GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

LeeAnne Love Woolley
621 S M-30
Gladwin, MI 48624

RE: License #: AF260401827
Investigation #: 2022A0466054
La Paz AFC

Dear Mrs. Love Woolley:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care and physical plant 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 (517) 284-9727.

Sincerely,

Julie Elkins, 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 #:	AF260401827
Investigation #:	2022A0466054
Complaint Receipt Date:	08/03/2022
Investigation Initiation Date:	08/04/2022
Report Due Date:	10/02/2022
Licensee Name:	LeeAnne Love Woolley
Licensee Address:	621 S M-30 Gladwin, MI 48624
Licensee Telephone #:	(989) 701-5717
Administrator:	N/A
Licensee:	LeeAnne Love Woolley
Name of Facility:	La Paz AFC
Facility Address:	621 S M-30 Gladwin, MI 48624
Facility Telephone #:	(989) 426-8517
Original Issuance Date:	05/27/2020
License Status:	REGULAR
Effective Date:	11/27/2020
Expiration Date:	11/26/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATIONS:

	Violation Established?
Guardian A1 was denied access to the home on 07/15/2022.	Yes
Resident A's hair was matted and she appeared unkept on 07/15/2022.	Yes
Resident A appeared thin and concern was she was not being fed properly due to her dietary restrictions.	Yes
Resident A sleeps on the couch as she cannot ambulate the stairs anymore.	Yes
Resident A missed a doctor's appointment to which the facility was supposed to take her.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/03/2022	Special Investigation Intake- 2022A0466054.
08/04/2022	Contact - Document Sent Email to Complainant.
08/04/2022	Special Investigation Initiated – Telephone call to Complainant, interviewed.
08/08/2022	Contact - Document Received from Sarah Watson ORR reported that the facility is COVID 19 positive.
08/16/2022	Inspection Completed On-site.
08/16/2022	APS Referral made.
08/17/2022	Contact - Telephone call received from APS Ryan Christianson, interviewed.
08/17/2022	Contact - Telephone call made to Guardian A1, interviewed.
08/22/2022	Inspection Completed On-site.
09/08/2022	Contact - Telephone call made to Shavonne Brubaker, CMH Supervisor interviewed.
09/09/2022	Contact - Telephone call made to Justice Petty, CMH case manager, interviewed.

09/09/2022	Contact - Telephone call made to licensee LeeAnne Love Woolley, interviewed.
09/21/2022	Contact - Telephone call made to licensee LeeAnne Love Woolley, interviewed.
09/27/2022	Contact - Telephone call made to ORR Sarah Watson, interviewed.
09/29/2022	Exit conference with licensee LeeAnne Love Woolley.

ALLEGATION: Guardian A1 was denied access to the home on 07/15/2022.

INVESTIGATION:
On 08/03/2022, Complainant reported that while at the adult foster care (AFC) home on 07/15/2022 to visit Resident A, Guardian A1 was denied entry into the AFC home by licensee LeeAnne Love Woolley. Complainant reported this information was told to Resident A's case manager Justice Petty.

On 08/16/2022, Sarah Watson, from Gladwin community mental health (CMH) Office of Recipient Rights (ORR), and I conducted an unannounced investigation and we interviewed licensee Love Woolley who reported she did not allow Guardian A1 into the AFC home on 07/15/2022. Licensee Love Woolley stated the reason for denying Guardian A1 entry was because Guardian A1 wanted to observe a bedroom being used by other residents, not Resident A. Licensee Love Woolley reported she explained to Guardian A1 that due to confidentiality she could not allow her access to the other residents' bedroom. Licensee Love Woolley reported she felt she and Guardian A1 understood why she did not allow her to enter the AFC home on 07/15/2022. Licensee Love Woolley reported Guardian A1 did not push the issue when she did not allow her entry into the facility, so she was of the impression Guardian A1 understood/agreed since she did not question it. Licensee Love Woolley reported there were no other witnesses to the conversation that she had with Guardian A1 about her entering the facility. Licensee Love Woolley reported that Resident A is non-verbal, so she is not able to describe the conditions of the facility and her bedroom to Guardian A1.

