GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 13, 2022

Ruth Stevens
2700 Condensery Road
Sheridan, MI 48884

RE: License #: AF590004463
Investigation #: 2022A1033008
Secluded Pines

Dear Ms. Stevens:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF590004463
Investigation #:	2022A1033008
Complaint Receipt Date:	05/19/2022
Investigation Initiation Date:	05/20/2022
Report Due Date:	07/18/2022
Licensee Name:	Ruth Stevens
Licensee Address:	2700 Condensery Road Sheridan, MI 48884
Licensee Telephone #:	616-835-6572
Administrator:	N/A
Name of Facility:	Secluded Pines
Facility Address:	2700 Condensery Road Sheridan, MI 48884
Facility Telephone #:	(989) 291-3993
Original Issuance Date:	12/01/1992
License **Status:**	REGULAR
Effective Date:	09/12/2021
Expiration Date:	09/11/2023
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 5/18/22, Resident A did not receive his heart medication at 8 AM.	No
The residents are not being provided with adequate meals in a timely manner.	No
The home is dirty with roaches and spiders.	Yes
The toilets at the facility are “rusted out.”	No
Resident A does not get his $50 per month.	No
Resident B has not been given prescription medications to manage his dementia and other medical and mental health issues since January 2022.	Yes
Resident B was denied access to staff from community agency.	Yes
DCS, Hayslip, used kitchen gloves, instead of disposable gloves, while providing personal care to Resident B.	No
Additional Findings	Yes

III. METHODOLOGY

05/19/2022	Special Investigation Intake 2022A1033008
05/20/2022	Special Investigation Initiated – Telephone call made- Attempt to interview Citizen 1. Voicemail message left.
05/23/2022	Inspection Completed On-site- Interviewed DCS, Michael Barnhill, Residents A, B, & C.
05/23/2022	Contact - Telephone call received- Interviewed Citizen 1 via telephone call.
05/26/2022	Contact - Face to Face- On-site visit on this date. Interviewed, Licensee, Ruth Stevens, reviewed resident records.
05/27/2022	Contact - Telephone call made- Interview Guardian A1.
06/01/2022	Inspection Completed-BCAL Sub. Compliance
06/02/2022	Document Received - Additional allegations received by email, online complaint.
06/13/2022	Inspection Completed Onsite

06/13/2022	Contact - Telephone call made, Interview Meghan Binkowski, Tandem 365 social worker for Resident B.
06/13/2022	Contact – Telephone call made, Interview DCS, Jenna Hayslip, via telephone.
06/13/2022	Contact – Telephone call made, Interview, responsible person, Morgan Barnhill, via telephone.
06/13/2022	Contact – Telephone call made, Interview Guardian B1, via telephone.
06/14/2022	Contact – Telephone call made, Attempt to interview nurse with Tandem 365, Kelli Singleton. Voicemail message left.
06/22/2022	Contact – Telephone call made, Interview with Meghan Binkowksi, Tandem 365 Social Worker.
06/22/2022	Contact – Telephone call received, Interview with Kelli Singleton, RN with Tandem 365.
06/22/2022	Contact – Document Received, Email from Tandem 365 with physician's progress note.
06/24/22	Exit Conference with Licensee, Ruth Stevens, via telephone.

ALLEGATION:

On 5/18/22, Resident A did not receive his heart medication at 8 AM.

INVESTIGATION:

I received a complaint, via email, from Adult Protective Services (APS) Centralized Intake office on 5/18/22 with the original complainant alleging Resident A did not receive his heart medication at 8AM on 05/18/2022. Centralized Intake office denied this APS complaint on 5/18/22. I completed an onsite investigation at the Secluded Pines facility on 5/23/22. I interviewed responsible person, Michael Barnhill, regarding Resident A's medications. Mr. Barnhill reported that he was unable to access resident *Medication Administration Records* (MARs) as Licensee, Ruth Stevens, was out of the state on a family emergency and he did not know where resident files or MARs were kept. When asked how he knew what medications to administer, he demonstrated use of the medication cart and reported administering current medications available for each resident based on the label instructions. Mr. Barnhill reported that after he administers the medications, he sends a text message

to Licensee Stevens, and she records the administration on the MARs. Mr. Barnhill reported no instance of missed doses of medications for Resident A on 5/18/22.

On 5/23/22, during onsite investigation, I spoke with Licensee Stevens via telephone. Licensee Stevens reported she had a family emergency and would not be returning to the facility until 5/25/22. She reported responsible person Michael Barnhill is in charge and cannot gain access to the resident records and MARs until she returns as she left them locked up at the facility.

