-site investigation regarding the allegations. DCS Siani Price, Resident A, Resident B, and Resident C were present. Mr. Price stated Resident D and Resident E were at workshop. Resident A was in the front room playing on his gaming system. I interviewed Resident A regarding the allegations. Resident A stated on 12/16/2021, the staff did not want him to call his mother after Resident A was trying to get his own medication from the medication cabinet. Resident A stated, “they (staff) didn’t put their hands on me, but I told them I need my medication to function. I was going to pop out the pill from the pack because when I lived at the semi-independent living home, I would do it myself.” Resident A stated staff tried to redirect Resident A by yelling at him, but Resident A stated, “I told staff if you come near me, I’m going to do something to you. I get I’m threatening, but I was only trying to get my meds and then she (Shirley) called the police on me.” Resident A stated Shirley batted his hands away as he was trying to get his own medication. Resident A was unable to state if he was given discontinued medication but then said, “Call my mom, she can tell you everything.” Resident A then began calling tech support on his cell phone regarding his gaming system not connecting. He was unable to focus on this interview and kept stating, “call my mom she can tell you everything.”

On 01/05/2022, I was unable to interview Resident B and Resident C as both are non-verbal.

On 01/05/2022, I interviewed DCS Siani Price regarding the allegations. Mr. Price has worked for this corporation for 19 years. He works all shifts at Alta Vista. Mr. Price stated he has never heard Shirley yell, scold, or put her hands on Resident A. He stated that residents including Resident A are not allowed in the kitchen and must ask and get permission from staff before residents can get something from the kitchen. Mr. Price stated it has been policy since he has been at Alta Vista regarding residents not allowed into the kitchen for safety reasons. Mr. Price stated, “I believe all residents’ individual plans of service (IPOS) reflects that they (residents) are not allowed in the kitchen.” Mr. Price stated he has never yelled at Resident A or any other resident. Mr. Price stated he and Resident A have a mutual respect and being that Mr. Price is tall in stature,

Resident A does not have behavioral issues during Mr. Price's shift. Mr. Price stated most of Resident A's behaviors occur during the weekend shift as that is when the female staff are working, and police is called on Resident A.

On 01/31/2022, I contacted the area supervisor Lori Mitchell via telephone regarding the allegations. Ms. Mitchell stated residents are not allowed into the kitchen because, "of safety issues." She was unable to state what the safety issues were, but indicated Resident A is not allowed into the kitchen. Ms. Mitchell stated DCS Shirley Wilson has a "loud voice," but does not yell at Resident A or any other resident. Ms. Mitchell has not received any complaints regarding Shirley yelling at anyone.

On 02/03/2022, I interviewed the home manager Shurlean Blount-Douglas regarding the allegations via telephone. Ms. Blount-Douglas has been with this corporation for 25 years. She works all shifts at Alta Vista. Ms. Blount-Douglas stated sometime last December 2021, DCS Shirley Wilson was working when Resident A took the medication magnet which is hung on the side of the refrigerator and opened the medication cabinet. Ms. Wilson tried to redirect Resident A, but Resident A continued to open the cabinet and took his medication out of the cabinet. Ms. Wilson was having difficult redirecting Resident A who is large in stature. Ms. Blount-Douglas stated Resident A yelled at Ms. Wilson and both began arguing and yelling at each other. Ms. Wilson was unable to calm Resident A down. Resident A then ran towards Ms. Wilson who then called the police for help. Ms. Blount-Douglas stated Resident A is large and tall in stature weighing over 500 pounds. She stated since Resident A moved into Alta Vista in July 2021, staff have quit because of Resident A's behaviors. She stated one of the staff died because Resident A got Covid-19 and refused to stay in his bedroom. Ms. Blount-Douglas stated Resident A refused to quarantine and the staff working that day contracted Covid-19 from Resident A and then that staff died. Ms. Blount-Douglas stated Resident A does not follow the house rules and does whatever he wants and when Resident A gets told otherwise, he has behaviors, the behaviors escalate and then the police is called.