On 08/17/2022, I interviewed Guardian A1 who reported that on 07/15/2022 Licensee Love Woolley denied her entry into the AFC home. Guardian A1 reported that prior to 7/15/2022 she had not been allowed entry into the AFC home due to COVID-19 restrictions which she understood and since those restrictions subsided, she wanted to see Resident A and the facility. Guardian A1 reported that on 07/15/2022, licensee Love Woolley reported to her she could not come in the AFC home because the house was a mess with laundry everywhere. Guardian A1 denied that she asked to have access/entry into any bedroom in the home other than Resident A's. Guardian A1 reported she asked to go into the home because

she had not been in the home in a long time due to COVID-19 and she wanted to see if Resident A was still sleeping on the sofa. Guardian A1 reported she did not push this issue with licensee Love Woolley as she did not want to upset her and give her a reason to not continue to take care for Resident A. Guardian A1 reported Resident A is non-verbal, so she is not able to describe the conditions of the facility and her bedroom to Guardian A1. Guardian A1 further stated there were no other witnesses to the conversation she had with licensee Love Woolley about entering the facility. Guardian A1 reported that she did get to see Resident A outside of the facility on the deck on 7/15/2022 since it was a nice day. Guardian A1 reported she was glad that she was able to see Resident A although she was disappointed and concerned as to why licensee Love Woolley would not allow her entry into the home.

On 09/09/2022, I interviewed Justice Petty, Resident A's case manager from Gladwin CMH, who reported that on 07/28/2022, Guardian A1 reported licensee Love Woolley denied her access to the AFC home on 07/15/2022. Case manager Petty reported Guardian A1 stated licensee Love Woolley made several different excuses about the house not being clean and the laundry not being done as reasons why Guardian A1 could not enter the home. Case manager Petty confirmed Resident A is non-verbal and unable to describe the conditions of the home or her resident bedroom. Case manager Petty also stated she was not aware of any witnesses that observed this conversation between Guardian A1 and licensee Love Woolley.

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
	(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: **(g) The right to associate and have private communications and consultations with his or her physician, attorney, or any other person of his or her choice.** **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time.** **(2) A licensee shall provide the resident and the resident's designated representative with a written copy of the rights outlined in subrule (1) of this rule upon a resident's admission to the home.**

ANALYSIS:	Licensee Love Woolley confirmed she did not allow Guardian A1 to visit with Resident A inside of the AFC home as requested on 07/15/2022. Guardian A1, case manager Petty and licensee Love Woolley all reported that Resident A is non-verbal, so she is not able to describe the conditions of the facility and her bedroom to Guardian A1 thus the need for Guardian A1 to have reasonable access to assure the conditions of the facility for Resident A. Licensee Love Woolley needed to provide the opportunity for Guardian A1 to see Resident A's bedroom and her living environment. Resident A's right to have private communication and visitors in the home was impeded by licensee Love Woolley.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's hair was matted and she appeared unkempt on 07/15/2022.

INVESTIGATION:
On 08/03/2022 Complainant reported Resident A's hair was matted on 07/15/2022.

On 08/16/2022, ORR Watson and I conducted an unannounced investigation and when we arrived at 9:30 am all the residents were still in bed. ORR Watson and I observed Resident A's hair to be matted but this may be due to just waking up. ORR Watson and I observed Resident A to be in clothing that was stained and possibly worn the day before. Although Resident A was just getting out of bed she was in shorts and a t-shirt not pajamas. Resident A also had food on her face and food under her fingernails. Resident A's teeth were observed to be rotted/decayed and some teeth were broken off.

On 08/16/2022, ORR Watson and I interviewed licensee Love Woolley who reported Resident A had been asleep when we arrived and had just woken up, so her hair had not been brushed yet. Licensee Love Woolley reported that she brushes Resident A's hair daily and washes it a couple of times a week when she showers. Licensee Love Woolley reported she has not observed Resident A's hair to be matted.

On 08/16/2022, I observed Resident B, Resident C, Resident D and Resident E who all were asleep when ORR Watson and I arrived at 9:30 am. As the resident's woke up, they appeared ungroomed and were all in clothing that was stained and possibly worn the day before. Additionally, none of the residents were in pajamas.

On 8/17/2022, I interviewed Guardian A1 who reported that in February 2022, Resident A was hospitalized unexpectedly and when she went to the hospital to visit with Resident A, that was first time she noticed that Resident A's hair was matted.