On 5/23/22 I interviewed Resident A who reported that there have been a couple of occasions when the responsible persons or staff have “slept in” and his breakfast and morning medications have been late. Resident A reported the morning medications have been as late as 1pm at times. He did not have specific dates to verify this statement.

On 5/23/22 I interviewed Resident B who reported that he feels his medications are administered in a timely manner and he has no concerns about the staff not administering medications on time.

On 5/23/22 I interviewed Resident C who reported that he has no concerns about timeliness of medication administration.

On 5/23/22 I interviewed Citizen 1 via telephone who reported Resident A calls her frequently with complaints about the Secluded Pines facility. She reported she lives out of the state and cannot visit him to validate whether the concerns are accurate. She reported Resident A had reported to her that for the first two weeks he was at the facility he did not receive any medications. She further reported that on 5/18/22 Resident A had called her to report that he had not received his heart medication at 8am as is ordered by his physician.

On 5/26/22 I completed an onsite investigation and I interviewed Licensee Stevens regarding Resident A’s medication. Licensee Stevens provided the MARs for all residents, and I reviewed them at this time. There were no missed doses, and all doses were accounted for on each resident MAR. Resident A’s heart medication was noted as being given on 5/18/22 at 8am. Licensee Stevens reported resident medications are administered at scheduled times of 8am, 12pm, 2pm, 6pm and 8pm, based on physician instructions. Licensee Stevens also reported that when she picked up Resident A, from his former placement, to move into the Secluded Pines facility, she was given his current medications from that facility staff.

On 5/27/22 I interviewed Guardian A1 who reported Resident A had made a complaint to her regarding the late medication administration on 5/18/22. Guardian A1 reported she called the facility and spoke with responsible person Morgan Barnhill. She reported that Ms. Barnhill reported to her that medications were administered later that morning due to staff sleeping in. Guardian A1 reported this was the first instance Resident A had made a complaint about late medications.

She reported, “he has no problem advocating for himself”. Guardian A1 further reported Resident A arrived at the facility with medications when he admitted to Secluded Pines. She reported that when Licensee Stevens picked up Resident A, from his former placement, she was given medications to administer to Resident A.

On 6/13/22 I interviewed responsible person Morgan Barnhill via telephone. Ms. Barnhill reported that she had been present at the facility on 5/18/22 when Guardian A1 had called to check on whether Resident A had received his morning medication. Ms. Barnhill reported that she had checked on all the residents that morning at 7am and they were still asleep. She reported that they did have a late breakfast that morning, around 11:30am as everyone had slept in. She reported that all resident morning medications were administered during breakfast, around 11:30am.

On 5/26/22 I reviewed Resident A’s MAR for the month of May. The prescription for Resident A’s heart medication, Carvedilol Tab 12.5mg reads, “Dr. Freiberg, Rhiannon, Take one tablet by mouth twice daily.” There was no specific time for administration listed on the label instructions.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	Based on interviews with responsible person, Morgan Barnhill & Michael Barnhill, and review of Resident A’s *Medication Administration Record,* there is not a specific time of day ordered to administer Resident A’s heart medication. The medication was administered twice on this date, as ordered by the physician, and reported by Ms. Barnhill and reflected on the MAR.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The residents are not being provided with adequate meals in a timely manner.

INVESTIGATION:

On 5/18/22 I received a complaint, via email, from APS alleging the residents of the Secluded Pines facility are not being provided adequate meals in a timely manner. During my onsite investigation on 5/23/22, I interviewed responsible person Michael Barnhill about meal service and preparation at the facility. Mr. Barnhill reported the food is kept in the refrigerator on the main floor of the home. The residents reside on the basement level of the home. There was no food kept in the resident area as

Mr. Barnhill reported they have experienced difficulties with residents eating all the food that was stored in the resident area, leaving no food to prepare meals. Mr. Barnhill further reported that they provide three meals per day and snacks for the residents. He reported that they prepare the food on the main level of the home and take it down to the residents at designated mealtimes. Mr. Barnhill reported he had prepared pancakes and scrambled eggs for the residents this morning (05/23/2022). I was able to view the food in the refrigerator and cabinets on the main floor of the home. The amount of food available was adequate for the number of people currently residing in the home.

On 5/23/22 I interviewed Resident B concerning meals and the availability of food at the facility. Resident B noted that the food being provided is good and delivered in a timely manner.