On 02/03/2022, I interviewed Resident A's MORC case manager Keturah Bell via telephone regarding the allegations. Ms. Bell stated she has been Resident A's case manager on/off since 2017. She stated that Resident A she was not informed that Resident A was not allowed into the kitchen at Alta Vista. She is aware that Resident A's mother wants Resident A to make better food choices and lose weight as Resident A weighs 540 pounds. Resident A is constantly eating and sometimes goes into the kitchen to prepare himself meals right after staff has made him breakfast that he has eaten. Ms. Bell stated Resident A will eat all day if he is allowed to eat, so staff may have this rule about not entering the kitchen to prevent Resident A from eating. Ms. Bell stated she will review Resident A's IPOS and speak with the staff about accessing the kitchen.

On 02/08/2022, I interviewed DCS Shirley Wilson regarding the allegations via telephone. Ms. Wilson has been with this corporation for nine years and only works one day a week on Sundays. Ms. Wilson stated there have been two incidents with Resident

A that escalated to Ms. Wilson having to call the police. The first incident was last year while Ms. Wilson was cooking dinner. Ms. Wilson stated the home manager advised her that policy of Alta Vista was that no resident is ever allowed to enter the kitchen and if a resident needed something from the kitchen, staff would get it for the resident. Resident A came into the kitchen and Ms. Wilson told Resident A, “get out of the kitchen. You can’t be in here, I’m cooking.” Resident A said, “No, I don’t have to,” and then called Ms. Wilson a “bitch.” Resident A was yelling and screaming at Ms. Wilson, so Ms. Wilson stated, “I grabbed his arm to direct him out of the kitchen and that’s when he said, Fuck You, leave me alone and pushed me. He then came towards me and so I told Resident A I’m calling the police.” Ms. Wilson stated Resident A is over 500 pounds and very intimidating when Resident A does not get his way. Ms. Wilson stated, “I’m 61 years old and I’m not going to tolerate his behavior.”

Ms. Wilson stated the other time she called the police on Resident A was this past Christmas. Resident A wanted “ham,” for Christmas so the home manager Shurlean Blount-Douglas was going to purchase one. Resident A’s mother brought a ham to Alta Vista, but Ms. Blount-Douglas told Ms. Wilson, “We’re not going to accept her (mother) ham because the mother throws it in our face whenever she brings something to Alta Vista.” Ms. Wilson told Resident A, “we can’t accept the ham from your mother.” Resident A was upset and told his mother who also was upset. Ms. Wilson stated, “Resident A’s mother wilds Resident A up and that’s when Resident A’s behavior escalates.” Resident A began screaming at Ms. Wilson stated, “I want ham.” Resident A then began pulling things out of the kitchen cabinets and the refrigerator throwing them on the floor. Ms. Wilson stated, “I can’t control him, so I called the police.” Ms. Wilson stated, “I told Resident A, you and your mother seem to be trying to get us into trouble all the time.”

On 02/07/2022, I received a telephone call from the home manager Shurlean Blount-Douglas stating that Resident A was in the hospital and this past weekend, he was discharged back to Alta Vista. Resident A’s mother accompanied Resident A to Alta Vista along with police. Ms. Blount-Douglas is not sure why the police were accompanying them but stated that the mother brought garbage bags full of linen and then a bed frame for Resident A. Ms. Blount-Douglas stated Alta Vista had an infestation of bed bugs that was remedied in January 2022, but now the bedbugs have returned. Ms. Blount-Douglas stated right after the mother brought the bag of linens, Resident A complained of bedbugs biting him. Ms. Blount-Douglas looked at the linens and saw a significant number of bedbugs. Ms. Blount-Douglas stated she does not communicate with Resident A’s mother because she cannot have a normal conversation with the mother. Ms. Blount-Douglas stated she informed management and contacted pest control again.

Note: Ms. Blount-Douglas forwarded me invoices from Terminix dated 01/20/2022 indicating that they treated Alta Vista and found bed bugs in a bed frame and are treating it.