Guardian A1 reported that when she visited Resident A on 07/15/2022 at the AFC home, Resident A's hair was also matted and uncombed/brushed.

On 08/22/2022, adult protective services (APS) worker Ryan Christiansen reported he conducted an unannounced inspection on 08/19/2022 around 3pm and he reported observing Resident A's hair which was matted.

On 09/09/2022, I interviewed case manager Petty who reported that she goes to the AFC home monthly to visit Resident A. Case manager Petty reported that she last was at the home to see Resident A in person on 08/23/2022. Case manager Petty reported she has never observed Resident A's hair to be matted. Case manager Petty reported that while visiting with Resident A, she grabs Case Manager Petty's hand and puts her hand in Resident A's hair and twirls it. Case manager Petty wonders if Resident A does this same thing with her own hand also which could cause the hair to matte. Case manager Petty reported that Guardian A1 reported on 07/28/2022 that Resident A's hair was matted on 07/15/2022 when she visited with her outside on the deck at the AFC.

APPLICABLE RULE	
R 400.1420	**Resident hygiene.**
	(6) A licensee shall afford a resident the opportunity to receive assistance in bathing, dressing, or personal hygiene from a member of the same sex, unless otherwise stated in the home's admission policy or written resident care agreement.

ANALYSIS:	Complainant and Guardian A1 reported Resident A's hair was matted on 07/15/2022. Guardian A1 also reported Resident A's hair was matted when she was hospitalized unexpectedly in February 2022. APS Christiansen reported he also observed Resident A's hair to be matted on 08/19/2022 at approximately 3PM. Although Resident A's hair has been observed to be matted by others, case manager Petty, who has monthly contact with Resident A, has never observed Resident A's hair matted. Additionally, case manager Petty reported that when she visits with Resident A, she grabs her hand and puts her hand in Resident A's hair while twirling her hand around Resident A's hair which may explain her hair being matted. Even though this may be an explanation for the condition of Resident A's hair, licensee Love Woolley maintains responsibility to provide personal care to Resident A including combing/brushing her hair. Additionally, all five residents were observed on 08/16/2022, were observed to be unkempt wearing dirty clothing with food stains and matted hair. Resident A was also observed to have food on her face, hands and under her fingernails. The residents are not being provided with assistance in bathing or personal hygiene as they had not even eaten breakfast upon my arrival to the facility on 08/16/2022 so the food on their clothing remained from a previous meal.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A appeared thin on 07/15/2022 and Complainant expressed concern Resident A was not being fed properly due to her dietary restrictions.

INVESTIGATION:
On 08/03/2022, Complainant reported that on 07/15/2022, Resident A appeared thin and Complainant expressed concern Resident A was not being fed properly due to her dietary restrictions.

On 08/16/2022, ORR Watson and I conducted an unannounced investigation, and I reviewed Resident A's record which contained W*eight Records* from 2019 and 2020 but nothing since October 2020. Resident A's last weight was documented on 10/14/2020 and was noted at 128 pounds.

On 08/16/2022, I reviewed Resident A's written *Adult Foster Care (AFC) Assessment Plan* which was dated 09/06/2020 and signed by licensee Love Woolley, case manager Justice Petty and Guardian A1. In the "eating" section of the

report it stated, “cut food into small pieces and urge [Resident A] to slow down.” In the “special diet” section of the report” it stated, “small foods and urge to slow down.”

On 08/16/2022, I reviewed Resident A’s *Health Care Appraisal* which was dated 08/02/2022 and documented that Resident A is 68 years, 5 feet 6 inches tall and weighed 110 pounds. In the “Current Medications and Instructions” section of the report it stated, “starch thickening powder/pk prn.” In the “general appearance” section of the report it stated, “well developed.” In the “Special Dietary Instructions” it stated, “Boost x 3.” Attached to Resident A *Health Care Appraisal* was a *My Michigan Family Medicine Office Visit* Report dated 08/02/2022 which stated in the “Progress Notes” section of the report, “She has slowly started to gain more weight after hospitalization 2/22-3/7.” In the “general health” section of the report it documented, “Concerned weight yes doing boost 2 time daily) current diet general including boost twice daily.” In the “review of symptoms” section of the report it stated, “positive for gait problem uses walker and wheelchair. Using wheelchair in office today.” In the “plan” section of the report it stated, “increase boost to 3 times daily. High fiber/low fat diet, 150 minutes of aerobic activity weekly, low cholesterol and low salt diet, pertinent recommended screening. She will establish care with neurology for presumed Parkinson’s in a few months.”

