GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL700289594
Investigation #: 2023A0583002
Cambridge Manor - South

Dear Mrs. Clauson:

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.

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.

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) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700289594
Investigation #:	2023A0583002
Complaint Receipt Date:	09/26/2022
Investigation Initiation Date:	09/27/2022
Report Due Date:	10/26/2022
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
Licensee Designee:	Connie Clauson
Name of Facility:	Cambridge Manor - South
Facility Address:	151 Port Sheldon Road Grandville, MI 49418
Facility Telephone #:	(616) 457-3050
Original Issuance Date:	03/25/2013
License Status:	REGULAR
Effective Date:	09/23/2021
Expiration Date:	09/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
The facility is insufficiently staffed resulting in residents not receiving adequate care.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/26/2022	Special Investigation Intake 2023A0583002
09/27/2022	Special Investigation Initiated - On Site Staff Robin Rogers
09/27/2022	Contact - Telephone call made Staff Maranda Maulson
09/28/2022	Inspection Completed On-site Regional Director Amanda Beacham, Licensing Consultant Megan Aukerman, Resident B, Resident C
10/03/2022	Contact - Document Received Staff Rebecca Jiggens
10/04/2022	Contact - Document Received Staff Rebecca Jiggens
10/04/2022	Contact - Telephone call received Relative 1
10/05/2022	Contact - Telephone call made Staff Rebecca Jiggens
10/06/2022	Contact - Document Received Relative 1
10/06/2022	Contact - Telephone call made Staff Stephanie Brown
10/06/2022	Contact - Telephone call made Staff Jennifer Davidson
10/07/2022	Contact - Document Received Staff Rebecca Jiggens

10/07/2022	Contact - Telephone call made Staff Tricia VanKoevering
10/07/2022	Contact - Telephone call made Staff Danasia Vaughn
10/10/2022	Contact - Telephone call made Jada McClenton-Russel
10/10/2022	Contact - Telephone call made Relative 2
10/14/2022	Contact – Telephone call made Staff Rebecca Jiggens
10/14/2022	APS Referral
10/25/2022	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: The facility is understaffed resulting in residents not receiving adequate care.

INVESTIGATION: On 09/27/2022 I interviewed staff Maranda Maulson via telephone. Ms. Maulson stated the facility is understaffed. Ms. Maulson stated the facility houses multiple residents who require two staff for transfer assistance. Ms. Maulson stated that on 09/24/2022 she worked alone at the facility from 7:00 AM until 7:30 AM, 9:00 AM until 9:30 AM, and from 1:00 PM until 2:00 PM.

On 09/28/2022 I completed an unannounced onsite investigation at the facility and interviewed Regional Director Amanda Beacham. Licensing Consultant Megan Aukerman was present during the inspection. Ms. Beacham confirmed that the facility houses sixteen total residents, including multiple residents who require the assistance of two staff for safe transfers. Ms. Beacham acknowledged the facility has struggled with low staffing levels. Ms. Beacham stated the facility is always staffed with two staff on third shift from 11:00 PM until 7:00 AM however there have been recent incidents in which the facility operated with one staff during the day. Ms. Beacham stated on 09/24/2022 there was “a very good chance” staff Maranda Maulson worked alone at the facility due to a staffing shortage. Ms. Beacham stated that due to the high volume of “staff call-ins” both herself and Licensee Designee Connie Clauson have worked at the facility but failed to add that information to the staff schedule.

Resident B stated the facility needs “more staff” to assist with resident care. Resident B stated “sometimes” the facility operates with one staff. Resident B stated

the facility typically operates with two staff during the day and one staff third shift. Resident B stated staff assist her with taking her medications and grooming but the wait for assistance is “long” at times.

Resident C stated she is happy with the level of care provided. She stated she receives her medications on time and expressed no concerns related to adequate resident care.

