GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 28, 2022

Karen Gardner
4522 Old Lansing Road
Lansing, MI 48917

RE: License #: AM330015780
Investigation #: 2022A0783029
Gardners Adult Foster Care

Dear Ms. Gardner:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations established in this report and the fact you were placed on a 1st provisional license on February 1, 2022 for the violations established in the renewal licensing study report dated February 1, 2022, 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 (517) 284-9730.

Sincerely,

Leslie Herrguth

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330015780
Investigation #:	2022A0783029
Complaint Receipt Date:	03/01/2022
Investigation Initiation Date:	03/01/2022
Report Due Date:	04/30/2022
Licensee Name:	Karen Gardner
Licensee Address:	4522 Old Lansing Road Lansing, MI 48917
Licensee Telephone #:	(517) 322-4050
Administrator:	Karen Gardner
Name of Facility:	Gardners Adult Foster Care
Facility Address:	2924 W Willow Road Lansing, MI 48917
Facility Telephone #:	(517) 886-1114
Original Issuance Date:	01/09/1995
License Status:	1ST PROVISIONAL
Effective Date:	02/01/2022
Expiration Date:	07/31/2022
Capacity:	12
Program Type:	AGED

ALLEGATION(S)

	Violation Established?
Resident A fell on February 25, 2022 and did not receive prompt medical treatment.	Yes
Resident A fell four times in ten days at the facility.	No
Direct care staff member Dorothea Jarrett stated Resident A was “clowning around,” and Ms. Jarrett was agitated with Resident A.	Yes
Additional Findings	Yes

II. METHODOLOGY

03/01/2022	Special Investigation Intake – 2022A0783029
03/01/2022	Special Investigation Initiated – Telephone call with Complainant
03/11/2022	Inspection Completed On-site
03/11/2022	Contact - Face to Face interviews with facility manager Natalie Gardner, Resident B, and Resident C
03/11/2022	Contact - Document Received – Resident A's resident record
04/14/2022	Contact - Telephone call made to direct care staff member Deborah Redman
04/14/2022	Contact - Telephone call made to Relative A1
04/15/2022	Contact - Telephone call made to direct care staff member Dorothea "Dottie" Jarrett
04/16/2022	Contact - Telephone call made to direct care staff member Jan Chambers
04/16/2022	Contact - Document Received - Written *AFC Licensing Division Incident/Accident Report* for Resident A dated 2/24/22
04/18/2022	Exit Conference – with Karen Gardner

ALLEGATION:

Resident A fell on February 25, 2022 and did not receive prompt medical treatment.

INVESTIGATION:

On March 1, 2022, I received a denied APS complaint via centralized intake that stated on February 24, 2022 Resident A was at the hospital for a fall and was discharged around at approximately 12:30 am on February 25, 2022 and Relative A1 transported Resident A back to Gardners Adult Foster Care facility. The complaint stated Relative A1 called the home at 2:00 am, 3:30 am, and 5:30 am and no direct care staff member answered the telephone. The complaint stated Relative A1 received a call at 11:00 am on February 25, 2022 stating that Resident A had another fall at 3:30 am while she was in the bathroom. The written complaint stated the direct care staff member working at the time Resident A fell did not call an ambulance for Resident A. The written complaint stated when Resident A was brought to the hospital by Relative A1, she was observed to have abrasions and a contusion on the back of her head. The complaint stated Resident A was in bloody clothing, had blood on the back of her head, and had significant scratches and bruising to her arms.

On March 1, 2022, I spoke to the denied APS referral source (Complainant) who stated Resident A was observed in the hospital with blood on the back of her head as well as a contusion on the head and that she had scratches and bruises "all over" her arms. Complainant said Resident A was treated in the hospital for a head injury and she required two staples for the laceration on her head. Complainant said Resident A was admitted to the hospital and would not be returning to the facility.

On March 11, 2022, I received a written *AFC Licensing Division Incident/Accident Report* for Resident A dated February 24, 2022. The written incident report was signed by direct care staff member Dorothea "Dottie" Jarrett and stated that at approximately 3:30 am "[Resident A] sitting on the toilet and I left to get her clean clothes. She got up and slipped, fell back and hit her head on the seat. 3 skin tears. 1 on each hand, 1 on right shin." In the "action taken by staff" section of the written report it stated, "Cleansed area and stopped bleeding, put bandage on skin tears." In the "corrective measures taken" section of the written report it stated, "[Resident A] needs her walker at all times she was just home from ER. Moved facility, no longer a safe environment." The written incident report stated Resident A was diagnosed with a head injury at Sparrow Hospital and needed "2 or 3" staples in her head.