On 08/16/2022, ORR Watson and I interviewed licensee Love Woolley who reported Resident A is a good eater and is supplemented with three boost per day. Licensee Love Woolley reported she provides Resident A with three meals plus snacks per day and all Resident A’s food is cut into very small pieces and/or moistened. Licensee Love Woolley showed me the Boost she had in the refrigerator for Resident A, the starch thickening powder, and the blending device used for Resident A’s food. Licensee Love Woolley reported in February 2022, Resident A was hospitalized for aspiration and that is when the dietary instructions changed. Licensee Love Woolley reported Resident A has always been a fast eater and at risk for choking which is why her food has always been cut into small pieces and she is urged to slow down.

On 08/17/2022, I interviewed Guardian A1 who reported that although she visits Resident A at the AFC, she has never observed licensee Love Woolley provide any moistened food to Resident A. Guardian A1 reported that in February 2022, Resident A was hospitalized for seven days in the intensive care unit (ICU) for aspiration and a mass on her lung. Guardian A1 reported that is when the doctor ordered no solid food for Resident A, her food has to be pureed/thickened into small bites. Guardian A1 reported that on 07/15/2022, she brought cookies to the AFC and licensee Love Woolley gave Resident A a cookie without breaking it into small pieces or moistening it. Guardian A1 reported that Resident A does eat fast and reported that she was afraid that Resident A was going to choke on the cookie. Guardian A1 reported that Resident A’s weight has dropped as low as 104 pounds, and she is 5 feet four inches tall. Guardian A1 reported that Resident A is just “skin and bones and she is always hungry.” Guardian A1 reported that because Resident

A's weight continues to decrease. Guardian A1 expressed concern that Resident A is not being provided enough food at the facility.

On 08/17/2022, Resident A could not be interviewed as she is non-verbal and unable to articulate if her dietary requirements are being met. The other residents in the home are either non-verbal and/or unable to articulate the dietary needs of other residents.

On 08/17/2022, ORR Watson and I observed the facility to have both perishable and non-perishable food items.

On 08/22/2022, I conducted a second unannounced investigation and interviewed Licensee Love Woolley who reported that she does not keep any records of what Resident A eats daily. While I was at the facility, I observed Daniel Woolley break up a pop tart and give that to Resident A for breakfast. Licensee Love Woolley reported that everyone in the home eats the same foods for all meals.

On 08/22/2022, I reviewed resident records for Resident B, Resident C, Resident D and Resident E and none of the records contained a *Weight Record*.

On 09/09/2022, I interviewed case manager Petty who reported she has never observed Resident A eat anything while she has been in the home as she has not been to the home during mealtime. Case manager Petty reported that in February 2022, Resident A was hospitalized for aspiration and that is when the doctor ordered Resident A's food to be pureed/thickened or cut into small bites.

On 09/27/2022, ORR Watson reported that she contacted Resident A's primary care physician and the nurse that she spoke with reported that Resident A has a body mass index (BMI) of 17.5% which is low. ORR Watson reported that the hospital after discharged ordered "minced moist diet" not the primary care physician. ORR Watson expressed concern that Resident A's teeth appeared to be rotted/decayed and some teeth were broken off which may be causing her pain and impacting her ability to eat and stay nourished. ORR Watson reported that when she reviewed Resident A's record, she found no documentation that Resident A has been seen by a dentist.

APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(4) Special diets shall be prescribed only by a physician. A resident who has a special diet prescribed by a physician shall be provided such diet.

ANALYSIS:	Resident A's weight was 128 pounds in October 2020 and 110 pounds during her most recent healthcare visit in August 2022, meaning she experienced an 18-pound weight loss in 22 months. During the unannounced onsite investigation, I observed household member Daniel Woolley provide Resident A with small pieces of a pop tart which were not minced or moistened per the hospital instructions. Resident A's physician also increased her Boost intake to three cans per day starting in August 2022 in an effort to increase her caloric intake as well. Licensee Love Woolley did not have any documentation to verify she was providing Resident A with a minced/moistened diet, nor did she have any updated monthly weights to assure Resident A was maintaining her current weight and thus receiving enough caloric intake given her special dietary instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A sleeps on the couch as she cannot ambulate the stairs anymore.