APPLICABLE RULE	
R 400.14304	**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: (b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.
ANALYSIS:	Based on my investigation and information gathered, DCS at Alta Vista violated Resident A's rights when DCS did not allow Resident A to access the kitchen. The home manager Shurlean Blount-Douglas created a policy at Alta Vista that no resident will be allowed in the kitchen and if a resident needed something from the kitchen, DCS would get it for the resident. According to Resident A's IPOS, there are no restrictions in his IPOS that stated Resident A cannot access the kitchen of his own home. In addition, I spoke with the Vice President of New Life Services, Inc. Cheryl Schmidt who stated this is not a policy of New Life Services, Inc., and that Resident A and all the other residents should be able to access the kitchen of their home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (iii) Derogatory remarks about the resident or members of his or her family.
ANALYSIS:	Based on my investigation and information gathered, Resident A was subjected to both verbal abuse and derogatory remarks about Resident A and Resident A's mother/guardian. DCS Shirley Wilson told Resident A that Resident A and his mother/guardian are always trying to get DCS into trouble all the

	time. In addition, the home manager Shurlean Blount-Douglas reported that she lost three DCS because of Resident A's behaviors and one of the DCS died because he contracted Covid-19 from Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A has been receiving his medications late and not as prescribed.

INVESTIGATION:

On 12/29/2021, the guardian stated staff have not been administering Resident A's medication timely and have been administering discontinued medications to Resident A. Resident A's doctor discontinued steroids that were prescribed to Resident A, but staff filled that medication and administered it to Resident A.

On 01/05/2022, Mr. Price stated Resident A has medications at 8AM and 8PM, but as of 01/01/2022, he had a new prescription that must be given at 2PM. Mr. Price stated staff must administer medications to Resident A, but due to Resident A coming from a semi-independent living home, Resident A believes that Resident A can administer his own medications. Mr. Price stated, "He (Resident A) takes his pills in the cup and sometimes walks away. Resident A takes his medications when he wants to take them, and we don't always watch him take them."

On 01/05/2022, I reviewed Resident A's medications and medication logs and found the following errors:

- **Divalproex 500MG ER Tab**: take two tablets by mouth at bedtime were given at 8PM from 10/26/2021-10/31/2021, 12/01/2021, 12/04/2021, 12/12/2021 and 01/04/2022, but staff did not initial the medication log.
- **Montelukast 10MG Tab**: take one tablet by mouth at bedtime were given at 8PM from 10/26/2021-10/31/2021, 12/04/2021, 12/12/2021 and 01/04/2022, but staff did not initial the medication log.
- **Tamsulosin 0.4MG Cap**: take one capsule by mouth in the evening was given at 8PM from 10/26/2021-10/31/2021, 12/04/2021, 12/12/2021 and 01/04/2022, but staff did not initial the medication log.
- **Topiramate 100MG Tab**: take one tablet by mouth at bedtime was given at 8PM from 10/26/2021-10/31/2021, 12/01/2021, 12/04/2021, 12/12/2021 and 01/04/2022, but staff did not initial the medication log.
- **Topiramate 200MG Tab**: take one tablet by mouth at bedtime was given at 8PM from 10/26/2021-10/31/2021, but staff did not initial the medication log.
- **Bupropion HCL 150MG XL Tab**: take one tablet by mouth in the morning was given at 8AM from 10/27/2021-10/31/2021, 12/04/2021 and 01/05/2022, but staff did not initial the medication log.

- **Sertraline 100MG Tab**: take two tablets (200MG) by mouth in the morning was given at 8AM from 10/26/2021-10/31/2021, 12/04/2021 and 01/05/2022, but staff did not initial the medication log.
- **Atenolol 25MG Tab**: take one tablet by mouth daily was given at 8AM from 10/26/2021-10/31/2021, 12/04/2021 and 01/05/2022, but staff did not initial the medication log.
- **Furosemide 40MG Tab**: take one tablet by mouth daily was given at 8AM from 10/26/2021-10/31/2021, 12/04/2021 and 01/05/2022, and it was given at 2PM on 01/04/2022, but staff did not initial the medication log.
- **Latuda 80MG Tab**: take one tablet by mouth daily with dinner was given at 8PM from 10/26/2021-10/31/2021, 12/04/2021 and 01/04/2022, but staff did not initial the medication log.
- **Levothyroxine 75MCG Tab**: take one tablet by mouth daily was given at 8AM from 10/26/2021-10/31/2021, 12/04/2021 and 01/05/2022, but staff did not initial the medication log.
- **Topiramate 200MG Tab**: take one tablet by mouth at bedtime was given at 8PM on 12/01/2021, 12/04/2021 and 01/04/2022, but staff did not initial the medication log.

