GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 18, 2022

Rekha Panati
Alaya Care L.L.C.
7330 Tottenham
Shelby Twp, MI 48317

RE: License #: AS500393894
Investigation #: 2022A0990029
Alaya Care

Dear Ms. Panati:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

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 #:	AS500393894
Investigation #:	2022A0990029
Complaint Receipt Date:	08/19/2022
Investigation Initiation Date:	08/24/2022
Report Due Date:	10/18/2022
Licensee Name:	Alaya Care L.L.C.
Licensee Address:	46175 Sterritt St. Utica, MI 48317
Licensee Telephone #:	(586) 453-5653
Administrator:	Rekha Panati
Licensee Designee:	Rekha Panati
Name of Facility:	Alaya Care
Facility Address:	46175 Sterritt St. Utica, MI 48317
Facility Telephone #:	(586) 453-5653
Original Issuance Date:	10/19/2018
License Status:	REGULAR
Effective Date:	04/18/2021
Expiration Date:	04/17/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS; AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a visitor that overheard the caregiver across the room saying negative things about Resident A. The caregiver started yelling at the visitor telling her not to walk up on her.	Yes
Resident A mentioned that one of the caregivers is mean to her.	Yes
This past weekend, Resident A fell out her bed during the night and hurt her arm. She called for help, and no one came. The staff did not notify Resident A's emergency contact person.	No
The staff are not bathing Resident A. Resident A is only bathed when her friend or daughter comes in and care for her.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/19/2022	Special Investigation Intake 2022A0990029
08/19/2022	APS Referral Adult Protective Services (APS) denied investigation at intake.
08/24/2022	Special Investigation Initiated - On Site I conducted an onsite unannounced investigation. I interviewed Resident A. I observed Resident B. Relative B was present but not interviewed onsite. I briefly spoke to direct care staff Sibyl Brown. I interviewed Rekha Panati, licensee designee (LD).
08/24/2022	Contact - Document Received I received documents from Ms. Panati. I responded via email on 08/26/2022 because information was missing.
09/20/2022	Contact - Document Sent I emailed Ms. Panati for Ms. Brown employee training records and Workforce Background Check. I received on 09/21/2022.
09/20/2022	Contact - Telephone call made I conducted an interview with Relative B.

09/20/2022	Contact - Telephone call made I conducted a phone interview with Relative A.
09/20/2022	Contact - Telephone call made I conducted a phone interview with Gary, physical therapist.
09/20/2022	Contact - Telephone call made I conducted a phone interview with Sibyl Brown.
09/21/2022	Exit Conference I conducted an exit conference with Ms. Panati.

ALLEGATION:

Resident A had a visitor who overheard the caregiver across the room saying negative things about Resident A. The caregiver started yelling at the visitor telling her not to walk up on her.

INVESTIGATION:

On 08/19/2022, I received the complaint via email. The complainant is anonymous. The complainant reported that Resident A is deaf in one ear. It was reported that on 08/13/2022, the complainant went to cut Resident A's hair. The complainant is a beautician and a friend of Resident A. The complainant said that while visiting Resident A she overheard the caregiver having a conversation about Resident A to another visitor that was disrespectful. The complainant confronted the caregiver and was yelled at by the caregiver. The complainant said that the caregiver began yelling at her and told her that she could only visit Resident A in her bedroom. The complainant said that the caregiver was yelling about how she will "go off on people who walk up on her." The complainant recorded the yelling. Shortly thereafter, the owner [Rekha Panati, licensee designee] told her that she needed to put her mask on although, none of the staff were wearing them. The complainant said that the owner then called Resident A's relative and told her that the friend could only come and cut Resident A's hair outside, then she would need to leave. The complainant reported that she is limited to the amount of time that she is allowed to visit Resident A. In addition to the allegation above, it was reported Resident A tends to be a little disoriented, so she believes that she may have dementia.

On 08/24/2022, I conducted an onsite unannounced investigation. I interviewed Resident A. I observed Resident B. Relative B was present but not interviewed onsite. Resident B was not interviewed due to his limited cognitive abilities. I briefly spoke to direct care staff Sibyl Brown. I interviewed Rekha Panati, licensee designee (LD). There are currently two residents in the home and one staff, Ms. Brown who works in the home.