INVESTIGATION:
On 08/03/2022, Complainant reported Resident A has been sleeping on the couch downstairs since March 2022.

On 08/16/2022, ORR Watson and I conducted an unannounced investigation and upon entry into the home we observed a couch in the family room that had a sheet, a blanket and pillow on it.

On 08/16/2022, ORR Watson and I interviewed licensee Love Woolley who reported when Resident A returned to the facility after being hospitalized in February 2022, she had Resident A sleep on the couch in the family room since she could not ambulate the stairs. Licensee Love Woolley reported she thought Resident A's ambulation would get better so she could eventually return to her bedroom on the second floor. Licensee Love Woolley stated Resident A was using a walker at the time of this investigation and remained sleeping on the facility couch. Licensee Love Woolley stated she left Resident A's belongings in her upstairs bedroom in hopes that she would return to that room. Licensee Love Woolley reported the home does have an available resident bedroom on the first floor, but licensee Love Woolley had Resident A sleep on the couch rather than move bedrooms. Licensee Love Woolley reported that the first-floor bedroom allows for three residents and there were only two female residents in that bedroom while Resident A was sleeping on the couch. Licensee Love Woolley reported case manager Petty was aware Resident A was sleeping on the couch in the family room. Licensee Love Woolley reported she moved Resident A into the bedroom on the first floor on 08/01/2022 however there was no evidence of that when ORR Watson and I were in the home on 8/16/2022. ORR Watson and I observed Resident A's belongings in the second-floor bedroom.

Licensee Love Woolley reported Resident A is up all night and she is easier to supervise from the couch so that she does not disturb the two other residents in the first-floor bedroom.

On 08/16/2022, ORR Watson and I observed the lower-level bedroom to have three beds in it but there were no sheets on the third bed. The two other residents were in their beds so I could not determine if sheets were on those beds or not. Resident A did not have access to her belongings as those were still in the second-floor bedroom and Resident A was not able to traverse the stairs during the unannounced onsite investigation. When ORR Watson and I went upstairs we observed Resident A's belongings in her second-floor bedroom.

On 08/17/2022, I interviewed Guardian A1 who reported Resident A has been sleeping on the couch in the living room since March 2022. Guardian A1 reported that due to Resident A's impaired mobility she requires the use of a walker and Resident A was no longer able to navigate the flight of steps to get to her second-floor bedroom. Guardian A1 reported she does not know the date or if licensee Love Woolley ever moved Resident A into the first-floor bedroom as that was not reported to her. Guardian A1 reported she asked for a picture to show that all three resident beds were in the first-floor bedroom and that was never received from licensee Love Woolley. Guardian A1 requested to see the bedroom that Resident A was staying in on 07/15/2022 and licensee Love Woolley would not allow her entrance into the home.

On 08/22/2022, I conducted a second unannounced investigation and when I arrived at 9:30am, Resident A was still in bed in her first-floor bedroom with two other residents.

On 09/09/2022, I interviewed case manager Petty who reported licensee Love Woolley did tell her Resident A would be sleeping in the living room temporarily however case manager Petty reported licensee Love Woolley led her to believe Resident A was sleeping on a cot not a couch. Case manager Petty reported licensee Love Woolley reported Resident A was sleeping in the living room due to her impaired mobility which began in February 2022 after being released from the hospital. Case manager Petty reported licensee Love Woolley told her Resident A sleeping downstairs was just until she could ambulate the stairs. Case manager Petty reported she was unclear as to why licensee Love Woolley did not move Resident A into the open spot in the downstairs bedroom. Case manager Petty thought that by July 2022, Resident A was back in her second-floor bedroom however case manager Petty later learned that was not accurate. Case manager Petty reported she realized Resident A remained sleeping on the facility couch after being interviewed as part of the ORR investigation. Case manager Petty reported Resident A continues to use her walker to assist with ambulation. Case manager Petty reported she had a case note dated 08/01/2022 which stated licensee Love Woolley reported Resident A was not yet sleeping in the first-floor bedroom but she was getting it ready. Case manager Petty reported all the residents that reside in

the first-floor bedroom can ambulate and navigate the stairs therefore case manager Petty reported being confused as to why licensee Love Woolley put Resident A on the couch when the other residents could have been moved up stairs if needed.