On April 15, 2022, I spoke to direct care staff member Dorothea "Dottie" Jarrett who stated she was working alone on the overnight shift on February 24 – February 25, 2022. Ms. Jarrett said Relative A1 brought Resident A to the facility from the hospital

at approximately 3:00 am on February 25, 2022 because she had fallen earlier in the day. Ms. Jarrett said Resident A did not want to come into the facility and Relative A1 had to physically manage Resident A to get her inside. Ms. Jarett said by the time Resident A got inside she was “freezing and disheveled.” Ms. Jarrett said she assisted Resident A to the bathroom and told her she was getting Resident A “ready for bed” and left Resident A on the toilet and went to get Resident A’s clothing which was on Resident A’s bed in the room across the hall from the bathroom. Ms. Jarrett said when she returned to the bathroom Resident A was “bent over, reaching for something in the tub.” Ms. Jarrett said she “had [Resident A] by the arm” to assist her back into an upright position as she was reaching into the tub and then Resident A “snatched away from [Ms. Jarrett] so hard [Resident A] fell.” Ms. Jarrett said Resident A hit her head on the toilet when she fell. Ms. Jarrett said Resident A “was screaming and hollering” and woke every Resident in the home before she could “get [Resident A] calmed down.” Ms. Jarrett said Resident A’s head was bleeding and she had skin tears on both arms and one leg. Ms. Jarrett said she applied pressure to the wound on Resident A’s head and applied bandages to the skin tears. Ms. Jarrett said the head wound stopped bleeding and she kept Resident A in the common area of the home so she could observe her. Ms. Jarrett said Resident A was adamant that she did not want to go to the hospital. Ms. Jarrett said she telephoned facility manager Natalie Gardner but did not reach her. Ms. Jarrett stated she did not telephone Relative A1 nor call an ambulance for Resident A because Resident A’s head stopped bleeding, Resident A did not want to go to the hospital, Resident A had just returned from the hospital, and it was only “a couple of hours until morning” when Relative A1 could be called and Resident A could be taken back to the hospital if he wished.

On March 11, 2022, I interviewed facility manager Natalie Gardner who said on February 25, 2022, Resident A returned from the hospital at approximately 2:30 am and according to Ms. Jarrett who was working, Resident A did not want to come inside the house and Relative A1 had to physically manage Resident A to get her inside. Ms. Gardner said Ms. Jarett told her she took Resident A to the bathroom to get her changed and Resident A fell in the bathroom and hit her head almost immediately after returning from the hospital from a previous fall. Ms. Gardner said Ms. Jarrett told her when she left the bathroom momentarily to get Resident A’s clothing that was when she fell and hit her head. Ms. Gardner said Ms. Jarrett told her she did not see Resident A fall and that when she observed Resident A she was on the floor and her head was bleeding. Ms. Gardner said Ms. Jarrett telephoned her at approximately 3:00 am to notify her of the fall but she did not receive the message until approximately 10:00 am at which time she notified Relative A1, and he came to the facility and took Resident A to the hospital because she had a head injury. Ms. Gardner said she did not see Resident A before Relative A1 took her to the hospital, so she was not aware what condition Resident A was in. Ms. Gardner denied that she ever saw scratches or bruising on Resident A’s arms but said Ms. Jarrett told her it happened when Resident A fell. Ms. Gardner said she discussed the incident with Ms. Jarrett and was told Ms. Jarrett did not telephone an ambulance for Resident A because Resident A said she was freezing and did not want to go to the

hospital and because the bleeding stopped. Ms. Gardner said she advised Ms. Jarrett that in the future if a resident falls and sustains an injury she should call 911 for an ambulance so the resident can be evaluated for the needed treatment immediately. Ms. Gardener acknowledged that Ms. Jarett should have called an ambulance for Resident A.