On 09/30/2022 I completed a licensing file review. I observed that special investigation 2022A0583039 indicates that on 08/5/2022 the facility violated licensing rule 401.15206 (2) due to inadequate staffing levels. That Special Investigation found that the facility often operates with only one staff from 11:00 PM until 7:00 AM despite the facility providing care to residents who required the assistance of two staff to safely transfer. Staffing schedules indicated that the facility operated with one staff from 11:00 PM until 7:00 AM on 07/12/2022, 07/13/2022, 07,14/2022, 07/16/2022, and 07/20/2022. The corrective action plan was signed by Licensee Designee Connie Clawson on 08/30/2022 and stated effective immediately the facility would ensure adequate staffing levels.

On 10/03/2022 I received an email from staff Rebecca Jiggens which contained Resident Evaluations for the following residents:

Resident D’s Resident Evaluation is signed by his legal decision maker on 07/21/2022 but is not signed by the Licensee Designee or Administrator. Resident D’s document states he requires “two-person assistance with transfers”.

Resident E’s Resident Evaluation is signed 07/28/2020. Resident E’s document states she requires “two-person assistance with transfers”.

Resident F’s Resident Evaluation is signed by her on 07/18/2022 but lacks the required signature of the Licensee Designee or Administrator. Resident F’s document states she requires “two-person assistance with transfers”.

Resident G’s Resident Evaluation lacks all required signatures but was completed by staff Robin Rogers 08/15/2022. Resident G’s document states she is “wheelchair bound” and requires “1-2 staff for assistance with transfers”.

Resident H’s Resident Evaluation is signed by the resident but lacks the date the document was signed. Resident H’s document was not signed by the Licensee Designee or Administrator. Resident H’s document was signed by staff Robin Rogers on 03/30/2022. Resident H’s document states she requires a wheelchair and requires “1-2 staff for assistance with transfers”.

Resident I’s Resident Evaluation is signed by the resident’s legal decision maker on 05/13/2022 but lacks the signature of the Licensee Designee or administrator.

Resident I's document states he requires "1-2 staff for assistance with transfers and utilizes a wheelchair or scooter".

On 10/03/2022 I received an email from staff Rebecca Jiggens which contained a Resident Evaluation for Resident J. The document is from Resident J's previous facility and is signed by her legal decision maker on 09/24/2021 and is not signed by the Licensee Designee or administrator.

On 10/03/2022 I received an email from staff Rebecca Jiggens which contained a Resident Evaluation for Resident K. The document is from Resident K's previous facility and was signed on 07/13/2020.

On 10/03/2022 I received an email from staff Rebecca Jiggens which contained the staff schedule for the September 2022. The staff schedule was poorly constructed, difficult to decipher, was not updated and did not document when all staff started and ended their shifts.

On 10/04/2022 I received an email from Rebecca Jiggens that confirmed that Resident J and Resident K require two staff for assistance with safe transfers however Assessment Plans have not been completed for the Resident J and Resident K despite Resident J residing at the facility since 09/08/2022 and Resident K residing at the facility since 07/05/2022.

On 10/06/2022 I interviewed staff Stephanie Brown via telephone. Ms. Brown stated she routinely works at the facility from 11:00 PM until 7:00 AM "by myself". Ms. Brown stated "two nights ago" she worked alone at the facility. Ms. Brown stated that the facility provides care to residents that require two staff for safe transfers. Ms. Brown stated she routinely calls staff "other units" to request assistance with resident care. Ms. Brown stated that the staff schedule is "never updated" to include staffing "call offs".

On 10/06/2022 I interviewed staff Jennifer Davidson. Ms. Davidson stated that the facility is often staffed with only one person on third shift. Ms. Davidson confirmed that the facility houses multiple residents that require two staff for transfer assistance. Ms. Davidson stated she often requests staff assistance from other facilities on the campus to assist with resident care. Ms. Davidson stated first shift is often staffed with two staff however that is not enough to provide adequate resident care. Ms. Davison stated on one occasion during the month of September 2022 the facility was staffed first shift with two staff, and she observed "residents left in their bedrooms until 11:00 am".

