GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 17, 2022

Donita Strickland
RSR Serenity LLC
47640 Gratiot Avenue
Chesterfield, MI 48051

RE: License #: AM500408373
Investigation #: 2022A0617009
Sandalwood Village I

Dear Ms. Strickland:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM500408373
Investigation #:	2022A0617009
Complaint Receipt Date:	01/04/2022
Investigation Initiation Date:	01/05/2022
Report Due Date:	03/05/2022
Licensee Name:	RSR Serenity LLC
Licensee Address:	47640 Gratiot Avenue Chesterfield, MI 48051
Licensee Telephone #:	(586) 949-6220
Administrator:	Donita Strickland
Licensee Designee:	Donita Strickland
Name of Facility:	Sandalwood Village I
Facility Address:	47640 Gratiot Avenue Chesterfield, MI 48051
Facility Telephone #:	(586) 949-6220
Original Issuance Date:	11/30/2021
License Status:	TEMPORARY
Effective Date:	11/30/2021
Expiration Date:	05/30/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident falls with injuries but not documented.	No
Resident B and Resident C are sharing Insulin pens.	No
Medications are passed late.	Yes
Untrained staff pass medications.	Yes
Diabetic diets are not followed.	No
There is not enough food for all residents.	No
Insufficient staffing and untrained staff.	Yes
On 01/15/22, Residents were wet with soiled briefs when morning staff arrived at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/04/2022	Special Investigation Intake 2022A0617009
01/05/2022	Contact - Document Received Email received from AFC Consultant Lashonda Reed.
01/05/2022	Special Investigation Initiated – Face to face Special Investigation was initiated by Ms. Reed. Ms. Reed conducted and unannounced onsite.
01/12/2022	Contact - Document Received Email received from Ms. Reed.
01/13/2022	Inspection Completed On-site I conducted an unannounced onsite investigation at the Sandalwood Village I facility. During the investigation I interviewed and observed Resident A, Ms. Morgan, Ms. Robin Bassett, Ms. Kayla Hill and Ms. Shaundria Washington.
01/18/2022	Contact - Document Sent Email sent to Ms. Morgan
01/18/2022	Contact- Phone call made I conducted a phone interview with former staff Ms. Dasha Ware.
01/18/2022	Contact- Phone call made I interviewed staff Shyisha Bracey via telephone.
01/19/2022	I conducted an unannounced onsite investigation at the Sandalwood Village I facility. During the investigation I interviewed

	and observed Resident C, Ms. Morgan, Ms. Robin Bassett, Ms. Frankie Dawkins and Ms. Shaundria Washington.
01/21/2022	Contact - Document Received Email received from AFC Consultant Kristine Cilluffo.
01/24/2022	Contact - Document Received Received- IR, Resident Registry and Resident ID forms
01/24/2022	Contact - Document Sent Email sent to Ms. Morgan
01/24/2022	Contact - Document Sent Email sent to Ms. Cilluffo
01/24/2022	Contact - Document Received Email received from Ms. Cilluffo
01/25/2022	Contact - Document Received Email received from Ms. Cilluffo.
01/25/2022	Contact - Document Sent Email sent to Ms. Morgan
01/25/2022	Contact - Document Received Email received from Ms. Morgan. Documents included - Staff List with phone numbers and Resident ID records
01/25/2022	Contact - Document Received Email Received from Ms. Morgan. Documents received - IR, Resident ID, Resident Registry, Resident MAR
01/26/2022	Contact - Document Received Email received from Ms. Cilluffo.
01/26/2022	Contact - Document Sent Email sent to Ms. Cilluffo.
01/26/2022	Contact - Document Received Email from Ms. Morgan
01/26/2022	Contact - Document Received Email from Monica Sarin
01/26/2022	Contact - Document Sent Email sent to Ms. Morgan

01/27/2022	Contact - Document Received Email from Ms. Morgan. Documents received included: what appeared to be employee files for David Reygaert, Shaudria Washington, Dasha Ware and Kayla Hill, January 2022 schedule and staff list with phone numbers.
02/16/2022	Contact- Document Received Received email from Monika Sarin with clearance form, training records, diploma, medical and TB test to qualify Donitia Strickland as Licensee Designee/Administrator
02/17/2022	Exit Conference Exit conference was held with Ms. Reed, Ms. Cilluffo, Ms. Morgan, Ms. Sarin, and Ms. Strickland. The findings of the investigations were discussed.
02/18/2022	Contact- Document Received Received email from Monika Sarin with letter appointing Donitia Strickland as licensee designee/administrator and Ms. Strickland's resume.