On April 14, 2022, I spoke to direct care staff member Deborah Redman who said she relieved Ms. Jarrett at approximately 9:00 am on February 25, 2022 and was told that Resident A had fallen in the bathroom during the early morning hours and hit her head. Ms. Redman said when she observed Resident A she had “quite a bit of blood on the back of her robe and in her hair,” but Resident A was not actively bleeding until Ms. Redman tried to clean the blood off Resident A’s head and hair and then the wound began to bleed again. Ms. Redman said Resident A appeared to be “in pain,” based on the fact she was “wincing.” Ms. Redman said she contacted Relative A1 because the wound started bleeding again, Resident A was clearly in pain, and she had “blood gummed up in her hair.” Ms. Redman said Ms. Jarrett told her she did not call an ambulance for Resident A because the head injury stopped bleeding and Ms. Redman stated, “I would have sent [Resident A] back [to the hospital] for a head injury.”

On April 14, 2022, I spoke to Relative A1 who said on February 24, 2022, Resident A fell at the facility and he took her to the hospital where she was seen in the emergency room and released at approximately 2:30 am on February 25, 2022. Relative A1 said he transported Resident A back to the facility and within 30 minutes of being dropped off Resident A fell again. Relative A1 said he telephoned the facility at least three times between 3:00 am and 5:30 am and nobody answered the telephone. Relative A1 said at approximately 10:00 am he received a telephone call from home manager Natalie Gardner who told him Resident A fell right after she was dropped off at 3:00 am and that she hit her head in the fall. Relative A1 stated he went straight to the facility to take Resident A to the hospital to be evaluated for a head injury and when he arrived Resident A was “all bloodied up.” Relative A1 said Resident A’s hair and clothing were bloody when he picked her up and took her to the hospital. Relative A1 said Resident A required two staples in her skull due to the injury sustained in the fall for which she did not receive treatment for approximately eight hours. Relative A1 said he never received an explanation about why an ambulance was not called for Resident A nor was he notified promptly when she fell and hit her head.

On March 11, 2022, I received and reviewed Resident A’s written *Assessment Plan for AFC Residents* dated February 15, 2022. The written assessment plan stated Resident A does not need assistance with walking nor mobility.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on statements from Complainant, Ms. Jarrett, Ms. Gardner, Ms. Redman, and Relative A1 as well as the written incident report regarding Resident A's fall on or about February 25, 2022 Resident A sustained a head injury which required two staples at approximately 3:30 am but did not receive medical treatment until approximately 11:00 am when Relative A1 took Resident A to the hospital. Ms. Jarett and Ms. Redman who worked the morning of Resident A's fall neglected to call an ambulance on behalf of Resident A as did Ms. Gardner who was made aware even though Resident A was actively bleeding from the head and sustained other injuries to her arms and legs when she fell at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 the interviews conducted and the documentation in Resident A's resident record I determined that Ms. Jarrett's account of what occurred was not consistent as she told Ms. Gardner she did not witness Resident A's fall on February 25, 2022, yet she told me that she witnessed the fall. According to Ms. Jarrett, Resident A fell when in Ms. Jarrett's words Resident A "snatched away" from her as she was holding Resident A's arm. According to Resident A's written assessment plan Resident A did not need staff assistance with mobility so there was no reason for Ms. Jarrett to have a hold of Resident A's arm, which ultimately at least contributed to her falling.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A fell four times in ten days at the facility.

INVESTIGATION:

On March 1, 2022 I received a denied adult protective services (APS) complaint via centralized intake that stated Resident A (age 95) is diagnosed with mild confusion and a history of TIA (transient ishaemic attack). The complaint stated Resident A used to use the assistance of a walker to ambulate but now needs the assistance of a wheelchair to ambulate. The complaint stated Resident A has been at the facility for ten days and has fallen on four separate occasions.

On March 1, 2022 I spoke to Complainant who confirmed the allegations in the complaint and had no further information to add.

On March 11, 2022 I interviewed facility manager Natalie Gardner who said Resident A fell four times in total between when she was admitted on February 15, 2022 and when she was discharged on February 25, 2022. Ms. Gardner said on one occasion (date unknown) Resident A "slipped out of her chair" in the dining room but was laughing and not injured. Ms. Gardner said on February 18, 2022 Resident A fell to the floor in her bedroom and the staff member working did not witness the fall. Ms. Gardner said after the fall, paramedics were called who came to the facility, assisted Resident A off the floor and examined her but did not take her to the hospital because Resident A declined to go, and she was not injured. Ms. Gardner said "days later" she observed bruising on Resident A's ribs, but Resident A never complained of pain nor requested medical treatment. Ms. Gardner said Resident A fell during the day on February 24, 2022 and paramedics came to the facility and transported Resident A to the hospital because she was in pain. Ms. Gardner said Resident A was treated and released during the early morning hours of February 25, 2022. Ms. Gardner said Resident A fell again approximately 30 minutes after returning to the facility and was admitted to the hospital later that day. Ms. Gardner said she was not notified upon admission that Resident A tended to fall but upon observing Resident A's gait after admission, she gave Resident A a walker to use and staff members reminded her to use it. Ms. Gardner said staff members encouraged Resident A to stay in the common area where she could be observed. Ms. Gardner acknowledged those efforts were not enough to prevent Resident A from falling and ultimately, she was discharged because direct care staff members could not keep Resident A safe at the facility due to the falls.