On 10/07/2022 I interviewed staff Tricia VanKoevering via telephone. Ms. VanKoevering stated that the facility is understaffed, and it affects residents' care. Ms. VanKoevering stated residents have "gone a week without receiving a shower" and other residents are not getting regularly shaved. Ms. VanKoevering stated residents are "being neglected somewhat" as a result of the lack of staffing.

On 10/07/2022 I interviewed staff Danasia Vaughn via telephone. Ms. Vaughn stated first and second shifts are typically staffed with “two or three staff”. Ms. Vaughn stated that when the facility is staffed with two staff on first or second shifts, she has observed that not of a lot of required resident care is being done. Ms. Vaughn elaborated by stating that two staff working first or second shift does not allow staff the ability to assist residents with showering and sometimes residents have gone a week without showering.

On 10/10/2022 I interviewed Relative 2 via telephone. Relative 2 stated Resident A was diagnosed with dementia, and he was concerned “she wasn’t getting enough to eat” while residing at the facility because he often observed that at 10:00 AM she was still in bed and had not received breakfast. Relative 2 stated he visited Resident A often and observed that staff were unfamiliar with her care needs and were difficult to locate for assistance. Relative 2 stated Resident A “went a week” without receiving a shower although she was scheduled to receive staff assistance with showering twice weekly. Relative 2 stated that on one occasion he, “found a pill” in Resident A’s bed while she resided at the facility and staff had no idea how the pill could have gotten there.

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but requested time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Staff Maranda Maulson stated that on 09/24/2022 she worked alone at the facility from 07:00 AM until 07:30 AM, 09:00 AM until 09:30 AM, and from 01:00 PM until 02:00 PM. Regional Director Amanda Beacham stated on 09/24/2022 there was, “a very good chance” staff Maranda Maulson worked alone at the facility due to a staffing shortage. Ms. Beacham confirmed that the facility houses sixteen residents including multiple residents who require two staff to safely transfer them.

	Staff Stephanie Brown stated she routinely works at the facility from 11:00 PM until 7:00 AM by herself. Ms. Brown stated two nights ago she worked alone. Staff Jennifer Davidson stated the facility often has only one staff working on third shift. The staff schedule was poorly constructed and difficult to decipher. In addition, it was not updated or easily discernable, and did not document when all staff started and ended their shifts. There is a preponderance of evidence to substance violation of R 400.15206 (1).
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**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:	Staff Maranda Maulson that on 09/24/2022 she worked at the facility independently from 7:00 AM until 7:30 AM, 9:00 AM until 9:30 AM, and from 1:00 pm until 2:00 PM. Staff Jennifer Davidson stated the facility often has only one staff working on third shift. Ms. Davidson stated first shift is often staffed with two staff however that is not enough to provide adequate resident care. Ms. Davison stated on one occasion during the month of September 2022 the facility was staffed first shift with two staff, and she observed residents left in their bedrooms until 11:00 am. Staff Tricia VanKoevering stated residents have gone a week without receiving a shower and other residents are not getting regularly shaved.

	Staff Danasia Vaughn stated first, and second shifts are typically staffed with two or three staff. Ms. Vaughn stated that two staff working first or second shift does not allow staff the ability to assist residents with showering and "sometimes" residents have gone "a week" without showering. Relative 2 stated Resident A was diagnosed with dementia, and he was concerned "she wasn't getting enough to eat" while residing at the facility because he often observed that at 10:00 AM she was still in bed and had not received breakfast. Relative 2 stated Resident A "went a week" without receiving a shower although she was scheduled to receive staff assistance with showering twice weekly. A review of Resident Assessment Plans indicates eight residents require the assistance of two staff for safe transfers. There is a preponderance of evidence to substance violation of R 400.15206 (2).
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED 2022A0583039 (08/05/2022)**

ADDITIONAL FINDINGS: Staff are not capable of appropriately handling emergency situations.

