STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

August 9, 2022

Paul Wyman
Retirement Living Management of Cedar Springs, LLC
1845 Birmingham
Lowell, MI 49331

RE: License #: AL410384428
Investigation #: 2022A0357026
Green Acres of Cedar Springs

Dear Mr. Wyman:

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 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 (616) 356-0100. ..

Sincerely,

Arlene B. Smith, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410384428
Investigation #:	2022A0357026
Complaint Receipt Date:	06/27/2022
Investigation Initiation Date:	06/27/2022
Report Due Date:	07/27/2022
Licensee Name:	Retirement Living Management of Cedar Springs, LLC
Licensee Address:	1845 Birmingham Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Judy Olson
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres of Cedar Springs
Facility Address:	420 Main Street Cedar Springs, MI 49319
Facility Telephone #:	(616) 439-3213
Original Issuance Date:	06/20/2017
License Status:	REGULAR
Effective Date:	12/20/2021
Expiration Date:	12/19/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff Aaron Burton has been setting-up resident's medications in advance.	Yes
Staff Aaron Burton has made medication errors including giving a resident another resident's medication.	Yes
Staff Aaron Burton refuses to give showers to residents when it is their shower day.	Yes
Staff Aaron Burton will not provide trays for residents who eat in their rooms.	Yes
Staff Aaron Burton throws soiled resident clothes in their laundry baskets instead of washing them and therefore the resident's rooms smell of urine or BM.	Yes
Staff Aaron Burton does not check residents or change their brief.	Yes

III. METHODOLOGY

06/27/2022	Special Investigation Intake 2022A0357026
06/27/2022	APS Referral Refused because there was no individual named.
06/27/2022	Special Investigation Initiated - Telephone
06/30/2022	Contact - Telephone call made Called complainant no answer, left message to call me.
07/15/2022	Contact - Telephone call made To complainant.
07/21/2022	Contact - Telephone call made I called the Licensee Designee, Paul Wyman of Retirement Living Management of Cedar Springs, LLC. to discuss the complaint.
07/25/2022	Inspection Completed On-site Unannounced inspection.
07/25/2022	Contact - Face to Face Judy Olsen, Administrator, Summer Blair, and Resident Care Coordinator, and we reviewed Aaron Burton's, DCW (Direct Care Worker) file.
07/26/2022	Inspection Completed On-site

	Received and reviewed the Resident Register and other facility documents.
07/26/2022	Contact - Face to Face Conducted interviews with Direct Care Staff: Aaron Burton, Med Passer/DCW Karish Clark, Med Passer/DCW Jersey Brown, Team Lead: Brianna Hartman, and DCW, Alexis Drake. Interviews with Judy Olson, Administrator, Summer Blair, Resident Care Coordinator, and Emily Haynes, Home Manger.
07/26/2022	Inspection Completed On-site
07/27/2022	Contact - Face to Face I conducted a face-to-face interview with Direct Care Workers: Tehya Perkins, and Shirley Rivera. Med Passer/ Direct Care Worker: Brookelyn Overla. Administrator Judy Olsen, Resident Care Coordinator Summer Blair, and Emily Hayes, Home Manager, Emily Haynes.
08/03/2022	Contact – Telephone call made To Summer Blair and Emily Haynes.
08/04/2022	Contact – Telephone call mase to Summer Blair and Emily Haynes.
08/09/2022	Exit conference by telephone with Licensee Designee, Paul Wyman.

ALLEGATION: Staff Aaron Burton has been setting-up resident's medications in advance.

INVESTIGATION: On 07/15/2022, I spoke with the complainant and was given information that staff Aaron Burton has been setting-up residents' medications in advance.