On April 14, 2022, I spoke to direct care staff member Deborah Redman who said Resident A ambulated independently with a walker and "did okay." Ms. Redman said she was not told that Resident A had a history of nor that she was at risk of falling. Ms. Redman said Resident A fell once while she was working which was on February 18, 2022. Ms. Redman said she did not witness the fall as Resident A was in her bedroom and Ms. Redman was in the kitchen. Ms. Redman said Resident A's roommate came and told her that Resident A fell in the bedroom and when Ms. Redman went in there, Resident A was sitting on her bottom on the floor and speaking regularly. Ms. Redman said Resident A was not injured but she could not

get her off the floor as she was “too heavy,” so Ms. Redman called 911 for assistance and paramedics came and lifted Resident A off the floor and back to bed. Ms. Redman said Resident A had pain in her rib area, but she did not see any bruising or other marks on Resident A. Ms. Redman said Resident A stated she did not want to go to the hospital and paramedics assessed her, took her vitals, and determined no altered mental status so Resident A did not go to the hospital. Ms. Redman said staff members reminded Resident A to use a walker when ambulating and encouraged her to stay in the common area where staff members could more easily monitor her to address Resident A’s tendency to fall.

On April 16, 2022, I spoke to direct care staff member Jan Chambers who said Resident A ambulated independently with a walker but would often “just get up and start walking” without the walker. Ms. Chambers said she was not made aware of any fall history for Resident A but said she quickly noticed that Resident A “would stumble” when she walked independently without a walker. Ms. Chambers said because of Resident A’s tendency to ambulate without her walker, “[Resident A] needed someone with her every second” to address her falling. Ms. Chambers said staff members “tried to keep eyes on” Resident A but according to Ms. Chambers one staff member could not care for four other residents and keep Resident A in line of sight, especially because Resident A “wouldn’t sit still and was all over the place.” Ms. Chambers said on February 24, 2022, Resident A fell in the living room while she was in another resident’s bedroom. Ms. Chambers said she was only away from Resident A for “seconds” before she returned to the living room and observed Resident A on the floor. Ms. Chambers said Resident A complained of back pain and Ms. Chambers called an ambulance on behalf of Resident A and Resident A was taken to the hospital.

On April 15, 2022, I spoke to direct care staff member Dorothea “Dottie” Jarrett who said Resident A often ambulated independently without any assistive devices but she had a walker that staff members encouraged her to use. Ms. Jarett stated staff members were not aware that Resident A had a history of falling. Ms. Jarrett said Resident A fell once while she was working as described previously in this report. Ms. Jarrett stated in addition to reminding Resident A to use her walker staff members encouraged Resident A to remain in the common area where she could be more closely monitored by the staff member working.

On April 14, 2022, I spoke to Relative A1 who said Resident A fell three times in total while living at the facility for approximately ten days on February 18, 2022, February 24, 2022 and February 25, 2022. Relative A1 said he was notified via telephone that Resident A fell in her bedroom on February 18, 2022 and he was told Resident A was assessed by paramedics and not injured and Resident A did not go to the hospital. Relative A1 said he was notified via telephone that Resident A fell on February 24, 2022 and that she was in pain and was being transported to the hospital by paramedics. Relative A1 said he met Resident A at the hospital, she was not seriously injured, and she was released back to the facility in the early morning hours of February 25, 2022. Relative A1 said Resident A fell a third time on February

25, 2022, just 30 minutes after returning from the hospital and was injured as described earlier in this report. Relative A1 said when Resident A admitted to the facility, she used a cane and that home manager Natalie Gardner gave Resident A a walker to use, but he was not aware of any additional measures to address Resident A's falls. Relative A1 said after Resident A fell on February 25, 2022, he received a telephone call from Natalie Gardner explaining that the facility was no longer a safe environment for Resident A because there was "no way" one direct care staff member could "keep eyes on" Resident A all the time to prevent her from falling.