On 5/23/22 I interviewed Resident C concerning meals and the availability of food at the facility. Resident C reported that the food at the facility is “pretty good”, and he feels he is getting enough food to eat. Resident C reported that he does not go hungry. Resident C reported that the food is delivered timelier when Mr. Barnhill is working compared to when Licensee Stevens is working, but he always has food to eat. Resident C further reported that they do receive snacks at the facility. Resident C reported that breakfast is served between 10am – 12pm, lunch between 2p- 4pm and dinner is served between 6p – 8pm, depending on when the previous meals were served.

On 5/23/22 I interviewed Resident A concerning meals and the availability of food at the facility. Resident A reported that he is served three meals per day at the facility. He reported that breakfast is usually around 10:30am, lunch around 2pm and dinner around 6pm. Resident A reported that he wished there were more fresh fruit and vegetables available with the meals being served.

On 5/23/22 I interviewed Citizen 1, via telephone. Citizen 1 reported Resident A has called her on at least four occasions to complain about meals being served late at the facility. She reported that this usually occurs on the weekends.

On 5/26/22 I completed an onsite investigation and I spoke with Licensee Stevens who had just finished serving the lunch meal and was cleaning up from this meal service. It was 2pm when I arrived at the facility. All residents reported that they had just eaten their lunch meal. Licensee Stevens reported meals are prepared on the main level and brought down to the residents. She reported having adequate supplies to make meals for all household members and residents.

On 6/13/22 I completed an onsite investigation and during this investigation, the lunch meal was served to residents at approximately 1245pm. There appeared to be adequate food portions and substance being served at this time.

APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular nutritious meals daily. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on interviews with Residents A, B, and C, responsible person Michael Barnhill and Licensee Stevens, as well as my observations from onsite investigations on 5/23, 5/26, & 6/13 there was not sufficient evidence to substantiate this allegation. There was adequate food in the facility and reports of regular meal service from residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home is dirty with roaches and spiders.

INVESTIGATION:

On 5/18/22 I received a complaint, via email, from APS' original complainant alleging the facility is dirty with roaches and spiders. I completed an onsite investigation on 5/23/22 and interviewed responsible person Michael Barnhill. Mr. Barnhill reported that he has not experienced any issues with insect infestations of any form in the resident area of the facility.

On 5/23/22 I interviewed Resident A who reported he is experiencing significant issues with spiders in the facility. He reported he had not noticed other insects but there are many large black spiders in the facility. Resident A pointed toward the bathroom where I was able to see several large black spiders on the floor around the toilet that Resident A noted he had killed that morning. Resident A reported to "look through the towels" in the bathroom as there are usually spiders hiding on the shelves where the towels are kept. I did not observe spiders in the towels today, but I did conduct an inspection of the facility and took photographs of multiple living spiders in corners, along floorboards, in windowsills, and near the medication cart. There were living spiders in resident bedrooms as well.

On 5/23/22 I interviewed Residents B and C regarding the spiders in the facility. Both Residents B and C denied any issues with spiders or other insects.

On 5/26/22, during my onsite investigation, I interviewed Licensee Stevens concerning the spiders in the facility. Licensee Stevens acknowledged the issue and stated, "we're infested." Licensee Stevens reported that she has plans to spray the outside of the home to help eliminate the issue.

APPLICABLE RULE	
R 400.1424	**Environmental health.**
	(4) Effective measures shall be taken to protect against the entrance of vermin into the home and against the breeding or presence of vermin on the premises.
ANALYSIS:	Based on interviews with Resident A and Licensee Stevens, as well as direct observations of living and dead spiders during onsite investigation on 5/23/22, there is evidence of a spider infestation at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The toilets at the facility are "rusted out."

INVESTIGATION:

On 5/28/22 I received a complaint stating the toilets at the facility are "rusted out." I completed an onsite investigation on 5/23/22. I directly observed the only toilet in the resident area. This toilet was found to be clean and in good working condition. There was no issue with the toilet that could be observed at this time. No residents interviewed had any complaints about the condition of the toilet in their bathroom.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(5) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief valve, both of which shall be in good working condition.
ANALYSIS:	Based on direct observations during onsite investigation on 5/23/22 there was no evidence to support that the toilet at the facility was "rusted out" or in poor condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A does not get his $50 per month.