NOTE: Furosemide 40MG tab: 2PM blister pack for 01/05/2022 had been popped out and the pill placed in a cup sitting on the shelf of the locked medication cabinet. Mr. Price stated he popped the pill out of the blister pack and placed it in the cup because he was going to administer the medication to Resident A prior to them leaving Alta Vista. Mr. Price simulated a medication pass and stated he usually initials the medication log after he administers the medications but forgot to initial the medication log for all the 8AM medications he passed today, 01/05/2022.

On 01/05/2022, I reviewed Resident A's IPOS completed by Macomb-Oakland Regional Center (MORC) on 04/02/2021 and it stated, "Caregivers will monitor Resident A taking all medications and will assist with the documentations on the medication sheets."

On 01/31/2022, Lori Mitchell stated that Resident A's medications are given as prescribed. She stated that Resident A's guardian changed pharmacies and the medication never arrived at the home. She stated staff had to wait until the guardian dropped off the medication, but again stated Resident A has always received his medications as prescribed. I advised Ms. Mitchell that I reviewed Resident A's medication logs and there were many missing initials on the logs. Ms. Mitchell stated she will be discussing these issues with staff.

On 02/03/2022, the home manager Shurlean Blount-Douglas stated that Resident A always receives his medications as prescribed. Resident A was only prescribed medications at 8AM and 8PM until 01/01/2022, when he was prescribed a new medication at 2PM. Ms. Blount-Douglas stated the only issue with Resident A's medications was when Resident A was out of his medication for a few days. She does not recall the name of the medications but stated it was December 2021 when that

happened, and that the pharmacist required a new script from Resident A's doctor. Ms. Blount-Douglas stated that Resident A's mother takes Resident A to all his doctor appointments and as of 02/01/2022, Resident A has a new pharmacist; therefore, Resident A's mother drops off his medications. Ms. Blount-Douglas stated currently, there are no issues with Resident A's medications.

On 02/03/2022, Resident A's case manager Keturah Bell stated that Resident A's medication must be administered by staff and staff must supervise Resident A taking his medications. Ms. Bell stated staff have reported that Resident A refuses to take his medications as prescribed and wants to take his medications whenever "he wants to." Ms. Bell stated she is waiting to hear back from Resident A's physician to find out the window of time for Resident A to take his medications as right now it is an hour before or an hour after. Ms. Bell is trying to find out if the time can be extended to two to three hours before or after the prescribed time to alleviate all the refusals.

On 02/08/2022, Ms. Wilson was interviewed regarding Resident A's medications. Ms. Wilson stated Resident A always gets his medications as prescribed when she passes medications on Sundays. She stated that she takes the medications to Resident A along with a snack and supervises Resident A taking the medication. Ms. Wilson stated she supervises Resident A because in the past when another DCS has passed medications to Resident A, Resident A had the medication in his possession when Ms. Wilson began her shift. Ms. Wilson stated a couple of weeks ago, she arrived at her shift and DCS Siani Price passed Resident A's steroid medication, but Resident A had not taken the pill because Resident A told Ms. Wilson that Resident A's mother told Resident A, "the steroids were discontinued. Don't take them just flush them down the toilet." Ms. Wilson stated Resident A did not flush the pill in the toilet but instead showed Ms. Wilson the pill and told Ms. Wilson, "You guys are giving me pills that are discontinued." Ms. Wilson stated the mother never advised any DCS that the steroids were discontinued nor did the mother provide a discontinued script. Ms. Wilson then received a call from the mother telling Ms. Wilson the steroid pill was discontinued. Ms. Wilson told the mother she nor any other DCS have received any calls or discontinued scripts; therefore, staff cannot just stop giving Resident A medications because the mother told us to stop. Ms. Wilson stated these are the types of issues staff deal with regarding Resident A and his mother.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my review of Resident A's medications and medication logs, Resident A receives his medications as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Based on my investigation and information gathered, DCS Siani Price does not supervise Resident A taking his medications. Mr. Price hands Resident A his cup of medications and then Resident A walks away with the medications without taking them in front of Mr. Price. According to Resident A's IPOS, staff must administer and supervise the taking of Resident A's medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of a 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: (v) The initials of the person who administers the mediation, which shall be entered at the time the medication is given.
ANALYSIS:	Based on my review of Resident A's medication logs, there were missing initials October 2021, December 2021 and January 2022 where staff administered the medication to Resident A but staff did not initial the medication log at the time the medication was given.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was left unsupervised in the van on 10/02/2021 while the home manager Shurlean Blount-Douglas went grocery shopping.