On March 11, 2022, I reviewed Resident A's entire written resident record and did not locate any hospital discharge summaries or information related to Resident A's hospitalizations from falls on February 24, 2022 and February 25, 2022. On April 14, 2022, when I spoke to Relative A1 he said he was unable to provide such documentation. I also reviewed documentation provided by staff members at the facility where Resident A resided previously and there was no fall history noted.

On March 11, 2022, I reviewed Resident A's entire written resident record and found two incident reports. One was dated February 24, 2022 and is described previously in this report and another was dated February 18, 2022 and stated, "[Resident A's] roommate came out to the kitchen and said, 'the lady fell.' [Resident A] complaining her 'ribs' are hurting." In the "action taken by staff" section of the written report it stated, "Staff called 911 and followed up with [Relative A1]. Paramedics asked resident if she wanted to go to the hospital, she declined." In the "corrective measures taken" section of the written report it stated, "Paramedics picked [Resident A] up and put her back into bed."

On April 16, 2022, I received a third written incident report dated February 24, 2022 and completed by direct care staff member Jan Chambers. The written incident report stated, "[Resident A] got up without her walker and she lost her balance. Complained of pain. Skin tear on leg." In the "action taken by staff" section of the written report it stated, "Called 911. Sent to Sparrow." There was nothing further written on the report.

On March 11, 2022, I reviewed Resident A's written *Assessment Plan for AFC Residents* dated February 15, 2022. The written assessment plan indicated Resident A used a cane or walker to ambulate independently, and the only physical limitation documented was "age related."

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 statements from Ms. Gardner, Ms. Redman, Ms. Chambers, Ms. Jarrett and Relative A1 and well as reviewing all the documentation in Resident A's resident record at the facility I determined that there was nothing documented in the written forms provided by Resident A's former placement to indicate Resident A was at risk for nor that she had a history of falling. There were three documented falls in the short amount of time that Resident A was admitted to the facility and appropriate action was taken by staff members who called 911 on behalf of Resident A. Staff members described taking internal actions such as increased monitoring and encouraging the use of an assistive device to address Resident A's tendency to fall. When it became apparent that Resident A's needs could not be met at the facility, she was discharged. Considering those factors and with no documentation from the medical professionals who assessed and treated Resident A subsequent to the falls there is a lack of evidence to indicate that staff members neglected to ensure Resident A's safety at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff member Dorothea Jarrett stated Resident A was "clowning around," and Ms. Jarrett was agitated with Resident A.

INVESTIGATION:

On March 1, 2022, I received a denied APS complaint via centralized intake that stated Relative A1 overheard direct care staff member Dorothea "Dottie" Jarrett say that Resident A "has been clowning around" and made other statements that make it seem Ms. Jarrett is "agitated" with Resident A.

On March 1, 2022, I spoke to Complainant who verified the allegation as described in the written complaint and had no additional information to provide.

On March 11, 2022, I interviewed facility manager Natalie Gardner who said she is familiar with Dorothea "Dottie" Jarrett who regularly works the overnight shift at the facility. Ms. Gardner described Ms. Jarrett as "not warm and fuzzy but not abusive whatsoever." Ms. Gardner denied that she ever heard Ms. Jarrett use the phrase "clowning around" when describing resident behavior. Ms. Gardner said Resident A never made any allegations against Ms. Jarrett, but another resident once said Ms. Jarrett "screamed in [the resident's] face" and when she and Ms. Jarrett discussed the allegation with the resident, Ms. Jarrett never admitted to screaming in the

resident's face but did apologize to the resident. Ms. Gardener said there have been no further problems with Ms. Jarrett.

On April 15, 2022, I spoke to direct care staff member Dorothea "Dottie" Jarrett who denied that she ever made the statement that Resident A nor any other resident was "clowning around" nor that she was agitated by Resident A. Ms. Jarrett said she made the statement to Relative A1 that Resident A was "out of control," but she never commented that Resident A was "clowning around."