INVESTIGATION:

On 5/28/22 I received a complaint stating Resident A does not receive his $50 per month allowance while at this facility. I completed an onsite investigation on 5/23/22. Resident A's record was not available to view on this date. I interviewed Resident A regarding his monthly cash allowance. Resident A reported his monthly cash allowance comes from Guardian A1 and is distributed by Licensee Stevens. Resident A reported he is receiving his $60 per month from Licensee Stevens but at his previous placement he was receiving $100 per month and now this allowance has decreased to $60 per month. Resident A was upset about the change in his allowance.

I returned to the facility on 5/26/22 and interviewed Licensee Stevens. Licensee Stevens provided Resident A's *Resident Funds Record Part I* and *Resident Funds Part II* forms. I reviewed these forms. On the *Resident Funds Record Part I* form it indicates that Licensee Stevens is sent $60 allowance with Resident A's room and board payment each month. It is noted on this form that the $60 is given to Resident A when the room and board payment is received from Guardian A1. The *Resident Funds Part II* form reflects room and board payment as well as the $60 cash that is given to Resident A each month.

On 5/27/22 I interviewed Guardian A1 via telephone. Guardian A1 reported that Resident A was previously receiving $100 per month for his cash allowance due to the fact that his previous facility was not charging the resident the full State payment rate and there was extra money in his account each month. Guardian A1 reported that the Secluded Pines Facility is charging the entire State payment rate and this technically only leaves Resident A with $44 per month, but he is receiving $60 at this time. Guardian A1 reported that the $60 is sent to Licensee Stevens each month to distribute, in full, to Resident A for his direct access. Guardian A1 reported that Licensee Stevens is not managing funds for Resident A.

APPLICABLE RULE	
R 400.1421	**Handling of resident funds and valuables.**
	(11) A licensee shall provide a complete accounting of all resident funds and valuables held for safekeeping and in trust fund accounts or paid to the home to the resident or to his or her designated representative on a quarterly basis. A receipt for resident expenditures shall be maintained by the licensee and shall be provided to the resident or designated representative upon request. The accounting of a resident's funds and valuables held for safekeeping or

	paid to the home shall also be provided, upon the resident's or designated representative's request, not later than 5 banking days following the request and at the time of the resident's discharge from the home.
ANALYSIS:	Based on interviews with Resident A, Licensee Stevens, & Guardian A1, as well as review of *Resident Funds Record Part I* and *Resident Funds Part II* forms, Licensee Stevens is giving Resident A his $60 per month cash allowance as agreed upon with Guardian A1.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B has not been given prescription medications to manage his dementia and other medical and mental health issues since January 2022.

INVESTIGATION:

On 6/6/22 I received an additional online complaint alleging Resident B had not received medications to address his dementia diagnosis since January 2022. This complaint had also been reported to Adult Protective Services and an open APS investigation had been initiated. I completed an onsite investigation on 6/13/22. I interviewed Licensee Stevens regarding Resident B's medications. Licensee Stevens reported that she received the referral for Resident B through the Care Patrol organization. She reported that she agreed to admit Resident B. His mother, Guardian B1, and his brother drove him to the facility on 1/31/22. Licensee Stevens reported that Resident B came with one medication, Centrum Silver. She reported that Resident B had previously been in an unlicensed facility, and they did not receive records of his care there. Licensee Stevens further reported that she made arrangements for Resident B to become established with the Visiting Physicians Association (VPA) for ongoing medical needs. VPA assumed care for Resident B on 4/22/22, per *Health Care Appraisal* form that was completed and signed by Amanda Huver, DO, on 5/27/22.

On 6/13/22 I interviewed Guardian B1 via telephone. Guardian B1 reported Resident B had previously been residing in an non-licensed facility, receiving care. She reported that she had not been aware this facility was unlicensed until she was told the facility was closing and that she would need to find a new placement for Resident B. She reported that when she arrived to move Resident B from the facility on 1/31/22 she asked for his medications. She reported she was handed the Centrum Silver medication and nothing else. She reported she inquired about his previous medications that his former physician, Dr. Delaap, had prescribed. She reported she was told that the owner of the facility had stopped purchasing Resident B's medications and was now only providing Centrum Silver. She reported she had not been made aware of this and did not know how long it had been since that

owner had stopped providing Resident B his medications. Guardian B1 reported that she made efforts to connect with Dr. Delaap to reorder the medications that had been missing and was told she would need to schedule an office visit for Resident B. Guardian B1 reported that she was aware Licensee Stevens was planning to have Resident B seen by VPA and agreed to allow this practice to assume care for Resident B's medications and medical needs.