On 07/25/2022, I made an unannounced inspection of the facility. I met with the Administrator, Judy Olson and the Resident Care Coordinator, Summer Blair. Both explained that Aaron Burton, Med Passer/DCW, (Direct Care Worker) had been trained in medication administration before he was employed at the facility, and he had more training when he was hired by the facility. Ms. Blair stated that she caught Mr. Burton pre-setting resident medications. She was unable to provide a date for her findings. She stated she educated him not to pre-set medications and redirected him to not set-up resident medications in advance but to take them from the pharmacy labeled pharmacy containers each resident at a time. Ms. Blair stated he agreed to administer medications correctly and she stated she had checked on him several times and he was not pre-setting resident medications. Ms. Olsen stated that

Mr. Burton had again pre-set resident medications and had placed them in the med cart. on 07/05/2022 she was at work early and she found Mr. Burton pre-setting resident medications and they gave Mr. Burton a three-day suspension (7/6, 7/7, and 7/8).

On 07/26/2022, I conducted a face-to-face interview with Aaron Burton. He reported he works first shift but picks up open shifts when needed. He acknowledged that he had pre-set resident medications up in advance and had them in the med cabinet. He stated that it saved him time and was easier to pass them. He stated that he had not done this for quite some time since the administration had spoken to him and told him he could not present resident medications.

On 07/26/2022 I conducted a face-to-face interview with Karish Clark (DCW), Alexis Dake (DCW), Tahya Perkins (DCW) and Brookelyn Overla (DCW). All four stated that they had observed Mr. Burton pre-set resident medications.

On 08/09/2022 I conducted a telephone exit conference with the Licensee Designee, Paul Wyman and he agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being See.1101 et seq. of the Michigan Complied Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Direct Care Workers, Karish Clark, Alexis Dake, Tehya Perkins and Brookelyn Overla, all stated that they had observed Mr. Bruton pre-set resident's medications. Direct Care Worker Aaron Burton acknowledged that he had pre-set resident's medications because it was easier to have them preset. During this investigation there was evidence found that Mr. Aaron Burton pre-set resident medications instead of taking them from the original pharmacy-supplied container at the time of administration. Therefore, there is a violation with the rule.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Staff Aaron Burton has made many medication errors.

INVESTIGATION: On 07/15/2022, I spoke with the complainant who stated that staff Aaron Burton had over ten medication errors. Information regarding the specific medication errors was not provided.

On 07/25/2022, I made an unannounced inspection of the facility. I met with the Administrator, Judy Olson and the Resident Care Coordinator, Summer Blair. I explained that we had received an allegation that Mr. Aaron Burton had made numerous medication errors. They did not know how many medication, errors Mr. Burton had made, but they knew he had medication errors. I asked them if they had knowledge of Mr. Burton giving a resident another resident's medications.

On 07/26/2022, I conducted a face-to-face interview with staff Arron Burton. He acknowledged that he had taken a controlled medication from a resident's blister pack and given it to another resident. He quickly explained that the medications between the two residents were exactly the same.

On 07/27/2022, Ms. Emily Hayes, Home Manager, provided me with a '*Medication Discrepancy Report,'* dated 03/15/2022 for Resident D. The box checked on the form was "*Narcotic Count Off… another residents gab. (gabapentin) 300 mg…Med given from another residents blister pack…..Wrong residents med was given to (Resident D) by Aaron Burton.'* This document *was* signed by Mr. Burton on 03/18/2022 and it was signed by Summer Blair.

On 07/27/2022, Ms. Hayes provided a *'Medication Discrepancy Report,'* dated 03/15/2022 for Resident E. The box checked on the form was *'Narcotic Count Off…Another resident was given one 300 mg cap to make count off. Wrong med passed to another resident.'* Ms. Blair stated the medication was 300 mg Gabapentin. She stated both Resident D and Resident E has scheduled medications for Gabapentin, but Mr. Burton took the Gabapentin from the wrong blister pack.

On 07/27/2022, Ms. Summers acknowledged that she had signed the two Medication Discrepancy Reports and she reported Mr. Burton had made this medication error.