INVESTIGATION: On 09/27/2022 I completed an unannounced onsite investigation at the facility and privately interviewed staff Robin Rogers. Ms. Rogers stated that on 09/25/2022 staff Maranda Maulson discovered Resident A deceased in her bed. Ms. Rogers stated Resident A had a medical history of Alzheimer's Disease, but she had "no idea" what caused her death. Ms. Rogers confirmed Resident A did not have hospice services involved. Ms. Rogers stated staff subsequently telephoned 911 emergency services and the sheriff's office was dispatched to the facility. Ms. Rogers stated an ambulance was never dispatched to the facility and Resident A's body was transferred directly to the funeral home.

On 09/27/2022 I interviewed staff Maranda Maulson via telephone. Ms. Maulson stated that on 09/25/2022 she entered the facility at approximately 7:00 AM through the Cambridge North door and was immediately approached by Cambridge North staff Stephanie Brown. Ms. Maulson stated Ms. Brown asked her, "what do you do if a resident is not responsive, cold, and stiff"? Ms. Maulson stated she asked Ms. Brown if a DNR order was in place and Ms. Brown stated she did not know. Ms. Maulson stated she asked Ms. Brown, "how long (Resident A) had been gone" and Ms. Brown stated she had "no idea". Ms. Maulson stated she subsequently telephoned "911" and requested assistance. Ms. Maulson stated she did not

observe Resident A's body during the incident. Ms. Maulson stated police were dispatched to the facility and Resident A's body was transferred to a funeral home.

On 10/03/2022 I received an email from staff Rebecca Jiggens which contained Resident A's Health Care Appraisal. The document was signed on 06/17/2022 by Tuyen Dang Nguyen, DO and states Resident A, age 72, was diagnosed with, "late onset of Alzheimer's disease, latex allergy, osteoporosis, OA of left knee, HTN, SNHL". The document stated Resident A appeared, "not in acute distress, not ill appearing" and was a fall risk due to limited range of motion.

On 10/06/2022 I interviewed staff Stephanie Brown via telephone. Ms. Brown stated that she worked from 11:00 PM 09/24/2022 until 07:00 AM 09/25/2022 at Cambridge North. Ms. Brown stated, "agency staff" Jada McClenton-Russel and staff Danasia Vaughn were both working overnight at Cambridge South from 09/24/2022 to 09/25/2022 "third shift". Ms. Brown stated that at approximately 06:45 AM staff Jada McClenton-Russel entered Cambridge North and stated Resident A was deceased in her bed at Cambridge South. Ms. Brown reported that Ms. McClenton-Russel stated she did not know what to do regarding Resident A's death. Ms. Brown stated she left Cambridge North, entered Cambridge South, and observed Resident A deceased in her bed. Ms. Brown stated she had never encountered a resident death in which hospice wasn't involved, therefore she telephoned management to request instructions regarding how to handle the situation but, "no one answered". Ms. Brown stated Resident A appeared "stiff" and, "looked as if she had been there for hours". Ms. Brown stated staff Maranda Maulson happened to enter the facility at 07:00 AM and Ms. Brown informed Ms. Maulson of the situation. Ms. Brown stated Ms. Maulson telephoned "911". Ms. Brown stated police arrived shortly after 07:00 AM and Resident A was transported to the funeral home.