APPLICABLE RULE	
R 400.1431	**Bedrooms generally.**
	(1) A living room, dining room, hallway, basement, or other room not ordinarily used for sleeping shall not be used for sleeping purposes by residents of the home. **(7) A resident having impaired mobility, as determined by a licensed physician, shall not sleep in or be assigned a bedroom located above the street floor in a single-family residence.**
ANALYSIS:	Complainant, Guardian A1, licensee Love Woolley and case manager Petty all reported that since Resident A's hospitalization in February 2022, she had been sleeping on the couch in the home because she could no longer navigate the stairs. Resident A's mobility impairment now required her to use a walker for ambulation. At the time of the first unannounced onsite investigation on 8/16/2022, there was a resident bed available on the first floor of the facility, but licensee Love Woolley did not utilize this for Resident A. Instead, licensee Love Woolley continued to have Resident A sleep on the facility couch from the time she was discharged from the hospital in February 2022 until August 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
	(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: **(p) The right of access to his or her room at his or her own discretion.** **(2) A licensee shall provide the resident and the resident's designated representative with a written copy of the rights outlined in subrule (1) of this rule upon a resident's admission to the home.**

ANALYSIS:	Licensee Love Woolley continued to have Resident A sleep on the facility couch from the time she was discharged from the hospital in February 2022 until August 2022. Licensee Love Woolley left Resident A's belongings in her upstairs bedroom even though Resident A could not ambulate the stairs which did not provide her access to her room and her belongings at her discretion.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A missed a doctor's appointment to which the facility staff were supposed to take her.

INVESTIGATION:
On 08/03/2022, Complainant reported Resident A missed a doctor's appointment to which facility staff were supposed to take her.

On 08/16/2022, ORR Watson and I interviewed licensee Love Woolley who reported Resident A did miss a doctor's appointment on 07/07/2022. Licensee Love Woolley reported she was having issues with her telephone and therefore did not receive the reminder call so Resident A missed the appointment. Licensee Love Woolley reported that once she realized the appointment was missed, she promptly rescheduled the appointment and Resident A was seen by the doctor on 08/02/2022. Licensee Love Woolley provided a copy of the *Health Care Appraisal* for department review.

On 08/16/2022, I reviewed Resident A's record which contained a *Resident Care Agreement* which signed and dated by licensee Love Woolley on 03/30/2020, case manager Petty on 03/30/2020 and Guardian A1 on 04/06/2020. Resident A's *Resident Care Agreement* documented that "the basic fee includes all transportation services."

On 08/16/2022, I reviewed Resident A's record which contained Resident A's *Health Care Appraisal* which was dated 08/02/2022.

On 08/17/2022, I interviewed Guardian A1 who reported Resident A missed a doctor's appointment recently due to the AFC's phone not working. Guardian A1 reported licensee Love Woolley reported that because the phone was not working, she did not receive the reminder call so Resident A missed her appointment.

On 09/09/2022, case manager Petty reported that she was not aware that Resident A missed a doctor's appointment as that is licensee Love Woolley's responsibility.

APPLICABLE RULE	
R 400.1407	**Licensee, responsible person, and member of the household; qualifications.**
	(11) A licensee shall provide a resident or his or her designated representative and responsible agency with a statement of the fee policy at the time of admission. A fee statement shall include all of the following: **(a) A description of services to be provided and the fee.** **(b) A description of additional costs above the basic fee policy.** **(c) A description of the transportation costs in the basic fee structure and the transportation which is provided at extra cost.**
ANALYSIS:	Licensee Love Woolley admitted to being responsible to take Resident A to her medical appointments and missing Resident A's doctor's appointment in July 2022. Resident A's *Resident Care Agreement* documented that "the basic fee includes all transportation services" including transportation to medical appointment. Licensee Love Woolley is responsible to manage, track and attend all medical appointments with Resident A and licensee Woolley admitted that she missed Resident A's medical appointment in July 2022 due to her own error.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 08/16/2022, ORR Watson and I conducted an unannounced investigation and when we arrived, we observed an electrical cord, tree trimming equipment and a mattress on the front deck of the home. While ORR Watson and I were at the facility licensee Love Woolley brought residents records and residents outside on the deck to talk and interact with us. Licensee Love Woolley reported she and residents spend a lot of time outside on the deck when the weather is nice. Before licensee Love Woolley allowed us access to the home, we observed her son attempting to clean up dog urine and feces on the floor entry way of the home.