ALLEGATION:

Resident falls with injuries but not documented

INVESTIGATION:

On 01/04/22, a complaint was received regarding Sandalwood Village I. The complaint indicated that multiple resident falls with little to no documentation or follow up on injuries. Resident's medications are missing. The Narcotic medication book count is off with no accountability. The facility is using the same insulin pen for two diabetic residents with no familial relation. There is little to no staff. There have been occasions where one staff has been on shift by themselves to cook, clean, pass meds and toilet 17 residents. There is zero to little staff therefore residents are not getting toileted and cleaned up for hours at a time. Zero staff accountability for missing and/or no charting being done. No proper policies or procedures put into place. Resident paper charts missing. Dishonesty on medications given to patients in charting system. Overworking staff. Having staff work from 3PM to 9AM the next day due to no call no shows that are never replaced with better staff and never held accountable. Incorrect charting done – there is nowhere to properly document occurrences on your shift for other staff knowledge. No proper diet given for diabetic residents.

On 01/18/22, another complaint was received regarding Sandalwood Village I. The complaint indicated that all residents were wet when complainant arrived at the facility.

Residents have soiled briefs and wet from urine. Medications are always late because the qualified staff do not show up to pass out meds.

On 01/18/22, another complaint was received regarding Sandalwood Village I. The complaint indicated that residents rarely have enough food to eat on a daily basis. They are not bathed or changed nearly as often as they should. They get their medications late. Complainant feels the residents are neglected. Management does not run the facility well at all.

According to the facility file, the licensee designee on file is Shella Minor. On 12/23/21, the department received an email from Shella Minor asking for her name to be removed as the licensee designee/administrator for the Sandalwood facilities as of 12/23/2021. Owner Monika Sarin appointed Ms. Jennifer Morgan as the next Licensee Designee.

On 01/04/2022, this special investigation was initiated by consultant LaShonda Reed. On 01/05/2022, Ms. Reed conducted an unannounced onsite at Sandalwood Village. Sandalwood Village consists of two large plus one medium connected facilities (Sandalwood Village I, Sandalwood Village II and Sandalwood Village III). During the unannounced investigation, Ms. Reed interviewed staff Shaundria Washington-Med Tech and David Reygaert-cook/maintenance staff. Ms. Reed was informed that there are a total of 17 residents and three direct caregivers present for all three facilities. Ms. Washington was working as a caregiver that day along with Ashley Massa. A third caregiver was observed but name was not provided. She observed several residents sitting at tables and living room areas throughout the home. Ms. Reed interviewed Mr. Reygaert who was in the kitchen preparing lunch. The lunch that was being served for the day was frozen/breaded fish fillet, French fries, Jell-O, juice/coffee. For breakfast, Mr. Reygaert said he served waffles, sausage, fruit cocktails/peaches and coffee. Mr. Reygaert has worked at the company as a maintenance worker for seven years and has acted as the cook for two weeks. Mr. Reygaert also said that he worked as a cook for six months as well as maintenance but more as a cook recently. Mr. Reygaert said that on 01/04/2022, he arrived at the home at 6:30AM and there was one caregiver present (name unknown). Mr. Reygaert went to prepare breakfast and the staff person that was present, left at 7:30AM without announcing it. Mr. Reygaert said that there was no direct care staff present. Mr. Reygaert said that breakfast was not served until 10:30AM because the next staff person did not arrive to get the residents up until 8:30AM. Mr. Reygaert said that he purchased dinner with his personal money yesterday which was pizza and breadsticks.

On Friday 12/31/2021, when Mr. Reygaert arrived, Jennifer Morgan the proposed licensee designee/administrator informed him that she was leaving for Las Vegs for vacation. Mr. Reygaert said when he went into the kitchen, he found it dirty, with old food and molded food in the refrigerator. Mr. Reygaert cleaned the kitchen. Ms. Reed observed the kitchen to be clean. Mr. Reygaert said that he is not formally trained as a cook but has had food serving training. Mr. Reygaert said he is aware of which residents require special diets. Ms. Reed observed the menus posted in the kitchen area. Mr. Reygaert said that his last day working for the company is tomorrow. Mr.

Reygaert said that the company has changed, and he is the last staff that worked under the previous owners. Mr. Reygaert said that there is a high staff turnover, lack of staff training, and the new administration does not listen to concerns. Mr. Reygaert has requested tools and a ladder, and they have not been provided. Donitia Strickland who is the assistant manager at Sandalwood Valley arrived at Sandalwood Village. Ms. Strickland said that there are three sides to the facility and there are 13 residents combined, three staff that float and one cook.

The special investigation was reassigned to me on 01/10/22.