On 10/07/2022 I interviewed staff Danasia Vaughn via telephone. Ms. Vaughn stated that she has worked at the facility for approximately "3 weeks". Ms. Vaughn stated that she worked at the facility from 09/24/2022 03:00 PM until 09/25/2022 07:00 AM. Ms. Vaughn stated from 09/24/2022 11:00 PM until 09/25/2022 07:00 AM she worked with "agency staff" Jada McClenton-Russel. Ms. Vaughn stated during that time staff Stephanie Brown worked at Cambridge North. Ms. Vaughn stated that at approximately 08:00 PM she helped Resident A change into her pajamas and helped her into bed. Ms. Vaughn stated at 08:00 PM Resident A appeared, "fine and happy", and she was "talking". Ms. Vaughn stated Resident A exhibited no signs of distress at 08:00 PM. Ms. Vaughn stated that resident bedtime checks, "start around 11:00 PM". Ms. Vaughn stated that to her knowledge, "no one checked on (Resident A) until 02:00 PM", at which time Ms. Vaughn attempted to do so. Ms. Vaughn stated that at approximately 02:00 AM Ms. Vaughn attempted to open Resident A's bedroom door but the door was locked. Ms. Vaughn stated she doesn't know who locked Resident A's bedroom door and the safety pin to open the lock was missing. Ms. Vaughn stated that due to Resident A's bedroom door being locked no staff observed Resident A between approximately 02:00 AM and 05:00 AM. Ms. Vaughn stated that Ms. McClenton-Russel was able to locate the safety

pin and opened Resident A's bedroom door at approximately 05:00 AM. Ms. Vaughn stated she was providing "morning cares" at 05:00 AM. Ms. Vaughn stated that at approximately 05:00 AM Ms. McClenton-Russel told Ms. Vaughn that Resident A was deceased in her bed. Ms. Vaughn stated she immediately went to Resident A's bedroom and observed that Resident A had "passed". Ms. Vaughn stated she had "no idea" how long Resident A had been deceased. Ms. Vaughn stated that she felt unprepared to handle the situation given that she was a new staff. Ms. Vaughn stated she continued getting residents up while Ms. McClenton-Russel left the facility and located staff Stephanie Brown at Cambridge North for assistance. Ms. Vaughn stated Ms. Brown telephoned the police at 7:00 AM and the sheriff arrived shortly thereafter.

On 10/10/2022 I interviewed staff Jada McClenton-Russel via telephone. Ms. McClenton-Russel stated she worked at the facility from 09/24/2022 11:00 PM until 09/25/2022 7:00 AM with staff Danaisha Vaughn. Ms. McClenton-Russel stated the 09/24/2022 third shift was her first day working at the facility. Ms. McClenton-Russel stated that at 2:00 AM Ms. Vaughn reported to Ms. McClenton-Russel that Resident A's bedroom door was locked. Ms. McClenton-Russel stated that between 5:00 AM and 6:00 AM she started awakening residents. Ms. McClenton-Russel stated she could not recall the exact time but recalled that, "closer to 06:00 AM" she observed Resident A's bedroom door was still locked therefore Ms. McClenton-Russel obtained a "pin key" located "on the cart" and unlocked Resident A's bedroom door. Ms. McClenton-Russel stated she immediately observed Resident A was in her bed unresponsive. Ms. McClenton-Russel stated Resident A, "looked like she had been there for a while" as evidenced by her body appearing "cold and stiff". Ms. McClenton-Russel stated Resident A lacked a pulse and was deceased. Ms. McClenton-Russel stated she informed staff Stephanie Brown who was working at separate facility of Resident A's death. Ms. McClenton-Russel stated Ms. Brown left the facility she was working at, "assessed" Resident A as deceased in her bed, and "made calls". Ms. McClenton-Russel stated she proceeded to get other residents up while Ms. Brown made calls for assistance. Ms. McClenton-Russel stated law enforcement arrived at the facility at approximately 7:00 AM.

On 10/10/2022 I interviewed Relative 2, Resident A's Power of Attorney and brother. Relative 2 stated Resident A resided at the facility for a short time until her death. Relative 2 stated he was informed of Resident A's death on 09/25/2022 at approximately 7:00 AM. Relative 2 stated there were no signs of trauma and no autopsy was completed.