ORR Watson and I conducted a walk though inspection of the home and found it to be kept in an unsanitary condition as the floor was littered with dog feces and dog urine. The feces and urine spots were located in areas used by residents to walk through the facility. Licensee Love Woolley explained that the family's dog is blind and paralyzed from running into a propane tank so family members take the dog outside as needed but reported that the dog cannot walk. ORR Watson and I

observed the kitchen to have hand tools, dirty dishes and other clutter in piles that covered all the counter tops/surfaces leaving no room for food preparation nor a safe environment for residents. ORR Watson and I observed the kitchen sink to be full of dirty dishes and additional dirty dishes scattered on the countertops. ORR Watson and I observed grease, food and dirt covering the appliances and stove. ORR Watson and I observed the facility to have a strong urine and garbage odor especially in the resident bedrooms. Licensee Love Woolley reported to ORR Watson and me that Resident A was incontinent and that her dirty sheets had not yet been cleaned.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(1) The premises shall be maintained in a clean and safe condition.
ANALYSIS:	On August 16, 2022, ORR Watson and I observed the home to be unsanitary and in an unsafe condition. The front deck contained an electrical cord, tree trimming equipment and a mattress within easy access to residents. The inside of the home contained dog feces and dog urine. The kitchen contained hand tools, dirty dishes and other clutter that was piled high and covered all the counter tops/surfaces leaving no room for food preparation nor a safe environment for residents. The facility contained a very strong odor of urine and garbage throughout the home but the smell was more potent in resident bedrooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/16/2022, ORR Watson and I conducted an unannounced investigation and we both observed the floor in the eating area/living room to be unfinished and without floor molding. The current flooring observed was a large piece of plywood. ORR Watson and I observed the eating/living room area to be to be in the process of the flooring being replaced although no one was working on the floors while we were at the home. Licensee Love Woolley explained that the floor is being replaced and that they are replacing it in sections. Licensee Love Woolley reported that after they lay the new floor, they place a large plywood board over the floor for it to set which allows the residents to be in the room while the flooring is being replaced. I observed that the plywood had a lift/lip on it and was not flush with the floor and therefore creating a tripping hazard for residents, especially for Resident A who uses a walker.

On 08/22/2022, I interviewed APS Ryan Christiansen who reported that he was at the home on 08/19/2022 and the eating area/living room was unfinished had a plywood board in the room and was without floor molding.

On 08/22/2022, I went back to the home and the floor was in the same condition it was previously. Between 08/16/2022 and 08/22/2022 no additional flooring has been laid with the project showing no progress. Licensee Love Woolley reported that she would have the floor worked on and it would take a couple of weeks to complete.

On 09/16/2022, APS Michael Worth called and reported that he had been at the home on 09/08/2022 and again on 09/15/2022 and he reported that the flooring in the dining/living room had not been completed, the eating area/living room was unfinished had a plywood board in the room and was without floor molding to minimize tripping. APS Worth reported that only a small portion of the flooring was completed by the kitchen table. APS Worth reported that he did observe a large board of plywood over the floor.

On 09/21/2022, licensee Love Woolley reported that the floors in the dining room/living room were completed. Licensee Love Woolley reported that she would send pictures on 09/22/2022.

On 09/21/2022, licensee Love Woolley sent pictures showing the flooring has been completed.

APPLICABLE RULE	
R 400.1426	**Maintenance of premises.**
	(4) Floors, interior walls, and ceilings shall be sound, in good repair, and maintained in a clean condition.

ANALYSIS:	On August 16, 2022, ORR Watson and I observed the eating area/living room to be unfinished and without floor molding. Again, on August 22, 2022, I observed the eating area/living room to be unfinished and without floor molding. On August 19, 2022, September 8, 2022 and September 15, 2022, APS Worth reported both he and APS Christensen observed the eating area/living room to be unfinished and without floor molding thus leaving the flooring in poor repair.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/16/2022, licensee Love Woolley told ORR Watson and I that her husband Daniel Woolley does not provide any direct care to the residents and therefore she does not have an employee record for him.