On 01/12/22, I received an email from Ms. Lashonda Reed with information regarding a phone interview she conducted with former staff member Autumn Gibson.

On 01/07/22, Ms. Reed interviewed former staff member, Autumn Gibson. According to Ms. Gibson, Resident A fell over the Christmas break. Ms. Gibson observed a major bruise and gash above Resident A's left eye. The wounds were not documented in the resident's chart or incident report (IR) written.

On 01/12/22, I received a copy of an incident report dated 12/25/21 regarding Resident A. The incident report indicated that Staff 1 was transporting Resident A in her wheelchair to her room. Staff 1 told Resident A to lift her foot and stop putting it down on the floor or she would fall. Resident A continued to put her foot down and fell out of the wheelchair. The report indicated that, "Staff 1 cleaned it up and put ointment on the side of her face". The report also indicated that as a corrective measure, staff put Resident A's foot pedals on her wheelchair to prevent her from putting her foot down on the floor while in motion.

On 01/12/22, I received a copy of an incident report dated 01/02/22 regarding Resident B. The incident report indicated that Resident B was sitting her wheelchair and had tried standing several times, but Resident B was told to stay seated. While staff was assisting another resident, he heard Resident B fall. When he looked over, Resident B was on the floor. Staff helped Resident B up and placed her back in the wheelchair.

On 01/13/21, I conducted an unannounced onsite investigation. I attempted to interview Resident A but she stated that she did not want to participate with the interview due to not feeling well. I observed her sitting in her room with no marks or bruising on her face. During the onsite investigation, I was not able to observe or interview Resident B due to her being diagnosed with COVID-19.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a

	written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	I reviewed completed required incident reports regarding falls for Resident A and Resident B. Resident A was observed with no marks or bruising during the unannounced onsite investigation on 01/13/22.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Medications are passed late.**
- **Untrained staff pass medications.**

INVESTIGATION:

During the interview between Ms. Reed and Ms. Gibson, Ms. Gibson stated that Resident B was a new resident that arrived on 12/30/2021 from McLaren Hospital. The hospital did not send over Resident B's meds until later that evening or next day. Ms. Gibson received a phone call from a physical therapist named Monica informing her that Resident B's blood glucose level was off the chart. The resident was not sent to the ER. The following day, glucose level was checked and it was normal, and her medications had not arrived. Ms. Gibson believed that Resident C's (who is a resident at Sandalwood Village II) insulin (Lantis) was given to Resident B because hers was empty. This was observed on 01/03/2022 by Ms. Gibson. Ms. Gibson said that there is dishonesty in charting. She brought this to Ms. Morgan's attention, and she responded that there is a lack of staffing so she will not address the charting issues. Ms. Gibson said that staff person Robin (has been employed there for 5 years) refused to do shift charting and threw away the shift charting book that Ms. Gibson started so that staff can be aware of what occurred on the shift for concerns. Ms. Gibson called it the "staff communication log."

During my unannounced onsite investigation on 01/13/22, I observed Resident B's medications, medication administration records (MARS) and the food menu. Resident B and Resident C each had their own Insulin Pen, and the MARs indicate that Resident B has received her all of her medications since her admission on 12/29/21.

On 01/13/22, I conducted an interview with Med tech/assistant manager Shaundria Washington. Ms. Washington stated that she started working at the facility on 12/22/21. According to Ms. Washington, she is a licensed nurse, but she has also been trained on medication administration by the facility. Ms. Washington stated that she is a contracted employee through another company. According to Ms. Washington, until 01/12/22, the only staff that were trained to pass medications were Ms. Jennifer Morgan and herself.

Ms. Washington stated that if she is not present, then Ms. Morgan will pass the residents medication. No other staff has passed medication to residents outside of Ms. Washington and Ms. Morgan from 12/22/21 to 01/13/22. According to Ms. Washington she has worked every day since 12/22/21, except for one or two day. She was unable to tell me which days she missed. Ms. Washington stated that she normally starts her shift around 08:30 AM to about 7 PM or later. According to Ms. Washington, medications can be passed within a time window. The morning meds are passed between 8 AM and 11 AM. Evening meds are passed between 4 PM and 7PM.

On 01/18/22, I conducted a phone interview with former staff Ms. Dasha Ware. According to Ms. Ware, anyone is allowed to pass meds even if they are not trained. If Ms. Ware or other staff did not feel like cooking or passing meds because it was not their job, they just wouldn't do it and the next staff who came in would have to do it.