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but requested time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.15204	**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.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Staff Maranda Maulson stated that on 09/25/2022 she entered the facility at approximately 7:00 AM and was immediately informed by staff Stephanie Brown that Resident A had been discovered deceased earlier that morning. Ms. Maulson stated Ms. Brown asked her what staff are supposed to do if they discover a resident is not responsive, cold, and stiff. Staff Stephanie Brown stated that she worked from 11:00 PM 09/24/2022 until 7:00 AM 09/25/2022 at Cambridge North. Ms. Brown stated, "agency staff" Jada McClenton-Russel and staff Danasia Vaughn were both working overnight at Cambridge South from 09/24/2022 to 09/25/2022. Ms. Brown stated that at approximately 6:45 AM Ms. McClenton-Russel entered Cambridge North and stated Resident A was deceased in her bed at Cambridge South. Ms. Brown reported that Ms. McClenton-Russel stated she did not know what to do regarding Resident A's death. Ms. Brown stated she left Cambridge North, entered Cambridge South, and observed Resident A deceased in her bed. Ms. Brown stated she has never encountered a resident death in which hospice wasn't involved, therefore she telephoned management to request instructions regarding how to handle the situation, but no one answered. Staff Danasia Vaughn stated at approximately 5:00 AM 09/25/2022 Resident A was observed deceased in her bed. Ms. Vaughn stated that she felt unprepared to handle the situation given that she was a new staff. Ms. Vaughn stated staff Stephanie Brown telephoned the police at 7:00 AM and the sheriff arrived shortly thereafter. There is a preponderance of evidence to substance violation of R 400.15204 (2).
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: The facility staffing schedule lacks required information.

INVESTIGATION: On 09/28/2022 I completed an unannounced onsite investigation at the facility and interviewed Regional Director Amanda Beacham. Licensing Consultant Megan Aukerman was present during the inspection. Ms. Beacham stated that due to "staff call-ins" both herself and Licensee Designee Connie Clauson have worked at the facility but failed to add that information to the staffing schedules.

On 10/03/2022 I received an email from Staff Rebecca Jiggens which I reviewed contained staffing schedules for the September 2022. I observed that the staffing schedules were poorly constructed and difficult to decipher. I observed that the staffing schedules were not updated and did not document when all staff started and ended their shifts.

On 10/06/2022 I interviewed staff Stephanie Brown via telephone. Ms. Brown stated that the staffing schedule is "never updated" to include staffing "call offs".

On 10/06/2022 I interviewed staff Jennifer Davidson. Ms. Davidson stated the facility staffing schedule is "never updated" to reflect staff "call ins". Ms. Davison stated that the staff schedule is neither clear nor discernable.

On 10/14/2022 I interviewed staff Rebecca Jiggens via telephone. Ms. Jiggens stated she observed the facility staffing schedule appears "hard to read and doesn't make sense".

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but requested time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	Regional Director Amanda Beacham stated administrative staff have been filling in shifts to assist with resident care. Ms. Beacham stated there have been dates in which administrative staff have assisted with resident care however the facility staffing schedule was not updated to reflect this. I reviewed contained staffing schedules for the September 2022. I observed that the staffing schedules were poorly constructed and difficult to decipher. I observed that the staffing schedules were not updated, easily discernable, and did not document when all staff started and ended their shifts. Staff Rebecca Jiggens stated she observed the facility staffing schedule appears “hard to read and doesn’t make sense”. There is a preponderance of evidence to substance violation of R 400.15208 (3).
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident Assessment plans are incomplete.

INVESTIGATION: On 09/30/2022 I completed a licensing file review. I observed that special investigation 2022A0583039 indicates that on 08/5/2022 the facility violated licensing rule 400.14301 (4) due to Resident Assessment Plans not being completed annually and without the appropriate signatures. I reviewed that the corrective action plan was signed by Licensee Designee Connie Clawson on 08/30/2022.