On 07/27/2022, Emily Haynes, the Home Manager, provided written information to me on medication errors made by Mr. Burton. I reviewed the documentation. The report was on a document entitled, *'Medication Discrepancy Report,'* was dated 12/03/2021, for Resident A and it indicated a medication was missed. *'Explained what happened/what was found: Employee passed medication in system but did not pass medication to resident.'* The staff notified was Linda Schutter, at 12/03/2021. The employee reporting the discrepancy was Brianna Hartman. The written explanation was, *'Employee did not physically pass medication*' and the employee

was Aaron Burton. The action taken was: *'Educated Employee.'* The report stated that the family member was notified, and Hospice staff was notified. Mr. Burton signed the document. This report failed to identify the name of the medication that was not passed to Resident A.

On 07/27/2022, Ms. Hayes provided a *'Medication Discrepancy Report',* dated 03/15/2022 for Resident B. The box checked on the form was *'Narcotic Count Off…med waste.'* The explanation was: *'Med wasted d/t (do to) being popped from blister pack.'* This document was signed by Aaron Barton and Summer Blair. Ms. Blair stated that Mr. Burton and punched out the medication when it should not have been punched out, so they had to destroy/waste the medication.

On 07/27/2022, Ms. Hayes provided a *'Medication Discrepancy Report',* dated 03/15/2022 for Resident C. The box checked was the explanation was *'Gave 1 cap instead of 2.'* Directions given, *'Give next dose on time, check vitals. 1 less cap given per order'* by Aaron Burton. Action taken, *'Check the computer order against the medication pack to ensure total is given*.' Signed by Aaron Burton with no date. There was no name of the medication listed. Ms. Blair stated it was Gabapentin,

On 08/09/2022, I conducted a telephone exit conference with the Licensee Designee, Paul Wyman and he agreed with my findings.

APPLICABLE RULE	
R 400.15312	**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:	According to two Medication Discrepancy Reports, dated 03/15/22, and signed by Mr. Burton, Mr. Burton had taken a medication, 300mg Gabapentin from Resident's E's blister pack and gave the medication to the wrong resident, Resident D. Mr. Burton acknowledged that he had taken a medication from the wrong blister pack and administered it to the wrong resident but stated that both residents had the same medication. Ms. Blair acknowledged that she has signed the two Medication Discrepancy Reports and that Ms. Burton had made a medication error. During this investigation there was evidence found that Mr. Burton took a prescription medication from Resident E's blister pack and administered the medication to Resident D.

	Therefore, the medication was used by another resident for who the medication was not prescribed, and a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Aaron Burton refuses to give showers to residents when it is their shower day.

INVESTIGATION: The complainant reported that residents are assigned shower days on first and second shifts, which is by resident choice. Staff, Aaron Burton does not provide the residents with their showers on their assigned day and he reports they refuse their showers.

On 07/26/2022, I conducted a face-to-face interview with staff Aaron Burton. I asked him about providing showers for residents. He explained that many of the residents are receiving Hospice care and their shower aid from Hospice provide resident showers. I asked if he had refused to provide showers for residents. He stated, "I don't refuse because female residents prefer showers from female staff. When I do the resident's medication pass, I ask them about their showers and the residents refuse their showers. I have never refused to give a resident a shower." He stated further that when he first started eight or nine months ago Resident C refused to let him give her a shower but now, she lets him. He stated that Resident G may have refused a shower, but he could not remember.

On 07/26/2022, I conducted a face-to-face with Med Passer/ DCW, Karish Clark. I asked her about any staff not giving showers and she stated that Aaron Burton has refused to give residents their showers multiple times. She stated that he clicks off on their check sheets on the computer that he has given their showers when he has not given them their showers. She reported that he does not give showers to Resident C and Resident H.

On 07/26/2022, I conducted a face-to-face with Brianna Hartman and she said she is the Team Lead on Second shift, and she has worked at the facility for five years. I asked her about residents receiving their showers. She reported that Resident C had refused to let Mr. Burton give her a shower and then they worked it out and Resident C now allows Mr. Burton to give her showers but he reported that she refused her showers. She reported that Mr. Barton had reported that Resident I has, refused his shower so he did not give him one. She stated that there were problems with Resident G not receiving her showers and Mr. Burton stated that she had refused her showers.