On 01/18/22, I interviewed staff Shyisha Bracey via telephone. According to Ms. Bracey, she was not trained to pass meds or cook but if there was no med tech or cook, then it was requested that she or other direct care staff would complete those tasks. If direct care staff on shift did not want to do it, then they wouldn't pass medications or cook until the next staff arrives. Therefore, medications are often given late. Ms. Bracey stated that there were a few times that she passed some residents medications due to the high number of call offs.

On 01/19/22, I interviewed staff Robin Bassett. According to Ms. Bassett, she has not witnessed untrained staff passing medications, but she has heard from other staff members that it has occurred on other shifts. Ms. Bassett stated that medications are to be given to residents within a one-hour timeframe. Medications are often given to the residents late (pass the one-hour window). Ms. Washington has been the only med tech for the last month and she is often late for her shift, which causes the residents to receive their medications late.

On 01/19/22, I interviewed staff Frankie Dawkins. Ms. Dawkins stated that she is unaware of untrained staff passing medications.

On 01/19/22, I interviewed Resident D. According to Resident D, he has not experienced any issues with receiving his medications. He stated that he is unaware if he receives his mediations late. Resident D stated that he only knows that he gets medication twice a day and he always receive them.

On 01/19/22. I interviewed interim Licensee Designee Ms. Jennifer Morgan. Ms. Morgan stated that prior to 01/12/22, Ms. Washington was the only trained Med Tech. Ms. Morgan stated that she is also trained to administer medications.

I requested verification of staff medication administration trainings, but they were not received.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Multiple staff have stated that residents often receive their medications late. Staff reported that when there is no med tech on shift, direct care staff are asked to pass medications and if they refuse, medications aren't passed until a med tech arrives. According to Ms. Gibson, there is dishonesty in charting. She brought this to Ms. Morgan's attention and she responded that there is a lack of staffing so she will not address the charting issues.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Multiple staff report that they are untrained and have passed medications. Verification of staff medication administration trainings were requested but not received.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	During my unannounced onsite investigation on 01/13/22, I observed Resident B's medications, medication administration records, and the food menu. Resident B and Resident C each had their own insulin Pen. The MARs indicate that Resident B has received her all of her medications since her admission on 12/29/21.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Diabetic diets not followed**
- **Not enough food for all residents**

INVESTIGATION:

On 01/07/22, Ms. Reed interviewed former staff member, Autumn Gibson. According to Ms. Gibson, the cook is making the same meal for all residents. The meals are not bad but are not to be served to diabetic residents such as desserts are not sugar free and corn beef and cabbage. There are no alternate meals served.

According to Ms. Cilluffo, the facility only had a regular diet menu from Gordon's Food Service. Jennifer Morgan who is the appointed acting Licensee designee, stated that she was going to try to find documentation that the Gordon's menu met diabetic diet requirements.

On 01/13/22, I conducted an unannounced onsite investigation. During the onsite investigation I interviewed staff Kayla Hill, Robin Bassett, Ms. Jenifer Morgan and Ms. Shaundria Washington. Ms. Hill stated that breakfast was late today due to the scheduled cook not showing for his shift. Staff Ms. Hill said that residents were served eggs, ham, grits, toast, and a muffin. I observed the residents eating lunch. Ms. Morgan stated that the scheduled cook for the day called off and she had to go out and purchase lunch for the residents. All the food for all three facilities is kept in one kitchen. I observed the refrigerator, freezer, and pantries with appropriate amounts of food. The menu matched the breakfast that was served. The lunch was purchased (carry out) and the menu was updated to reflect what was being served that day. I observed a one-week Gordons Food Service menu posted in the kitchen. The dates on the menu are as follows: 09/26-10/02, 10/24-10/30, 11/21-11/27, 12/19-12/25, 01/16-01/22, and 02/13-02/19. The menu did not list any diabetic options. According to Ms. Morgan, the Gordon's menu met diabetic diet requirements, but she did not have any documentation to confirm that. There are two residents, Resident B and Resident C who require diabetic meals.

On 01/19/22, I conducted an unannounced onsite investigation. I observed the residents eating lunch. For lunch the residents were served chicken nuggets, green peas, and a bread roll. I observed a one-week Gordons Food Service menu posted in the kitchen.

The dates on the menu are as follows: 10/3-10/09, 10/31-11/06, 11/28-12/4, 12/26-01/01, 01/23-01/29, 02/20-02/26. The menu did not list any diabetic options.

On 01/19/22, I interviewed staff Robin Bassett. According to Ms. Bassett, the cooks are expected to prepare the meals for the residents but when they are short staffed, direct care staff will cook if needed. Ms. Bassett stated that she has not received any food preparation training. Residents are fed daily, three times a day but sometimes their meals are late due to staffing issues.