On 10/03/2022 I received an email from Staff Rebecca Jiggens which I reviewed contained Resident Evaluations for the following residents:

Resident D’s Resident Evaluation is signed by his legal decision maker on 07/21/2022 but is not signed by the Licensee Designee or Administrator.

Resident E’s Resident Evaluation is signed 07/28/2020.

Resident F’s Resident Evaluation is signed by her on 07/18/2022 but lacks the required signature of the Licensee Designee or Administrator.

Resident G’s Resident Evaluation lacks all required signatures but was completed by staff Robin Rogers 08/15/2022.

Resident H’s Resident Evaluation is signed by the resident but lacks the date the document was signed. Resident H’s document is not signed by the Licensee

Designee or Administrator. Resident H's document is signed by staff Robin Rogers on 03/30/2022.

Resident I's Resident Evaluation is signed by the resident's legal decision maker on 05/13/2022 but lacks the signature of the Licensee Designee or administrator.

On 10/03/2022 I received an email from Staff Rebecca Jiggens which I reviewed contained a Resident Evaluation for Resident J. I reviewed that the document is from Resident J's previous facility. I reviewed that the document is signed by her legal decision maker on 09/24/2021 and is not signed by the Licensee Designee or administrator.

On 10/03/2022 I received an email from Staff Rebecca Jiggens which I reviewed contained a Resident Evaluation for Resident K. I reviewed that the document is from Resident K's previous facility. I reviewed that the document is signed 07/13/2020.

On 10/04/2022 I received an email from staff Rebecca Jiggens that confirmed Assessment Plans have not been completed for the Resident J and Resident K despite Resident J residing at the facility since 09/08/2022 and Resident K residing at the facility since 07/05/2022.

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but requested time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident D's Resident Evaluation is signed by his legal decision maker on 07/21/2022 but is not signed by the Licensee Designee or Administrator. Resident E's Resident Evaluation is signed 07/28/2020.

	Resident F's Resident Evaluation is signed by her on 07/18/2022 but lacks the required signature of the Licensee Designee or Administrator. Resident G's Resident Evaluation lacks all required signatures but was completed by staff Robin Rogers 08/15/2022. Resident H's Resident Evaluation is signed by the resident but lacks the date the document was signed. Resident H's document is not signed by the Licensee Designee or Administrator. Resident H's document is signed by staff Robin Rogers on 03/30/2022. Resident I's Resident Evaluation is signed by the resident's legal decision maker on 05/13/2022 but lacks the signature of the Licensee Designee or administrator. I reviewed contained a Resident Evaluation for Resident J. I reviewed that the document is from Resident J's previous facility. I reviewed that the document is signed by her legal decision maker on 09/24/2021 and is not signed by the Licensee Designee or administrator. I received an email from Staff Rebecca Jiggens which I reviewed contained a Resident Evaluation for Resident K. I reviewed that the document is from Resident K's previous facility. I reviewed that the document is signed 07/13/2020. On 10/04/2022 I received an email from staff Rebecca Jiggens that confirmed Assessment Plans have not been completed for the Resident J and Resident K despite Resident J residing at the facility since 09/08/2022 and Resident K residing at the facility since 07/05/2022. There is a preponderance of evidence to substance violation of R 400.15301 (4).
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED 2022A0583039 (08/5/2022)**

ADDITIONAL FINDINGS: Facility staff failed to record Resident D's weight monthly.

INVESTIGATION: On 10/06/2022 I received an email from Relative 1. I reviewed that the email stated "Here is Resident D's weight chart from the facility. He moved

to South hall in June. There isn't any documentation for June.,July or August. Going back to his May weight until the most recent weight, he is down 24 pounds."

I observed that the email contained a document entitled Resident Weight Record for Resident D. I observed the document indicated no weights were recorded for June 2022, July 2022, and August 2022. I observed the weight record indicated that in September 2022 Resident D weighted 205.2 lbs. and in October 2022 he weighed 194.6 lbs.