On April 15, 2022, I spoke to Relative A1 who said Resident A told him that direct care staff member Dorothea "Dottie" Jarrett was "mean" to her on multiple occasions but was unable to provide further details. Relative A1 said on February 25, 2022 Ms. Jarrett was working when Resident A returned from the hospital and she told him that Resident A "had been clowning around." Relative A1 said Ms. Jarrett seemed agitated with Resident A because Resident A was resistant to come into the house after returning from the hospital.

On April 14, 2022, I spoke to direct care staff member Deborah Redman and Jan Chambers and both stated they are familiar with Ms. Jarrett but that only one staff member works each shift so they have not seen Ms. Jarrett interact with residents. Both staff members denied that any resident, visitor, etc. has ever complained to them about Ms. Jarrett.

On March 11, 2022, I interviewed Resident B who said she was familiar with Ms. Jarrett and that she "likes" Ms. Jarrett. Resident B described Ms. Jarrett's speech as "rough," but stated she never observed that Ms. Jarrett was rude, mean, nor that she raised her voice. Resident B said she has heard Ms. Jarrett say "she won't take clowning around" or "knock that shit off" to Resident A.

On March 11, 2022, I interviewed Resident C who said she was familiar with Ms. Jarrett and said she does not believe Ms. Jarrett "likes" her because Ms. Jarrett has called Resident C rude names such as "druggie" or "pill head." Resident C said she observed that Ms. Jarrett was "short tempered with" Resident A though she never heard her make the statement "clowning around." Ms. Jarrett described Ms. Jarett as demanding and said that she rudely told Resident A "do this, do that, don't do this, don't do that."

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: **(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 rights specified in subrule (1) of this rule.**
ANALYSIS:	Though Ms. Jarrett denied that she remarked that Resident A was "clowning around," Relative A1 and Resident B both confirmed that heard Ms. Jarett say that Resident A was "clowning around," or Ms. Jarrett "wouldn't take clowning around." Resident C reported that Ms. Jarrett was "rude and short tempered with" Resident A and Resident B said Ms. Jarrett cursed at Resident A. Based on what Ms. Gardner told me Ms. Jarrett has been accused of "screaming in a resident's face" in the past and it appears there is a pattern of Ms. Jarrett violating residents' right to be treated with consideration and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On March 11, 2022, I examined Resident A's entire resident record and did not locate a written *Health Care Appraisal* for Resident A. I did not locate any documentation that indicated Resident A was an emergency admission to the facility on February 15, 2022.

On March 11, 2022, I asked facility manager Natalie Gardner for Resident A's written Health Care Appraisal and she searched for some time and was unable to locate the document. Ms. Gardner said she believed the document was inadvertently given to Relative A1.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health

	care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on a statement from facility manager Natalie Gardner and a review of Resident A's written resident record there is no documentation that at the time of admission to the home, the licensee required Resident A to provide a written *Health Care Appraisal* nor was there any documentation to indicate that Resident A was an emergency admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 11, 2022, I interviewed Natalie Gardner who told me when Resident A admitted to the facility on February 15, 2022 she came with a cane but Ms. Gardner did not feel the cane provided enough support so she got a walker from the basement that belonged to the licensee and instructed Resident A to use the walker. When asked, Ms. Gardner said she did not obtain a written physician's order for a walker for Resident A because Resident A used a walker in the past.

On April 14 and 15, 2022, I spoke to direct care staff members Deborah Redman, Dorothea "Dottie" Jarrett and Jan Chambers who all said Resident A used a walker that belonged to the licensee and there was no written physician's order for Resident A to use a walker.

On April 15, 2022, I spoke to Relative A1 who said when Resident A was admitted to the facility she had a cane that she used to help with ambulation but Ms. Gardner told him Resident A needed to use a walker and Ms. Gardner told him she had a walker that Resident A could use. Relative A1 said Resident A's physician was not contacted for nor did he issue an order for Resident A to use a walker.

On March 11, 2022, I reviewed Resident A's entire resident record and did not observe a written authorization signed by a physician for Resident A to use a walker.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on statements from Ms. Gardner, Ms. Redman, Ms. Jarrett, and Ms. Chambers along with my observations at the onsite investigation I determined that the use of a walker by Resident A was not authorized in writing by a licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Due to the facility being on a 1st provisional license because of the violations established in the licensing study report dated February 1, 2022, and the quality of care related violations established in this report, I recommend revocation of the license.

Leslie Herrguth 04/18/2022

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 04/18/2022

Dawn N. Timm Date
Area Manager