On 08/22/2022, I observed Daniel Woolley providing direct care to Resident A. I observed Daniel Woolley assisting Resident A out of her bedroom and into the bathroom after she woke up and I observed Daniel Woolley providing Resident A with breakfast as licensee Love Woolley was busy being interviewed and providing me with resident documents.

On 8/22/2022, licensee Love Woolley reported that she does not have an employee record for Daniel Woolley nor has he been fingerprinted as required. Licensee Love Woolley reported that Daniel Woolley was "just helping out" since she was busy with the investigation.

APPLICABLE RULE	
400.734(b)	**This amended section is effective January 9, 2009 except Section 734b(1)(e)(iv) after the word "or" which will not be effective until October 31, 2010** **Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents after April 1, 2006 until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5). This subsection and subsection (1) do not apply to

	an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. Beginning April 1, 2009, an individual who is exempt under this subsection shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (12). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006. That individual may transfer to another adult foster care facility that is under the same ownership with which he or she was employed or under contract. If that individual wishes to transfer to an adult foster care facility that is not under the same ownership, he or she may do so provided that a criminal history check is conducted by the new facility in accordance with subsection (4). If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under subsection (1)(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Daniel Woolley was observed providing personal care to Resident A on 08/22/2022 despite not being fingerprinted; therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/16/2022, licensee Love Woolley told ORR Watson and I that she was the only employee that worked at the facility. Licensee Love Woolley reported that her husband Daniel Woolley does not assist with resident care and that her responsible person died several months ago. Licensee Love Woolley reported she is running this facility alone and that it has been difficult. Licensee Love Woolley admitted she did not have a current arrangement with a responsible person in case an emergency occurred.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(8) A licensee shall have an arrangement with a responsible person who is available to provide care in an emergency situation for up to 72 hours.
ANALYSIS:	On 08/16/2022, Licensee Love Woolley reported her responsible person died several months ago and she admitted she did not have a current arrangement with a responsible person in case of emergency; therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/16/2022, I reviewed Resident A's record which contained a *Resident Care Agreement* which signed and dated by licensee Love Woolley on 03/30/2020, case manager Petty on 03/30/2020 and Guardian A1 on 04/06/2020. At the time of the unannounced investigation, Resident A's record did not contain an updated *Resident Care Agreement* or any documentation Resident A's *Resident Care Agreement* had been reviewed/updated in 2021 and 2022 with the resident or the resident's designated representative and responsible agency.

APPLICABLE RULE	
R 400.1407	**Licensee, responsible person, and member of the household; qualifications.**
	(6) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency at least annually or more often if necessary.
ANALYSIS:	At the time of the unannounced investigation on 08/16/2022, Resident A's record did not contain any documentation that the written resident care agreement had been reviewed annually in 2021 and 2022 with the resident or the resident's designated representative and responsible agency.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/16/2022, I reviewed Resident A's record which contained W*eight Records* from 2019 and 2020 but the record did not contain any documentation of any current weight being documented. The last weight for Resident A was documented on 10/14/2020 and recorded Resident A's weight at 128 pounds. I also reviewed the resident records for Residents B, C, D and E and there were no weight records maintained for those residents either.

APPLICABLE RULE	
R 400.1422	**Resident records.**
	(1) A licensee shall complete and maintain 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: (g) Weight record.
ANALYSIS:	At the time of the unannounced investigation on August 16, 2022, Resident A's record did not contain a monthly weight for Resident A since October 14, 2020. There were also no weight records for Residents B, C, D, and E.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/29/2022, I conducted an exit conference with licensee Leanne Love Woolley who reported that she does not wish to contest the issuance of a provisional license. Licensee Leanne Love Woolley reported that she has already began to make corrections to some of violations and she will continue to ensure that all of the violations are corrected timely.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional status due to the quality of care and physical plant violations cited in the report.

09/29/2022

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Julie Elkins Date
Licensing Consultant

Approved By:

09/29/2022

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Dawn N. Timm Date
Area Manager