INVESTIGATION:

On 12/29/2021, the guardian stated Resident A told the guardian that Shurlean Douglas left Resident A along with the other residents in the van unsupervised while Shurlean went grocery shopping. The guardian stated Resident A is autistic and must be at eyesight when in the community and should have never been left unsupervised with other residents. The guardian stated this has happened more than once.

On 01/05/2022, Resident A stated that Shurlean left him alone in the van with three other residents. He cannot recall which residents but stated it has happened more than once. Resident A stated it happened at Meijer and Save-A-Lot where Shurlean left him along with the other residents in the van for about an hour while she went into the grocery store and shopped. He stated, “I’m not supposed to be in the van by myself with the other residents.”

On 01/05/2022, Mr. Price stated he cannot speak as to Shurlean leaving Resident A and other residents alone in the van, but that he has never heard this complaint from anyone including Resident A. Mr. Price stated he is the person that usually transports and when he does, he has never left any resident unsupervised in the van.

On 01/05/2022, Resident A’s IPOS completed by MORC on 04/01/2021 stated, “Du to his (Resident A) legal status, he needs close monitoring while in the community.”

On 01/31/2022, Lori Mitchell stated that the home manager Shurlean Douglas would never leave any resident unsupervised inside the van to go grocery shopping. She stated, “Shurlean would never jeopardize any resident at Alta Vista as she’s been doing this job for 25 years.”

On 02/03/2022, the home manager Shurlean Blount-Douglas stated that she did leave Resident A along with all the other residents in the van during her shift to go grocery shopping. Ms. Blount-Douglas stated she needed items to make dinner; therefore, she was the only staff on shift, so she went to Walmart, parked the car in the handicap parking spot, left the van running and locked the doors while the residents were inside the van. She stated that she was only gone for about 20 minutes inside Walmart and then returned to the van where Resident A would unlock the doors for her. Ms. Blount-Douglas stated she did this a couple of times at Walmart and at Save-A-Lot where the residents were all left unsupervised inside the van. Ms. Blount-Douglas stated she was unaware that she could not leave them unattended, but now knows and will not be leaving them unsupervised again.

On 02/03/2022, Resident A’s case manager Keturah Bell stated she was not aware that the home manager Shurlean Blount-Douglas was leaving Resident A along with the other residents unattended in the van while she went into Walmart and/or Save-A-Lot to grocery shop. Ms. Bell’s supervisor told her about Ms. Blount-Douglas leaving the residents unattended; therefore, Ms. Bell talked to Ms. Blount-Douglas advising her she cannot leave Resident A or any other resident unattended to grocery shop. Ms. Bell

stated that Ms. Blount-Douglas acknowledged what she was doing was wrong and stated she would not leave any resident unsupervised. Ms. Bell stated that Resident A must at least be either at eight sight or at ear sight always when in the community.

On 02/08/2022, Ms. Wilson was interviewed regarding the home manager Shurlean Blount-Douglas leaving the residents unsupervised inside the van while grocery shopping. Ms. Wilson stated, “I don’t know anything about that, but what I know is that when I used to transport them to workshop, I never left any resident alone in the van.” Ms. Wilson stated she has not heard or been told that Ms. Blount-Douglas has left Resident A or any other resident unattended in the van to go into Walmart or Save-A-Lot to grocery shop. She stated, “I would never do that, and I can only speak for myself.”