On 10/07/2022 I received and reviewed an email from staff Rebecca Jiggens. I reviewed that the email stated "Attached is the weight record I have for Resident D. At this time, weights for August and September 2022" cannot be located. I reviewed that the weight record indicated that August 2022 and September 2022 weights were absent. I reviewed that the weight record indicated that Resident D was admitted to the facility on 06/10/2022 and weighed 216 lbs. I reviewed that the weight record indicated Resident D weighed 212.4 lbs. on 07/2022 and 194.6 lbs. on 10/2022.

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but requested time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	I received and reviewed an email from staff Rebecca Jiggens. I reviewed that the email stated "Attached is the weight record I have for Resident D. At this time, weights for August and September 2022" cannot be located. I reviewed Resident D's weight record indicated that August 2022 and September 2022 weights were absent. There is a preponderance of evidence to substance violation of R 400.15310 (3).
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: The facility did not provide Resident D with meals no more than 14 hours apart.

INVESTIGATION: On 10/04/2022 I interviewed Relative 1 via telephone. Relative 1 stated that on a "Friday in September" 2022, she entered the facility at approximately 10:15 AM and observed "all the hallway" lights in the facility "were dark" and "no staff were visible". Relative 1 stated she immediately entered Resident D's bedroom and observed that he was still in bed and had not had breakfast. Relative 1 stated Resident D requires staff assistance with dressing, two staff for assistance with safe transfers, and is wheelchair bound. Relative 1 stated she could not locate any staff to provide Resident D with assistance therefore she "walked over to administration" and located staff Rebecca Jiggens who then aided Resident D with transferring from his bed to his wheelchair, dressing, and securing breakfast. Relative 1 stated Resident D did not receive breakfast that morning until after 10:30 AM.

On 10/05/2022 I interviewed staff Rebecca Jiggens via telephone. Ms. Jiggens reported that "the first week of my employment" on an unknown date in September 2022 she was in her office working with staff Robin Rogers. Ms. Jiggens stated at approximately 10:00 AM Relative 1 entered the office and informed Ms. Jiggens that Resident D was still in bed and no staff were to be found to assist him. Ms. Jiggens stated she and Ms. Rogers left her office and assisted Resident D with dressing, grooming, and transferring into his wheelchair. Ms. Jiggens stated at approximately 10:30 AM she assisted Resident D to the communal dining area, and he was served breakfast. Ms. Jiggens stated that Resident D was served dinner at 5:30 PM the preceding day which indicates Resident D went 17 hours between meals.

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but requested time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

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:	Relative 1 stated that on a "Friday in September" 2022, she entered the facility at approximately 10:15 AM and Resident D was still in bed and had not had breakfast. Relative 1 stated

	Resident D did not receive breakfast that morning until after 10:30 AM. Staff Rebecca Jiggens reported that “the first week of my employment” on an unknown date in September 2022 she was in her office working with staff Robin Rogers. Ms. Jiggens stated at approximately 10:00 AM Relative 1 entered the office and informed Ms. Jiggens that Resident D was still in bed and no staff were to be found to assist him. Ms. Jiggens stated she and Ms. Rogers left her office and assisted Resident D with dressing, grooming, and transferring into his wheelchair. Ms. Jiggens stated at approximately 10:30 AM she assisted Resident D to the communal dining area, and he was served breakfast. Ms. Jiggens stated that Resident D was served dinner at 5:30 PM the preceding day which indicates Resident D went 17 hours between meals. There is a preponderance of evidence to substance violation of R 400.15313 (1).
CONCLUSION:	**VIOLATION ESTABLISHED**

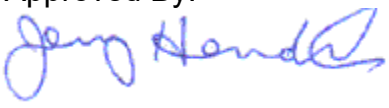
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license be changed to Provisional as a result of the above-cited quality of care violations.

10/25/2022

Toya Zylstra Date
Licensing Consultant

Approved By:



10/25/2022

Jerry Hendrick Date
Area Manager