On 07/26/2022, I conducted a face-to-face interview with DCW, Alexis Drake who works on second shift. She reported that she picks up other open shifts to help out. I asked her about resident showers, and she stated that staff Aaron Burton refuses to

give residents their showers. She said that he does not give a shower to Resident C and you have to give her a shower because she smells. She said Mr. Burton states that Resident C did not get her shower. She stated that Mr. Burton charted that he gave her a shower, but she checked Resident C and she had not received one.

On 07/26/2022, I conducted a face-to-face interview with Med Passer/DCW, Jersey Brown who reported she works second shift. I asked about resident showers and Ms. Brown said there have been issues with Mr. Burton not giving residents their showers.

On 07/27/2022, I conducted a face-to-face interview with DCW Shirley Rivera who works second shift. I asked her about resident showers, and she said that she showers Resident C lot. She reported that Mr. Burton states that Resident C refuses her showers. She stated that Resident C's daughter was upset because she was not showered.

On 07/27/2022, Ms. Haynes provided me a copy of a Disciplinary Report on Aaron Burton, dated 06/24/2022, "Written Warning." The Administrators Comments: read in part, '*Passing showers in ECP as you did them-resident's state you have not done them…'.* This document was signed by Judy Olson and Aaron Burton on 06/24/2022 and was Witnessed by Emily Haynes

On 08/09/2022 I conducted a telephone exit conference with the Licensee Designee, Paul Wayman and he agreed with my findings.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Mr. Burton stated he has never refused to give a resident a shower. He stated that residents refuse their showers. Staff Karish Clark stated that Aaron Burton has refused to give residents their showers multiple times. Team Lead, Brianna Hartman reported that Resident C had refused from Mr. Burton but when she was asked, she denied that she refused to have Mr. Burton give her a shower. She reported that Mr. Barton had reported that Resident I had refused his shower, but he denied refusing his shower. She stated Resident G had not been receiving her showers and Mr.

	Burton stated that she had refused her showers. Ms. Hartman stated that Resident C had not refused her showers Staff Alexis Drake reported Aaron Burton refuses to give residents their showers. She said that he does not give a shower to Resident C. She stated that he charted he gave her a shower, but she checked Resident C and she had not received her shower. Staff Jersey Brown reported that Mr. Burton has refused to give resident showers. Staff Shirley Rivera reported Mr. Burton refuse to give her Resident C' her shower. On 06/24/2022 Mr. Aaron Burton received a written warning in part for passing showers in ECP as you did them and residents state you have not done them. During this investigation there was evidence that Mr. Burton had not provided showers to several residents even though he charted he had given the showers. Therefore, there is a violation to the rule that residents were not bathed at least weekly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Aaron Burton will not provide trays for residents who eat in their rooms.

INVESTIGATION: The complainant reported that Residents who eat in their rooms are not being provided their food trays by staff Aaron Burton. There was an emphasis on at least one resident named, Resident K.

On 07/26/2022, I conducted a face-to-face interview with staff Aaron Burton. I asked about food trays being served to residents in their rooms. Mr. Burton stated that he usually goes to the kitchen and asks for trays for residents that don't go to the dining room to eat their meals. He did mention Resident K and that she had pancakes for breakfast every day. He stated that he probably missed her food trays several times, but it was not deliberate. He reported that she slept in many times and then it would be almost lunch time when she was awake and then her lunch tray would be there. I asked if he had missed other resident's meal trays and he said he could not remember.

On 07/26/2022, I conducted a face-to-face interview with staff Karish Clark. I asked about resident's meal trays if they did not go to the dining room to eat meals. She

stated that Resident K did not go to the dining room for her meals. She stated that she slept in. Ms. Clark reported that Mr. Burton would not wake Resident K at 9:00 AM but would let her sleep to 11:00 AM or later. She stated that he did not take her, her breakfast meal because it was so close to lunch time. She said that on those occasions Resident K went without her breakfast.