Upon arrival, the door was answered by Relative B who had to retrieve direct care worker Sibyl Brown. Ms. Brown appeared disheveled and as if she was awakened from sleeping. I informed Ms. Brown why I was present, and she was very dismissive and guided me to Resident A's bedroom. I observed that Ms. Brown went into a bedroom (no resident present) and shut the door.

I interviewed Resident A. Resident A said that Ms. Brown "does not like me, she hates me." Resident A said that her friend visited her last week and got into a verbal altercation with Ms. Brown because Ms. Brown was telling someone that she did not like Resident A. Resident A said that her friend was visiting her to give her a haircut. Resident A said that she did not hear what Ms. Brown said because she is hard of hearing. Her friend was very upset about what she heard and confronted Ms. Brown. Resident A said that the two had a verbal altercation which resulted in her friend leaving the home. Resident A informed Ms. Panati of this incident who did nothing but tell her that she could only have visitors in her bedroom or outside. Resident A described having relatives visiting from Tennessee recently and they were forced to sit outside to visit. Resident A said that Ms. Brown curses at her frequently and recently "ranted and raged" at her for wetting the bed. Resident A believes that Ms. Brown does not like her because she has corrected her for doing things incorrect as she is a retired registered nurse. Resident A is her own guardian and is looking for a new home. Resident A did not have the phone number for the friend that visited her.

On 09/20/2022, I conducted an interview with Relative B. Relative B said that she has not observed any disrespectful behavior from Ms. Brown or staff towards Resident A or Resident B. Relative B said that they are the only two residents in the home and it is quiet. Relative B said that she can visit the home during visiting hours which are from 11AM to 7PM. Relative B said that she is allowed to stay longer in the evenings because she assists with helping to care for Resident B. Relative B said that she does not have any concerns.

On 09/20/2022, I conducted a phone interview with Relative A. Relative A said that she has not directly observed Ms. Brown mistreating Resident A in a disrespectful manner. Relative A said that Resident A says this to her constantly and has expressed that she does not like residing in the home. Relative A said that she can visit during the visiting hours which are 11AM to 7PM. Relative A is allowed to visit Resident A outside of those hours inside or outside of her bedroom. Relative A prefers to visit with Resident A inside of her bedroom because it is easier to talk to her because she is hard of hearing. Relative A said that Resident A complains most of the time. Resident A is unhappy in the home, and she has submitted a 30-day discharge notice and will be moving to American House. Resident A has expressed many times that Ms. Brown does not like her.

I interviewed Ms. Panati who arrived at the home during the onsite. Ms. Panati said that Resident A is allowed visitors, but she does ask her to visit in her bedroom because she believes that she should have privacy. Ms. Panati was aware of the incident with the

visitor and Ms. Brown and addressed it. Ms. Panati said that Resident A's visitor was yelling at Ms. Brown and she intervened. Resident B and Relative B usually visit in the living room, and she prefers that Resident B visit elsewhere due to COVID-19 restrictions and there are too many distractions in the living room area. Ms. Panati denied having visitor restrictions but says she recommends that resident's visits are more private.

On 09/20/2022, I conducted a phone interview with Sibyl Brown. Ms. Brown said that she quit working for the facility the day prior. Ms. Brown began working in July 2022, was fully trained, and worked 8AM-11PM Wednesday through Sunday. Ms. Brown admitted to having a verbal altercation with Resident A's friend. Ms. Brown said that she was talking to a visitor and the friend was eavesdropping and listening to her conversation, which was not about Resident A. Ms. Brown said that the friend walked up to her in a threatening manner, and therefore, she yelled at her telling her to "get out of my face." Ms. Brown admitted and said, "I did not like Resident A because she was rude and disrespectful." Ms. Brown admitted to using profanity around Resident A but not directly to her. Ms. Brown denied yelling at Resident A for wetting the bed but admitted to using profanity and yelling "why did you shit and stop up the toilet." Ms. Brown said that she was upset because she stepped into urine and feces that flooded throughout the bathroom by Resident A. Ms. Brown continued to describe things using much profanity. Ms. Brown denied mistreating Resident A but said that they did not like one another. Ms. Brown said that Resident A could have visitors anywhere throughout the home however, she was informed by Ms. Panati that if Resident A "acts up" she must be sent her room.