On 6/22/2022 I interviewed Meghan Binkowski, Social Worker with Tandem 365. Ms. Binkowski reported the Tandem 365 agency received their referral to provide services to Resident B from his health insurance company, Priority Health. Ms. Binkowski reported that Resident B was enrolled in Tandem 365 services on 5/13/22. Ms. Binkowski reported she does not work directly with the medications and deferred questions related to Resident B's medications to the nurse with Tandem 365, Kelli Singleton. Ms. Binkowski did report Resident B had a discharge note in the hospital electronic medical record, Epic, from Sparrow Hospital Lansing, dated for 4/30/22. Ms. Binkowski reported reading this discharge summary which she reported stated Resident B was transported, via ambulance, to the Secluded Pines AFC with new scripts for prescriptions sent in an envelope with Resident B and also faxed to the LTC Pharmacy. Ms. Binkowski was not able to report the names or dosages of these prescriptions on this date.

On 6/22/2022 I interviewed Kelli Singleton, RN with Tandem 365. Ms. Singleton reported that she admitted Resident B to Tandem 365 services on 5/16/22. Ms. Singleton reported that Resident B was referred to Tandem 365 with a very minimal medical history and no medication list. Ms. Singleton reported that she reached out to Licensee Stevens regarding medications and Licensee Stevens reported Resident B only came to the facility with one medication due to the previous facility stopping his medications. Ms. Singleton reported she then spoke with Guardian B1 who confirmed Resident B was taken off his medications by his previous caregiver. Ms. Singleton reported she then reached out to Resident B's previous physician, Dr. Delaap, and received the most recent progress note from Dr. Delaap's office dated for 7/23/2020. Ms. Singleton reported that this progress note contained a list of medications that Resident B was prescribed by Dr. Delaap. Ms. Singleton reported that she communicated this list of medications to Resident B's current physician, Dr. Huver, and is awaiting a response as to whether Dr. Huver would like to order these previously prescribed medications.

During onsite investigation on 6/13/22 I reviewed Resident B's medications and MAR. Resident B's MAR noted a new prescription for Memantine tab HCL 5MG, that was ordered by Dr. Huver and the facility began administering on 5/25/22. This medication was noted on the MAR and marked as administered accurately. Also on Resident B's MAR was a listing for Vitamin B-1 tab 100MG, ordered by Dr. Ishaan Kumar on 5/3/22, prescribed as "take one tablet by mouth once daily." This medication was not available at the facility and not marked as administered on the resident MAR.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(b) Not adjust or modify a resident's prescription medication without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any adjustments or modifications of a resident's prescription medication.**
ANALYSIS:	Based on interviews with Licensee Stevens, Guardian B1, Ms. Binkowski and Ms. Singleton Resident B's dementia related medications were modified prior to his move to the Secluded Pines facility and no medications were prescribed for dementia related conditions at the time of Resident B's admission to the facility. Resident B's May 2022 MAR indicated he has been prescribed Vitamin B-1 by Dr. Kumar on 5/3/22 and this medication has not been marked as administered to Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B was denied access to staff from community agency.

Investigation:

On 6/6/22 I received an additional online complaint reporting Resident B was denied access to his Tandem 365 social worker, Meghan Binkowski. On 6/13/22 I interviewed Ms. Binkowski, via telephone. Ms. Binkowski reported she had a scheduled appointment to visit Resident B at the AFC facility on 5/27/22. She reported that she called Licensee Stevens the morning of 5/27/22 to remind her of the visit and inform she was running ahead of schedule. She reported that Licensee Stevens stated Ms. Binkowski could not make a visit today as Licensee Stevens was not present in the home. Ms. Binkowski reported that she had, later, rescheduled the visit with Resident B for 6/2/22 at 1pm. She reported that Licensee Stevens attempted to cancel this visit as well stating she would, again, not be at the home for the visit. Ms. Binkowski reported she explained to Licensee Stevens that she did not need to be present for the evaluation as she was not Resident B's guardian. She reported that she went ahead and made the visit to Resident B on 6/2/22.

On 6/13/22 I completed an onsite investigation at the Secluded Pines facility. I interviewed Licensee Stevens. She reported the reason she had cancelled the first, scheduled, visit on 5/27/22, was due to Resident B having a “bad” day. She reported that Resident B was in a bad mood and Ms. Binkowski would not have been able to communicate well with him due to his negative attitude that date. She reported she felt it would have been better to try another date when Resident B was in a better “mood.”