On 07/26/2022, I conducted a face-to-face interview with staff, Brianna Hartman. I asked her about trays being provided to residents who stayed in their rooms at mealtimes. She stated Resident K wanted to get up at 9:00 AM but Mr. Burton let her sleep until 10:00 AM, 11:00 AM or 12:00 noon. Mr. Burton would be bringing her lunch to her. She said that Resident K told her she still waned her pancakes and chocolate milk.

On 07/26/2022, I conducted a face-to-face interview with staff Alexis Drake. I asked her about the food trays for residents that wanted to stay in their rooms at mealtimes. She stated that Mr. Burton did not get meal trays to residents in their rooms. She stated that especially there were no breakfast trays for Resident K. She stated that Resident K wanted her breakfast, and she hardly ate any other meal.

On 07/26/2022 I conducted a face-to-face interview with staff Jersey Brown. I asked her about the food trays for residents that wanted to eat in their rooms. She explained that Resident K wanted to get up at 9:00 AM and she wanted to go to bed at 9:00 PM. She stated that Mr. Burton did not want to get her up and he would leave her in bed all day and therefore miss her meal trays. She stated that she would find Resident M in her bed with her food tray on her lap or it was on the floor.

On 07/27/2022, I conducted a face-to-face interview with staff Tehya Perkins. I asked her about resident's food trays, and she said she saw many of them sitting on the counter and no one had delivered them to the residents. She stated that staff Alexis Drake and Aaron Burton left food trays.

On 07/27/2022, I conduced a face-to-face interview with staff Brookelyn Overla and I asked her about the resident's food trays. She said it has happened a couple of times where she has seen the food trays not delivered. She said she has seen multiple times Resident N with food trays not even started for her. She also stated that one day last week Mr. Burton was on "meds" and she saw Resident H was sitting in her chair with her bed clothes on. She stated that Mr. Burton had brought her, her food tray at lunch time and nothing was touched. He just sat it down. She said she had to warm up her hot coca which only took 20 seconds. She stated that she needs help with her food tray, and he went off to the nurse's station and ate his lunch. Ms. Overla stated that Resident K receives her Ensure, that she thinks is chocolate milk, that should be to her at breakfast, but she does not get her breakfast at 9:00 AM. When she asked Mr. Burton about her breakfast meal, he claimed the women on staff are to assist her. She said she observed Resident K with her food tray siting on her table. She said she needs help with cutting her pancakes and help with putting the syrup on her pancakes. She stated that no one had helped her. She

then spoke about Resident L who is sleeping until 10:30 AM or 11:00 AM and was not ready for the day so she asked Mr. Burton about her, and he said she was not dressed, and he did not get her room tray because he was passing meds.

On 07/27/2022, I conducted a face-to-face interview with staff Shirley Rivera. I asked he about resident's food trays and she stated she has observed that the food trays were not taken to the resident's rooms, a handful of times. She said they missed Resident O and Resident K with their food trays.

On 08/09/2022 I conducted a telephone exit conference with the Licensee Designee, Paul Wayman and he agreed with my findings.

APPLICABLE RULE	
R 400.15313	**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:	Staff Aaron Burton acknowledged he had missed a few food trays for Resident K, He could not remember if he missed other resident's food trays. Staff Karish Clark, Brianna Hartman, Jersey Brown, Tehya Perkins, Brookelyn Overla and Shirley Rivera all reported that resident meal trays were not always distributed to residents at mealtimes. During this investigation there was evidence found that residents had not received their food trays, therefore, a rule violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Aaron Burton throws soiled resident clothes in their laundry baskets instead of washing them and therefore the resident's room smell of urine or BM.

INVESTIGATION: The complainant reported that Mr. Burton had left Resident H's night gown full of dried BM in her laundry basket in her room and this made the room smell of BM. Mr. Burton had worked the day before and he was asked why he had not taken the soiled nightgown to the laundry to be washed and he said he never saw the BM on the resident's nightgown.