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.
ANALYSIS:	On or about 08/13/2022, Resident A had a visitor. The visitor overheard direct care staff Sibyl Brown, saying negative things about Resident A. According to Resident A, the friend and Ms. Brown got into a verbal altercation. As a result of this, Resident A was told that she could only have visitors in her bedroom or outside.

	Ms. Brown admitted to having a verbal altercation with Resident A's visitor. Ms. Brown denied speaking negatively about Resident A to another person but admitted that she told Resident A's visitor to get out of her face. Relative A is allowed to visit Resident A during visiting hours of 11AM to 7PM, inside or outside of her bedroom. Relative A said that Resident A complains a lot about Ms. Brown not liking her. There is sufficient information to support that Resident A's visitor heard Ms. Brown saying negative things about her to a visitor which is a violation of her personal dignity and need for privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	There is sufficient information to support that Resident A is not treated with dignity and respect by Ms. Brown. Resident A said that Ms. Brown yells and used profanity around her specifically when she had a bed wetting accident. Ms. Brown admitted to using profanity towards Resident A because she flooded the toilet. Furthermore, Ms. Brown said that she did not like Resident A because she was rude and disrespectful. Additionally, Ms. Brown said that Ms. Panati told her to send Resident A to her room when she acts up.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED:** **Reference SIR #AS500393894 03/25/2022, CAP 04/07/2022.**

ALLEGATION:

This past weekend, Resident A fell out her bed during the night and hurt her arm. She called for help, and no one came. The staff did not notify Resident A's emergency contact person.

INVESTIGATION:

On 08/19/2022, it was reported that Resident A was checked on by staff one morning they found her on the floor, but never said anything to her relative. According to the

complainant, when the relative was contacted about the situation, the staff said that Resident A was “ok,” so they did not notify anyone.

On 08/24/2022, I conducted an onsite unannounced investigation. I interviewed Resident A. Resident A said that when she initially came to the home, she was not able to walk. Resident A said that she can walk again after receiving physical therapy. Resident A described that one night she woke up because she had to use the bathroom and when she stood up, she began to fall and was able to catch the side of her bed. Resident A said that although, she was able to sit on the side she was still slipping and eventually slid slowly to the floor. Resident A said that she was not hurt but she yelled for assistance, and no one came. Resident A said that she was able to pull the blanket and a pillow from the bed and she slept on the floor. Resident A slept on the floor because she was not able to get up from the floor. Staff (could not recall who) came in to check on her in the morning and found her sleeping on the floor. Resident A looked at her clock and it was 8:20AM. Resident A is unsure what time she fell but believes that she slept on the floor for hours. Resident A said that she was not taken to the be seen by the doctor because she was not injured. Resident A reported the incident to Relative A the next day. Relative A called Ms. Panati to discuss the fall. Resident A said that she fell twice before. One fall occurred outside when she was trying to walk up the ramp and the second fall was in the dining room however, the specific dates were not recalled. Resident A said that when she fell outside on the ramp area, she yelled for help for some time, and no one came. Resident A said that she sat outside on the ramp for “a long time” before staff found her and assisted her to stand. She was not injured but was more upset that no one checked on her. Resident A said as a result she no longer sits outside alone because she fears that if she falls no one will find her. Resident A denied being seen at the hospital for any falls.

On 08/26/2022, I reviewed Resident A’s *Assessment Plan*. Resident A requires assistance for toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility. I observed that the needs are described as “Staff will assist” except for toileting which is a “I person total assist.”

On 08/24/2022, I interviewed Ms. Panati. Ms. Panati described that when Resident A was admitted to the home, she was bed ridden and received help daily during that time. Ms. Panati said that Resident A began physical therapy from May 2022 to July 2022 and it stopped because she improved and could walk. Resident A has not had any falls, but she has slipped or lowered to floor when she has lost her balance. Ms. Panati said that Relative A is contacted when the falls occur. Resident A refuses medical treatment after falls and there are no apparent injuries. Ms. Panati said incident reports are not completed because there are no hospitalizations. When Resident A was recently found on the floor, Resident A reported it to Relative A before the staff could report it. Ms. Panati said they were not neglecting to report the incident, it was that Resident A reported it to a relative before they could, usually less than hour or so after the occurrence was discovered.