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibilities.**
	Rule 9. (1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time.**
ANALYSIS:	Based on interviews with Ms. Binkowski and Licensee Stevens, Resident B was denied a visit with Ms. Binkowski on 5/27/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

DCS, Hayslip, used kitchen gloves, instead of disposable gloves, while providing personal care to Resident B.

Investigation:

On 6/6/22 I received an additional online complaint reporting that DCS, Jenna Hayslip, used kitchen gloves, instead of disposable gloves, while providing personal care to Resident B and that Resident B was soaked from head to toe with feces and urine when Ms. Binkowski arrived for her appointment on 6/2/22. On 6/13/22 I completed an onsite investigation at the Secluded Pines facility. I interviewed Licensee Stevens. Licensee Stevens reported the responsible person at the facility on 6/2/22 was Jenna Hayslip. Licensee Stevens reported Ms. Hayslip was caring for the residents while Licensee Stevens was away. Licensee Stevens reported that the social worker with Tandem 365 made a visit to Resident B on this date. Licensee Stevens reported Ms. Hayslip did provide personal care to Resident B on this date. Licensee Stevens was not aware of what gloves were used for his personal care. She reported the facility does have disposable gloves on hand for Resident B’s personal care needs. Licensee Stevens could not produce a box of disposable gloves during this investigation. Licensee Stevens reported that when the facility is out of disposable gloves, they do use reusable Playtex cleaning gloves. She further reported that these reusable gloves are disinfected with bleach between each use.

Licensee Stevens reported Resident B can be difficult to manage in the mornings as he prefers to sleep in. She reported often responsible persons will check on Resident B and he will become moody with them and note he is not ready to get out of bed. She reported that he has given them trouble when it comes to showering and providing for his personal care needs. Licensee Stevens reported she has discussed these behavioral issues with Guardian B1, and she is aware of the issues they have had with trying to keep him clean and dry when he refuses care.

On 6/13/22, during onsite investigation, I interviewed Resident C. Resident C shares a bedroom with Resident B. Resident C reported Resident B likes to sleep in until lunch time or after. Resident C reported Resident B frequently tries to get out of taking a shower. He reported, “he gets grumpy” when the staff (responsible persons) want to change his incontinence briefs. Resident C reported staff do make attempts to change Resident B, in the mornings, but Resident B is usually not cooperative until afternoon.

On 6/13/22, at approximately 12:30p, during unannounced onsite investigation, I interviewed Resident B. Resident B was up, clean and dressed for the day during this interview. Resident B presented in good spirits and did not appear unhappy at this time. Resident B reported that he is pleased with the facility and the staff. Resident B reported “she’s been bugging me a little,” when discussing staff asking him to shower. Resident B reported he has been trying to be better about getting in the shower more frequently. Resident B reported he does not like to get cleaned up as much as they want him to.

On 6/13/22 I interviewed responsible person, Jenna Hayslip, via telephone. Ms. Hayslip reported she was present providing resident care on 6/2/22. She reported she did provide for Resident B's personal care while the social worker with Tandem 365 was present. She reported she did use Playtex cleaning gloves to provide for his care and did sanitize them with bleach after the care was provided. Ms. Hayslip reported she had checked on Resident B that morning and he had been cooperative to get up and use the bathroom. She reported he was clean and dry when he went back to his bed. Ms. Hayslip reported that she went back to check on Resident B, after noon, and he had been incontinent in his bed. She then provided personal care. Ms. Hayslip reported she rarely fills in at the home and was new to this resident. She was not able to give a historical accounting of his behaviors.

On 6/13/22 I interviewed Guardian B1, via telephone. Guardian B1 reported Resident B “is not a morning person at all.” She further reported, he could stay up all night and sleep all day. Guardian B1 reported Resident B does not like it when people try to tell him what to do. She reported Licensee Stevens has discussed with her that Resident B does not like to take showers for the staff. Guardian B1 reported she speaks with Resident B, frequently, by phone, and he has not made any complaints about the facility to her. Guardian B1 reported Resident B has dementia and typically he is in good spirits but lately can have an attitude and can get “grumpy.” Guardian B1 reported she has made several visits to Resident B at the

facility and has found him to be clean and well cared for while she is visiting. She reported the other residents have also appeared clean and well cared for.