On 07/26/2022, I conducted a face-to-face interview with Aaron Burton. I asked him about Resident H's nightgown with dried BM on it. He stated he did not recall her nightgown being soiled with dried BM. He stated that if any of the resident's clothing or nightclothes are soiled, he takes it to the laundry and washes it.

On 07/26/2022, I conducted a face-to-face interview with staff Karish Clark. I asked her about resident's laundry being completed. Ms. Cark stated that Mr. Burton does not do the laundry. She reported that staff left three to four days of laundry to see if he would do the laundry and he did not do the laundry. She stated that he left urine-soaked resident clothing in the laundry baskets in the resident's room, and it smelled. She stated you can go into every resident's room after him and you will find soiled clothes and soiled briefs in the wastebaskets.

On 07/26/2022, I conducted a face-to-face interview with Brianna Hartman. I asked her about laundry baskets left in resident's rooms and soiled briefs left in the trashcans. She stated it is not uncommon to find wet briefs in the trashcan after Mr. Burton leaves a resident's room. She said that the room reeks of BM and or urine. She reported that he does not take the soiled clothes to the laundry room.

On 07/26/2022 I conducted a face-to-face interview with staff Alexis Dake. She reported that she has found soaked nightgowns in Resident N's the laundry basket and her pads and briefs soaked found in the trashcans. She stated that Mr. Burton was responsible for her care. She stated that the room smelled.

On 07/27/2022, I conducted a face-to-face interview with staff Brookelyn Overla. I asked her about resident's laundry baskets. She stated that Mr. Burton and Ms. Dake have left soiled and wet laundry in the resident's laundry baskets in the resident's rooms, which make the rooms smell.

On 08/09/2022 I conducted a telephone exit conference with the Licensee Designee, Paul Wyman and he agreed with my findings.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Staff Karish Clark, Brianna Hartman, Alexis Dake and Brokkelyn Overla stated that soiled resident laundry has been left in resident bedrooms. Mr. Burton denied seeing any dried BM on Resident H's nightgown. He stated he takes resident's dirty clothes to the laundry, and he does the laundry.

	During this investigation evidence was found that urine-soaked clothes and clothes with BM on them are not taken to the laundry and washed. They remain in laundry baskets in resident's rooms. This does not adequately provide for the health, safety, and well-being of occupants. Therefore, there is a rule violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Aaron Burton does not check residents or change their brief.

INVESTIGATION: The complainant stated that resident's briefs are not changed by Mr. Barton for the entire eight-hour shift.

On 07/26/2022, I conducted a face-to-face interview with Mr. Burton. He denied the allegation and stated that he always checks on residents assigned to his care

On 07/26/2022, I conducted a face-to-face interview with Karish Clark. She stated that Mr. Burton "does not toilet anyone. He will leave a resident in the same brief the entire shift and not change them."

On 07/26/2022, I conducted a face-to-face interview with staff Brianna Hartman. She stated that Resident N had an appointment with the hairdresser and the hairdresser stated that she went to get Resident N and she lost her cool when she pulled her up to the table and found she was soaked with urine. Ms. Hartman stated that they toilet the residents every two hours. She could not have been toileted. The hairdresser reportedly confronted Mr. Burton about this and he responded that he thought another staff had toileted her.

On 08/09/2022 I conducted a telephone exit conference with the Licensee Designee, Paul Wyman and he agreed with my findings.

APPLICABLE RULE	
R 400.15305	**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:	Staff Karish Clark and Brianna Hartman reported that Mr. Burton does not properly check and change residents he is assigned to care for.

	Mr. Burton denied that he has failed to change residents assigned to his care. During this investigation evidence was found that residents care needs were not properly met. Therefore, a rule violation was found.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee provide an acceptable plan of correction and the license will remain the same.

08/09/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

08/09/2022

Jerry Hendrick Date
Area Manager