On 09/20/2022, I conducted a phone interview with Relative A. Relative A said that when Resident A fell out of bed, she was informed about it through Resident A. Relative A said that Ms. Panati did inform her, but she was already made aware of the incident. Resident A was not injured and did not need to be seen by a medical professional.

On 09/20/2022, I conducted a phone interview with Gary Cedilinia, physical therapist. Mr. Cedilinia said that he last worked with Resident A 3-4 weeks ago. Mr. Cedilinia said that Resident A made much improvement with her walking therefore, she was discharged. Mr. Cedilinia said that although, Resident A can walk, she requires supervision from a caregiver because of her mental confusion at times. Mr. Cedilinia was not made aware of specific falls but had spoken to Relative A that she requires monitoring although, she is very determined to walk. Mr. Cedilinia said that he was referred by a doctor to treat Resident A in the home.

On 09/20/2022, I conducted a phone interview with staff Sibyl Brown. Ms. Brown stated that on 08/14/2022, she found Resident A by her bed when she came out of the bathroom. Ms. Brown said that Resident A crawled down slowly to the floor from her bed. Ms. Brown helped Resident A to stand and asked her if she was in pain or if she wanted to go the hospital. Ms. brown said that Resident A denied being in pain. Ms. Brown walked Resident A to the dining room area for coffee. Ms. Brown said that Resident A proceeded to attend church at 11AM with Relative A with no concern. Relative A was informed of the fall at pick up and agreed with Resident A that a hospital visit would not occur. Ms. Brown could not specify if she did bed checks throughout the night.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
a	(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
ANALYSIS:	Resident A reported at least three falls at the facility. According to Resident A, one night she slid from the bed to the floor as she was waking up to use the bathroom. Resident A said she was not injured, and she reported the incident to Relative A. Relative A discussed the fall with Ms. Panati. According to Ms. Panati, she reported the fall however, before the call could be made to inform Relative A of the fall, Resident A had already called her relative. Ms. Brown said that she reported the fall to Relative A around 11AM when she was

	picking up Resident A to attend church. There is insufficient information to support that Resident A's fall was not reported.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14305	**Resident protection**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	According to Resident A's *Assessment Plan*, she requires assistance with walking/mobility and toileting. The *Assessment Plan* documents that she is requires one person assist for toileting and a walker/wheelchair for mobility. Resident A described sliding to the floor because she had to use the bathroom. As a result of staff not checking on Resident A throughout the night or early morning, Resident A had to sleep on the floor. Resident A also described an incident where she fell outside on the ramp and remained there for some time. There is sufficient evidence to support that Resident A requires assistance with walking/mobility and has had falls where she remained on the floor or ground for a substantial amount of time before being found by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The staff are not bathing Resident A. Resident A is only bathed when her friend or daughter comes in and care for her.

INVESTIGATION:

On 08/24/2022, I conducted an onsite unannounced investigation. I interviewed Resident A. As I entered Resident A's bedroom, she wreaked of a strong urine odor. Resident A said that she has had only two showers with assistance within the last six months. Resident A said that they have not provided her with clean wash cloths. Resident A said that she can change her own diapers and clothing. Resident A said that she has expressed concerns about the lack of assistance with showers and many other things to Ms. Panati, however she responds by saying that she has cameras in the living room area and knows everything that is going on.

I interviewed Ms. Panati. Ms. Panati said that Resident A is independent with bathing. Ms. Panati said when Resident A initially came, Resident A was bedridden and was given bed baths.

On 09/20/2022, I conducted a phone interview with Relative B. Relative B said that she does not have any concerns.

On 09/20/2022, I conducted a phone interview with Relative A. Relative A said that when Resident A arrived at the home her needs were greater because she was bed ridden. Relative A was told that Resident A takes a shower three times a week. Relative A said that she had concerns about her hygiene at one point because when she would visit, Ms. Brown would tell her that since she was there, she could help Resident A shower. Relative A said that she would do this on her visits, but she discussed this with Ms. Panati that Resident A pays $3000 per month and the staff are not able to assist her with showers. Relative A said that Ms. Panati agreed, and the staff assisted Resident A until she was able to shower herself.

On 08/26/2022, I reviewed Resident A's *Assessment Plan*. Resident A requires assistance for toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility. I observed that the needs are described as "Staff will assist" except for toileting which is a "I person total assist."