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibilities.**
	Rule 9. (1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative 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.**
ANALYSIS:	Based on interviews with Ms. Hayslip, Guardian B1, Licensee Stevens, Resident A and Resident B, Resident B's right to be treated with personal dignity and respect has not been violated. The staff are providing regular checks on Resident B and completing personal care when indicated and as allowed by Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I completed an onsite investigation at the Secluded Pines facility on 6/13/22. I interviewed Licensee Stevens during this investigation. Licensee Stevens reported that Resident B had been referred to her from the Care Patrol organization in January 2022. Licensee Stevens reported that she accepted this referral and Resident B was brought to Secluded Pines for admission on 1/31/22. She reported that Resident B's guardian and brother brought him to the facility for admission. Licensee Stevens reported that Resident B was seeing Dr. Delaap prior to his admission at Secluded Pines. She reported that Guardian B1 had only brought one medication, Centrum Silver, for Resident B. Licensee Stevens reported that she had plans to switch Resident B to the VPA group, that comes to the AFC, for ongoing physician services. Licensee Stevens reported no further medical information was delivered to Licensee Stevens upon Resident B's admission to Secluded Pines.

On 6/13/22 I interviewed Guardian B1 via telephone. Guardian B1 reported that she and her son did bring Resident B to the Secluded Pines facility on 1/31/22. She reported that Resident B had previously been residing in an unlicensed adult care facility. She reported when she arrived to pick up Resident B from the previous facility, she received only his Centrum Silver medication. She reported receiving no

additional medical paperwork. Guardian B1 reported that she made contact with Resident B's physician, Dr. Delaap, to discuss reordering medications that were missing and was told Resident B would need to be seen in the Dr. Delaap's office. Guardian B1 reported that Licensee Stevens had noted Resident B could use the VPA group as this physician group makes visits to the AFC home. Guardian B1 reported she waited for VPA to assume care of Resident B's health needs.

On 6/13/22 I reviewed Resident B's record. There was a completed *Health Care Appraisal*, dated for 4/22/22 and signed on 5/27/22 by Dr. Amanda Huver with VPA.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(9) If a resident is not under the care of a physician at the time of the resident's admission to the home, the licensee shall require that the resident or the resident's designated representative provide a written health care appraisal completed within the 90-day period before the resident's admission to the home. If a written health care appraisal is not available, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department
ANALYSIS:	Based on review of Resident B's record, there was not a written health care appraisal obtained prior to Resident B's admission to the Secluded Pines facility. The *Health Care Appraisal* form in Resident B's record was dated for 4/22/22, and Resident B was admitted to the facility on 1/31/22. This is more than 30 days past date of admission to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 5/26/22 I reviewed Resident A's MAR for the month of May. All morning medications were initialed as being administered at 8am on 5/18/22.

On 6/13/22 I interviewed responsible person Morgan Barnhill via telephone. Ms. Barnhill reported that she had been present at the facility on 5/18/22 when Guardian A1 had called to check on whether Resident A had received his morning medication.

Ms. Barnhill reported that she had checked on all the residents that morning at 7am and they were still asleep. She reported that they did have a late breakfast that morning, around 11:30am as everyone had slept in. She reported that all resident morning medications were administered during breakfast, around 11:30am.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: (a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.
ANALYSIS:	Responsible person, Morgan Barnhill, reported that resident medications were administered at 11:30am on 5/18/22. Resident A's MAR was initialed with dosage times of 8am on 5/18/22. Resident A's MAR was not updated with the correct time of medication administration on 5/18/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During onsite investigation on 5/23/22 I observed a displayed *Emergency Evacuation Plan* posted on the wall near the exit. This posted plan noted the use of residents to assist with evacuation of other wheelchair dependent residents during emergency situations.

On 6/2/22 I interviewed Licensee Stevens, via telephone, to discuss the emergency evacuation plan. Licensee Stevens reported that there are specific instructions on the *Emergency Evacuation Plan,* posted in the home, for certain residents to assist other residents out in an emergency. Licensee Stevens noted that during an emergency more able-bodied residents do like to help those who are more in need, and therefore it was noted on the *Emergency Evacuation Plan* in the home.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(2) A responsible person shall be other than a resident.

ANALYSIS:	Based on review of the *Emergency Evacuation Plan* and interview with Licensee Stevens the facility has residents listed to provide for the care of other residents in emergency situations. Residents shall not be utilized as a responsible person.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During onsite investigations on 5/26/22 I interviewed Licensee Stevens regarding current staffing and responsible persons living in the facility. Licensee Stevens reported that she was married on 2/22/22 and her spouse, Doug Imhoff, is now residing in the facility. She further reported that there are two other responsible persons residing at the facility and providing for resident care needs, responsible persons Michael Barnhill and Morgan Barnhill. Licensee Stevens was not able to produce evidence of background checks or fingerprinting proof for any of these individuals.