On 01/19/22, I interviewed staff Frankie Dawkins. Ms. Dawkins stated that residents are fed daily, three times a day but sometimes their meals are late due to staffing issues.

On 01/19/22, I interviewed Resident D. According to Resident D, he has not experienced any issues with receiving food. Meals can often be given later than he would like but he always eats.

On 01/19/22, I interviewed interim licensee designee Ms. Jennifer Morgan. Ms. Morgan stated that it is not expected for direct care staff to cook but there have been occasions where direct care staff had to prepare meals due to cooks calling off. According to Ms. Morgan, when direct care staff have to prepare meals, it is only for breakfast, as she will either find a replacement cook for lunch and dinner or she will step in and cover that role.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	During my two unannounced onsite investigations, I observed the residents eating lunch. The food for all three facilities is kept in one kitchen. I observed the refrigerator, freezer, and pantries with appropriate amounts of food.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.

ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is sufficient information to conclude that the facility did not provide special diets that are prescribed by a physician. I observed a one-week Gordons Food Service menu posted in the kitchen with incorrect dates. The menu did not list any diabetic options. According to Ms. Morgan, the Gordon's menu met diabetic diet requirements although she did not have any documentation to confirm. Resident B and Resident C require diabetic meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitutions shall be noted and considered apart of the original menu. **(5) Records of menus, including special diets, shall be provided upon request by the department.**
ANALYSIS:	During my unannounced onsite on 01/13/22, I observed a one-week Gordons Food Service menu posted in the kitchen. The dates on the menu were 09/26-10/02, 10/24-10/30, 11/21-11/27, 12/19-12/25, 01/16-01/22, and 02/13-02/19. The menu did not list any diabetic options. According to Ms. Morgan, the Gordon's menu met diabetic diet requirements, but she did not have any documentation to confirm. Resident B and Resident C require diabetic meals. On 01/19/22, during the unannounced onsite investigation, I observed the residents eating chicken nuggets, green peas and a bread roll for lunch. I observed a one-week Gordons Food Service menu posted in the kitchen which did not list any diabetic options.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is insufficient staffing.

INVESTIGATION:

On 01/07/22, Ms. Reed interviewed former staff member, Autumn Gibson. Ms. Gibson said she began working for the company on 12/20/2021 and quit on 01/03/2022 due to being overworked and due to the lack of staffing.

On 01/18/22, I interviewed Ms. Bracey. Ms. Bracey said there have been times where she was the only one on shift to cover all three buildings.

According to Ms. Cilluffo, during her onsite investigation, Ms. Morgan notified her that staffing is scheduled by operating all three facilities as one. Each facility did not have at least one person working at all times.

On 01/18/22, I interviewed Ms. Ware. Ms. Ware stated that she was employed at Sandalwood from November to early January 2022. Ms. Ware stated that residents aren't bathed often. Owner Monica Sarin and Ms. Morgan told her that residents are only bathed once a week. They don't have anyone to cook so direct care staff on shift are expected to cook and pass medications, but she stated that was not a part of the job description she agreed to at the time of hire. She stated that she was not trained to pass meds or cook. She never completed any new hire paperwork except for an application. The facility was desperate for staff, so she was hired on the spot from her interview and begin working the next day.

On 01/13/22, I conducted an unannounced onsite investigation. I observed staff Robin Bassett, Kayla Hill, Shaundria Washington and Ms. Jennifer Morgan working. I interviewed interim Licensee Designee Ms. Jennifer Morgan. Ms. Morgan stated that there has been a lot of staff turnover over the last several weeks. The facilities are currently operating as one facility and has one schedule to cover all three buildings. There were schedules available at the facility, but they often change due to call ins and schedule changes. According to Ms. Morgan, she tries to keep an updated schedule, but she was unable to locate the updated schedule at the time of the onsite. Ms. Morgan stated that the employees must clock in and out, and that is how she tracks who worked on which days and what times. I observed a schedule from 12/12/21-12/18/21. According to the schedule from 8 PM to 11 PM there are only two staff scheduled for all three buildings. Also, from 11 PM to 7 AM there are only one-two staff scheduled for all three buildings.

On 01/18/22, I sent an email to Ms. Morgan requesting the following documents:

- List of all staff members with position titles and current phone numbers
- Staff files for David Reygaert, Shaundria Washington, Robin Basset,Kayla Hill, Dasha Ware and Shyisha Goines Bracey
- Staff schedule for January 2022
- Contracts and job descriptions for David Reygaert and Shaundria Washington
- IR for Resident A
- Resident ID for all Sandalwood Village I residents

- Health Care Appraisals for all Sandalwood Village I residents
- Assessment plans for all Sandalwood Village I residents
- January MARS for all Sandalwood Village I residents.