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:	Based on my investigation and information gathered, Resident A was not provided with supervision and protection as specified in his assessment plan. Resident A’s IPOS/crisis plan completed by MORC on 04/01/2021, stated that Resident A must be supervised, at least at eyesight or ear sight when in the community. The home manager Shurlean Blount-Douglas has left Resident A and the other residents unsupervised in Alta Vista’s van outside of both Walmart and Save-A-Lot on several occasions while going into the stores to grocery shop. Ms. Blount-Douglas stated she was inside the stores for about 20 minutes and leaves the van running with the doors locked. Ms. Blount-Douglas did not know she was unable to leave the residents unattended.
CONCLUSION:	**VIOLATION 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:	Based on my investigation and information gathered, Resident A’s safety and protection were not attended to at all times when

	Resident A was left unattended in the van along with the other residents on a couple of occasions while the home manager Shurlean Blount-Douglas went into Walmart/Save-A-Lot to grocery shop for about 20 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Alta Vista's van used for transporting was in the repair shop for two weeks and there were no other forms of transportation available to the residents.

INVESTIGATION:

On 12/29/2021, the guardian stated the van at Alta Vista is not working. The guardian has been transporting Resident A to his doctor appointments. The guardian stated she is unsure what the issue is with the van, but that it has not been working for a while.

On 01/05/2022, Resident A was unable to provide any information as to the van not working other than he stated, it was not working.

On 01/05/2022, Mr. Price stated there are no issues with the van and he does not know why someone would state the van was not working.

On 02/03/2022, the home manager Shurlean Blount-Douglas stated that the van is currently working, but there have been times where the van was not working for two weeks. She stated that management knows about this, and the van would be in repair, but there is no alternative transportation provided to Alta Vista; therefore, the residents cannot go to workshop or any other outings.

On 02/08/2022, Ms. Wilson stated about a month ago, the transport van was out of service for two weeks and Alta Vista did not have another form of transportation for the residents. She stated the residents were unable to go to workshop or anywhere else in the community. Ms. Wilson stated currently, the van is operating properly.

On 02/09/2022, I followed up via email with ORR Kathleen Garcia regarding her investigation. Ms. Garcia stated she has not completed her investigation regarding these allegations.

On 02/09/2022, I conducted the exit conference with licensee designee Jason Schmidt's wife, Cheryl Schmidt who is the vice president of the corporation with my findings. Mrs. Schmidt stated that Mr. Schmidt had Covid-19; therefore, she was calling on his behalf. Mrs. Schmidt stated she was not aware of this special investigation as no one including Lori Mitchell, the area supervisor advised her of the complaint. Mrs. Schmidt was advised of my findings. Mrs. Schmidt stated there is no policy with New Life Services, Inc. that stated residents are not allowed to enter the kitchen of their home. Mrs.

Schmidt stated she will be addressing this issue with the home manager. Mrs. Schmidt stated Resident A receives his medications as prescribed but was not aware of the missing initials and not aware that DCS Siani Price was not supervising Resident A taking his medications. Mrs. Schmidt stated she also was not aware that the home manager left Resident A and the other residents unattended in the van to go grocery shopping and will be addressing this concern with the home manager too. Mrs. Schmidt stated the van needed to be repaired and due to the part not being readily available, the van was in the repair shop for about two weeks. Mrs. Schmidt stated the corporation does not have additional vans to provide to group homes; therefore, residents were unable to attend workshops; however, the repair was out of their control.

APPLICABLE RULE	
R 400.14303	**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 my investigation and the information gathered, the Alta Vista van used for transportation was not available for two weeks due to the van being in the repair shop. The residents were unable to attend workshop or doctor appointments. Resident A's mother/guardian began driving Resident A to his doctor appointments. However, the van was repaired, and it is currently operating properly.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Frodet Dawisha 02/10/2022

Frodet Dawisha Date
Licensing Consultant

Approved By:

Denise Y. Nunn 02/16/2022

Denise Y. Nunn Date
Area Manager