On 6/13/22 I interviewed responsible person, Morgan Barnhill, via telephone. Ms. Barnhill reported that she and her husband, Michael Barnhill, both reside in the home but are not considered responsible persons. She reported that she and Mr. Barnhill do provide for resident care in an emergency, if Licensee Stevens, needs someone to stay with the residents, but they do not receive reimbursement for their assistance.

On 6/13/22 I interviewed Licensee Stevens during onsite investigation. Licensee Stevens reported that responsible person, Jenna Hayslip, was present and providing care in the facility on 6/2/22. Licensee Stevens reported that she does not have a staff file for Ms. Hayslip or current background checks or proof of fingerprinting.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all of the following qualifications: **(a) Be of good moral character to provide for the care and welfare of the residents.**

ANALYSIS:	Licensee Stevens does not have proof of fingerprinting or background checks for responsible person, Doug Imhoff, Michael Barnhill, Morgan Barnhill or Jenna Hayslip.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During onsite investigation on 5/26/22 I interviewed Licensee Stevens about current responsible persons in the home. Licensee Stevens reported that she does not have physicians' statements of good health for responsible persons Doug Imhoff, Michael Barnhill or Morgan Barnhill.

On 6/13/22, during onsite investigation, I interviewed Licensee Stevens. Licensee Stevens reported that responsible person, Jenna Hayslip, was providing care to the residents on 6/2/22 and she does not have current physician's statement of good health for Ms. Hayslip.

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(2) A licensee shall have on file with the department a statement signed by a licensed physician or his or her designee with regard to his or her knowledge of the physical health of the licensee and each responsible person. The statement shall be signed within 6 months before the issuance of a license and at any other time requested by the department.
ANALYSIS:	Physicians' statements verifying the health for responsible persons/members of the household were not available for review for: Doug Imhoff, Michael Barnhill, Morgan Barnhill and Jenna Hayslip upon onsite investigation on 5/26/23 and 6/13/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During onsite investigation on 5/26/22 I interviewed Licensee Stevens who was not able to provide proof of tuberculosis testing for responsible persons/members of household: Doug Imhoff, Michael Barnhill, and Morgan Barnhill. Licensee Stevens reported that she knows responsible person, Michael Barnhill and Morgan Barnhill, have completed TB testing as they currently are employed by another adult foster care facility, but they have not provided this proof to Licensee Stevens at this time.

On 6/13/22, during onsite investigation, I interviewed Licensee Stevens who reported responsible person, Jenna Hayslip was providing care to the residents on 6/2/22. Licensee Stevens did not have copy of completed TB testing for Ms. Hayslip during this onsite investigation.

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(3) A licensee shall provide the department with written evidence that he or she and each responsible person in the home is free from communicable tuberculosis. Verification shall be within the 3-year period before employment and verification shall occur every 3 years thereafter.
ANALYSIS:	Proof of tuberculosis testing was not available for responsible persons/members of household: Doug Imhoff, Michael Barnhill, Morgan Barnhill and Jenna Hayslip during onsite investigation on 5/26/22 and 6/13/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 5/26/22 I completed an onsite investigation at the facility. I reviewed resident records for all residents. Resident A and Resident B did not have a completed *Health Care Appraisal* form in their resident records.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(2) A licensee shall maintain a health care appraisal on file for not less than 2 years from the resident's admission to the home.

ANALYSIS:	Health Care Appraisal forms for Residents A and B were not completed and in their records during onsite investigation on 5/26/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I completed an onsite investigation at the Secluded Pines facility on 5/23/22. During this investigation, the furnace room door was found to be propped open with a doorstop. The furnace room is located on the same level of the home as the resident bedrooms.

APPLICABLE RULE	
R 400.1440	**Heat producing equipment.**
	(6) Heat-producing equipment located in a basement shall be separated from the remainder of the home by means of a floor separation. Standard building material shall be sufficient for the floor separation and shall include at least a 1 3/4-inch solid wood core door or equivalent which is installed in a substantially fully stopped wood or steel frame and which is so constructed to effectively stop the spread of smoke and fire. The door shall be equipped with an automatic self-closing device and positive-latching hardware.
ANALYSIS:	During onsite investigation on 5/23/22 the furnace room door was found propped open with a doorstop.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, no change to status of current license recommended.

07/13/2022

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Jana Lipps Date
Licensing Consultant

Approved By:

07/13/2022

_____

Dawn N. Timm Date
Area Manager