On 01/19/22, I interviewed interim Licensee Designee Ms. Jennifer Morgan. Ms. Morgan stated that Ms. Shaudria Washington is a contracted employee, and she is not required to clock in and out. According to Ms. Morgan, Ms. Washington's hours are tracked between she and Ms. Washington. Ms. Morgan stated that sometimes she writes down the days Ms. Washington works, sometimes uses text messages between the two of them and other times she uses the dates that she provides ride services to Ms. Washington to track Ms. Washington's hours worked. Ms. Morgan could not provide any of that documentation at the time of the onsite and was requested to send it via email.

On 01/19/22, I interviewed staff Robin Bassett. Ms. Bassett stated that the facility is short staffed, and they do not have enough staff to properly care for the residents.

On 01/19/22, I interviewed staff Frankie Dawkins. Ms. Dawkins stated that the facility needs more help to properly care for the residents.

On 01/19/22, I interviewed Resident D. According to Resident D, the facility is in need of more staff. Resident D stated that there is hardly anyone working the night shifts and he rarely can get assistance. There have been times when Resident D had to use the restroom on himself due to lack of staff assistance.

During my unannounced onsite investigation on 01/19/22, I observed Robin Bassett (direct care staff), Frankie Dawkins (direct care staff), Kennedy Morgan (cook), Ashley Massa (helper), Shaundria Washington (Med Tech), Jennifer Morgan (Licensee Designee) and Matthew Robinson (maintenance/cook) working. During lunch, I observed Mr. Robinson preparing and passing meals. Ms. Washington was fielding calls to the facility. Ms. Jennifer and Kennedy Morgan were assisting a nurse who was there to administer COVID vaccines. Ms. Basset and Ms. Dawkins were in resident rooms assisting residents. I observed 13 residents in the dining area having lunch. I observed residents left unattended for several minutes while staff were busy completing the tasks mentioned above. I observed several residents needing assistance while eating and staff were not available to help. I observed one resident dump her entire plate of food on to the table and floor, then proceed to eat the food with her hands off of the table for several minutes. The resident had food all over her clothing. After several minutes, staff came over to assist her.

On 01/25/22, I sent Ms. Morgan an email indicating that I had not received the documents requested on 01/18/22. The email also indicated that she had been provided a full week to submit the documents and she now has until the close of business to submit the requested documents or it will be cited as a violation.

On 01/25/22, I received the following documents: Resident ID for all Sandalwood Village I residents, Health Care Appraisals for all residents a Sandalwood Village I, Assessment

plans for all residents at Sandalwood Village I, and January MARS for all Sandalwood Village I residents. I did not receive any of the requested staff information.

On 01/26/22, I received a phone call from Ms. Morgan stating that she has attempted to send all of the requested materials, but she is having issues with the server. According to Ms. Morgan, some of the scanned staff files are too large to send and she has worked on reducing the size so that they will be able to be delivered via email but that has not worked either.

On 01/27/22, I received and reviewed what appeared to be employee files for David Reygaert, Shaudria Washington, Dasha Ware and Kayla Hill. I also received a staff schedule from 01/01/22 to 01/15/22.

According to the staff schedule, there was no staff scheduled to work from 11 PM to 7 AM on the following days: 01/01, 01/07, 01/10, 01/12 and 01/15.

Mr. Reygaert's file did not have the following: application, copy of driver's license, verification of reference checks, TB testing results, verification of receipt of personnel policies and job descriptions, physician's statement at hire, workforce background check and the required trainings of First aid/CPR, safety and fire prevention. Originally it was stated that he was a cook and maintenance worker, but he has the following trainings: reporting requirements, personal care, resident rights, prevention of communicable diseases and assistive device/ physical restraint training. All of his documents are dated 01/25/22 and he was observed working at the facility on 01/05/22 by Ms. Reed.

Ms. Washington's employee file did not have the following: application, copy of driver's license, verification of reference checks, TB testing results, verification of receipt of personnel policies, job descriptions, and all required trainings.

Ms. Ware's file did not have the following: application, copy of driver's license, verification of reference checks, TB testing results, verification of receipt of personnel policies and job descriptions, physician's statement at hire and all required trainings.

Ms. Hill file is complete, but her application is dated 12/17/21 however all of her trainings are dated 01/24/22. According to the January staff schedule Ms. Hill was on the scheduled to work as early as 01/01/22.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.