On 09/20/2022, I conducted a phone interview with Gary Cedilinia, physical therapist. Mr. Cedilinia reported that he did not observe any hygiene concerns with Resident A.

APPLICABLE RULE	
R 400.14314	**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:	There is sufficient information to support that there is a lack of hygiene occurring with Resident A. Although, Resident A has become more independent with mobility, she still requires assistance with bathing per her *Assessment Plan*. On 08/24/2022, during my onsite, Resident A emitted a strong smell of urine.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/20/2022, I emailed Ms. Panati for Ms. Brown employee training records and Workforce Background Check. Ms. Panati said that Ms. Brown was not fingerprinted because she did not have identification. Ms. Brown was hired in July 2022 and resigned on 09/19/2022. Ms. Brown was fully trained.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	Ms. Brown was not fingerprinted to assess her suitability to work in an adult foster care home. Ms. Brown worked in the home for two months without background checks.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 08/24/2022, I conducted an onsite unannounced investigation. I interviewed Resident A. I observed Resident B. Relative B was present but not interviewed onsite due to his limited cognitive abilities. I briefly spoke to direct care staff Sibyl Brown.

Upon arrival, the door was answered by Relative B who had to retrieve direct care worker Sibyl Brown. Ms. Brown appeared disheveled and as if she were awakened from sleeping. I informed Ms. Brown why I was present, and she was very dismissive and guided me to Resident A's bedroom. I observed that Ms. Brown went into a room (no resident present) and shut the door.

I interviewed Resident A. Resident A said that Ms. Brown sleeps most of her shift in one of the empty resident rooms. Resident A said that Ms. Brown was on a two-day absence but returned and slept most of the day. Resident A described that more than once she to wake up Ms. Brown to remind her to make meals for them specifically for Resident B. Resident A said that she reported the sleeping to Ms. Panati, and she did nothing about it.

On 09/20/2022, I conducted a phone interview with Sibyl Brown. Ms. Brown admitted that she would fall asleep on her shift. Ms. Brown said that there were only two

residents and once they were taken care of, she would fall asleep. Ms. Brown said, “I did not neglect the residents.”

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	There is information to support that there is lack of supervision by staff. Resident A said that Ms. Brown sleeps most of her shift. I observed on 08/24/2022, that Ms. Brown was asleep upon my arrival by her appearance and orientation. Ms. Brown admitted that she would fall asleep during her shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 09/20/2022, I emailed Ms. Panati requesting Ms. Brown’s employee training records and Workforce Background Check. Ms. Panati said that she did not have identification for Ms. Brown because she took the copy she provided when she resigned.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: (d) Verification of the age requirement.
ANALYSIS:	Direct care staff Ms. Brown did not have identification to verify the age requirement.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 08/24/2022, I received documents from Ms. Panati via email per my request. On 08/26/2022 I observed that requested information was missing. I observed that Resident A’s *Resident ID* form did not have a name, address and telephone number for a next of kin.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (a) Identifying information, including, at a minimum, all of the following: (iv) Name, address, and telephone number of the next of kin or the designated representative.
ANALYSIS:	Resident A's *Resident ID* form was missing the name, address, and telephone number of the next of kin.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 08/24/2022, I conducted an onsite unannounced investigation. I interviewed Resident A. I observed that her bed was unmade, and the sheets appeared dingy. I observed that the bathroom toilet was dirty and there was a mop with dirty water in a bucket in the bathroom.

On 09/21/2022, I conducted an exit conference with Ms. Panati. Ms. Panati explained that Ms. Brown was not fingerprinted because she and her entire family had COVID-19 in August, and she did not get a chance to have this completed. Ms. Panati and I discussed some the documents sent that were not requested such as observations of Resident A's behaviors which were directly correlated to the allegations although, Ms. Panati framed Resident A as a racist and was combative. We discussed the recommendation and Ms. Panati was informed that further instructions would be provided in writing as to the recommendation for a provisional license.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On 08/24/2022, I observed the bathroom had a dirty toilet and a mop with old and dirty water sitting.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	On 08/24/2022, I observed that Resident A's bed was unmade, and the sheets were dingy.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

L. Reed 09/23/2022

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn 10/18/2022

Denise Y. Nunn Date
Area Manager