ANALYSIS:	According to Ms. Cilluffo, during her onsite investigation, Ms. Morgan notified her that staffing is scheduled by operating all three facilities as one. Each facility did not have at least one person working at all times. Sandalwood Village has approximately 17 residents in total between the three facilities. By only scheduling one to two caregivers to cover three buildings leaves residents unattended. I observed a staff schedule from 12/12/21-12/18/21. According to the schedule from 8 PM to 11 PM there are only two staff scheduled for all three buildings. Also, from 11 PM to 7 AM there are only one-two staff scheduled for all three buildings. According to the staff schedule, there was no staff scheduled to work from 11 PM to 7 AM on the following days: 01/01, 01/07, 01/10, 01/12 and 01/15.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(1) An applicant for an adult foster care small group home license shall make available at the facility, or arrange for the department's inspection and copying of all of the following items: **(c) A copy of any current agreement or contract between the applicant or licensee, agency, person, or organization that provides or proposes to provide funding, care, treatment, or supplemental services as described in the home's program statement.**
ANALYSIS:	Ms. Morgan indicated that the facility employs multiple contract employees. It was requested that Ms. Morgan provide the contracts for Ms. Washington and Mr. Reygaert. The contracts were never provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**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:	According to Ms. Cilluffo, during her onsite investigation on 01/11/22, Ms. Morgan notified her that staffing is scheduled by operating all three facilities as one. Each facility did not have at least one person working at all times. I observed a staff schedule from 12/12/21-12/18/21. According to the staff schedule from 8 PM to 11 PM there are only two staff scheduled for all three buildings. Also, from 11 PM to 7 AM there are only one-two staff scheduled for all three buildings. According to the staff schedule, there was no staff scheduled to work from 11 PM to 7 AM on the following days: 01/01, 01/07, 01/10, 01/12 and 01/15. Multiple staff members and residents indicate that the facility is in need of more staff to properly and adequately care for residents. During my onsite on 01/19/22, I observed several residents needing assistance during lunch but there were not enough staff to assist in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(a) Name, address, telephone number, and social security number.** **(b) The professional or vocational license, certification, or registration number, if applicable.** **(c) A copy of the employee's driver license if a direct care staff member or employee provides transportation to residents.** **(d) Verification of the age requirement.** **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**
ANALYSIS:	On 01/18/22, I sent an email to Ms. Morgan requesting staff files for David Reygaert, Shaundria Washington, Robin Basset, Kayla Hill, Dasha Ware and Shyisha Goines Bracey. On 01/27/22, I received and reviewed what appeared to be

	employee files for David Reygaert, Shaudria Washington, Dasha Ware and Kayla Hill. Mr. Reygaert, Ms. Washington and Ms. Ware's files were incomplete. Ms. Hill's file is complete, but her application is dated 12/17/21 however all of her trainings are dated 01/24/22. According to the January staff schedule, Ms. Hill was on the scheduled to work as early as 01/01/22. The other requested employee files were never received.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14208	**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.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	According to Ms. Morgan, there has been a lot of staff turnover over the last several weeks. The facilities are currently operating as one facility and has one schedule to cover all three buildings. There were schedules available at the facility, but they were in accurate due to call ins and schedule changes. According to Ms. Morgan she tries to keep an updated schedule, but she was unable to locate the updated schedule at the time of the onsite. Ms. Morgan stated that the employees must clock in and out, and that is how she tracks who worked on which days and what times. Ms. Morgan failed to provide the department with the verified timesheets as requested.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 01/15/22, residents were wet with soiled briefs when morning staff arrived at the facility

INVESTIGATION:

On 1/18/22, I interviewed Ms. Bracey. Ms. Bracey stated that she was hired in September while former Licensee designee Shella Minor was there, and everything was

fine. Once Ms. Minor left, everything went downhill fast. On Saturday 01/15/22, Ms. Bracey arrived at the facility around 7AM for her 7-3PM shift. She worked at all three facilities due them being treated as one. When she started getting the residents up for the day, many of them were soaking wet with urine and feces, to the point that the sheets on the bed were soaked. This was the situation for several residents in all three buildings. Several residents required showers. Ms. Bracey stated that there was another staff member there, but she did not know her well. She believes her name was Ms. Shella. There was a third staff there, but she was new and waiting to be trained by the med tech/assistant manager Ms. Shaundria Washington. Ms. Washington was late arriving, so the new person left. When Ms. Washington arrived, Ms. Bracey was very upset and started loudly verbalizing her frustration because she felt like the residents are being neglected and the facilities are being poorly ran. Ms. Jennifer Morgan then suspended Ms. Bracey and told her to clock out (around noon). Ms. Morgan told Ms. Bracey she would call her on Monday. However, later that day, a lady from Sandalwood Valley called and left Ms. Bracey a message stating that Monica told her that Ms. Bracey wanted to switch facilities and they offered her more money to make the change. Ms. Bracey reports that she declined the offer and would like to remain at Sandalwood Village.

On 01/19/22, I interviewed Resident D. According to Resident D, the facility is in need of more staff. Resident D stated that there is hardly anyone working the night shifts and he rarely can get assistance. There have been times were Resident D had to use the restroom on himself due to no lack of staff assistance.

On 01/19/22. I interviewed interim Licensee Designee Ms. Jennifer Morgan. Ms. Morgan stated that on 01/15/22, she received a phone call at 06:50 AM from Ms. Bracey asking who is working with her because she believed she was working alone. Ms. Morgan informed her that the midnight staff is going to stay over a few hours to help out. Ms. Bracey complained that the residents were late getting breakfast because most of the residents were wet and needed changing. According to Ms. Morgan, residents were wet because it was 7AM and most residents use the bathroom first thing in the morning. Staff are expected to check on the residents during sleeping hours every two hours or less. Ms. Morgan stated that she suspended Ms. Bracey due to her behavior in front of the residents.

According to the staff schedule (01/01/22 – 01/15/22) that I received on 01/27/22, Ms. Bracey is not listed as working. However, Ms. Morgan stated that Ms. Bracey was present that day and worked a partial day. However, this is not reflected on the staff schedule.

I conducted an exit conference on 02/17/22 with Ms. Reed, Ms. Cilluffo, Ms. Morgan, Ms. Sarin, and Ms. Strickland. The findings of the investigations were discussed.

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:	There are not enough staff scheduled to meet the needs and requirements of the residents. Resident D reported that he had to use the restroom on himself due to not being able to get assistance from staff. According to Ms. Bracey, when she started getting the residents up for the day, many of them were soaking wet with urine and feces, to the point the sheets on the bed were soaked. This was the same for several residents in all three buildings. Several residents required showers. During my onsite investigation on 01/19/22, I observed 13 residents in the dining area having lunch. I observed residents left unattended for several minutes while staff were busy completing other tasks. I observed several residents needing assistance while eating and staff was not available to help. I observed one resident dump her entire plate of food on to the table and floor, then proceed to eat the food with her hands off the table for several minutes with food all over her clothing. After several minutes, staff came over to assist her.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/21/2021, Ms. Cilluffo sent an emailed to Jennifer Morgan and Monika Sarin listing documents needed to quality a new licensee designee/administer, as she was notified that there was an open investigation regarding Shella Minor that could possibly result in her termination. Licensee designee/administrator, Shella Minor, was terminated on 12/23/2021. Jennifer Morgan was identified as the individual who would fill Ms. Minor's position. On 01/03/2022, a clearance, medical and TB test were provided for Ms. Morgan. No additional documents were received to qualify Ms. Morgan as licensee designee/administrator. Ms. Morgan indicated on 01/11/2022 that she is a licensed Nursing Home Administrator.

On 01/28/2022, Ms. Cilluffo received a phone call from Monika Sarin regarding appointing Donitia Strickland as licensee designee/administrator instead of Jennifer Morgan. On 02/16/2022, she received clearance forms, training records, diploma, medical and TB test for Ms. Strickland. On 02/18/2022, a letter from Monika Sarin was

received requesting to appoint Ms. Strickland as licensee designee/administrator for all their facilities along with her resume documenting Ms. Strickland's experience.

APPLICABLE RULE	
R 400.14202	**Administrator; qualifications.**
	(1) A home shall have an administrator who shall not have less than 1 year of experience working with persons who are mentally ill, developmentally disabled, physically handicapped, or aged.
ANALYSIS:	Sandalwood Village I did not have an approved licensee designee and administrator for almost two months, from 12/24/21 to 2/18/22. Licensee designee/administrator, Shella Minor, was terminated on 12/23/2021. Jennifer Morgan was initially identified to fill her position. However, all requested documents were not received to qualify Ms. Morgan. On 01/28/2022, owner Monika Sarin indicated that she was considering appointing Donitia Strickland as licensee designee/administrator. All requested documents were received for Ms. Strickland on 02/18/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

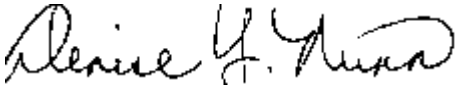
IV. RECOMMENDATION

I recommend revocation of the license.

03/10/22

Eric Johnson — Date
Licensing Consultant

Approved By:



03/10/2022

Denise Y. Nunn — Date
Area Manager