GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 1, 2022

Gladys Sledge
Packard Group Inc
P.O. Box 2066
Southfield, MI 48037

RE: License #: AS630367512
Investigation #: 2023A0605003
Woodward Group Home

Dear Ms. Sledge:

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630367512
Investigation #:	2023A0605003
Complaint Receipt Date:	10/24/2022
Investigation Initiation Date:	10/25/2022
Report Due Date:	12/23/2022
Licensee Name:	Packard Group Inc
Licensee Address:	Suite 303 731 Pallister Street Detroit, MI 48202
Licensee Telephone #:	(248) 626-3837
Administrator/Licensee Designee:	Gladys Sledge
Name of Facility:	Woodward Group Home
Facility Address:	2563 Lahser Road Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 335-0946
Original Issuance Date:	07/16/2015
License Status:	REGULAR
Effective Date:	01/16/2022
Expiration Date:	01/15/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 10/11/2022 while DCW, Anthony Bass was assisting Resident A, with a shower, Resident A began to shake and fell hitting his cheek which caused bruising and swelling. There was a dollar size bruise on his cheek. On 10/24/2022, Resident B choked on a jumbo marshmallow while DCS Shelby Langowski and DCS Anthony Bass were on shift. Resident B's food must be cut into 1-inch by 1-inch pieces.	Yes

III. METHODOLOGY

10/24/2022	Special Investigation Intake 2023A0605003
10/25/2022	APS Referral Adult Protective Services (APS) denied referral.
10/25/2022	Referral - Recipient Rights Oakland County Office of Recipient Rights (ORR) made referral.
10/25/2022	Special Investigation Initiated - Telephone Discussed allegations with ORR worker Aaron Winston.
10/25/2022	Contact - Telephone call received From ORR Aaron Winston.
10/25/2022	Contact - Document Received Received email from ORR Aaron Winston.
10/26/2022	Inspection Completed On-site I conducted an unannounced on-site investigation. Present was the home manager (HM) Cora Smith, direct care staff (DCS) Shelby Langowski, Resident A and Resident C.
10/26/2022	Contact - Document Received Email from ORR Aaron Winston.
11/02/2022	Contact - Telephone call made Interviewed DCS Anthony Bass regarding the allegations. Left message for DCS Shade Twinny.

11/03/2022	Contact - Telephone call received Interviewed DCS Shade Twinny regarding the allegations.
11/03/2022	Contact - Telephone call made Discussed allegations with APS worker Heather Goodin.
11/07/2022	Contact - Document Received Email from ORR Aaron Winston.
11/16/2022	Contact - Telephone call made Interviewed Resident A's mother/guardian and followed up with the HM and DCS Shelby Langowski.
11/16/2022	Contact - Document Sent Email to licensee designee Gladys Sledge requesting DCS Anthony Bass and DCS Shelby Langowski's training documents.
11/23/2022	Contact - Telephone call made Left message for licensee designee Gladys Sledge.
11/30/2022	Contact - Telephone call made Telephone call with Packard Group's Vice President Kenneth Sledge.
11/30/2022	Exit Conference Telephone call with Packard Group, LLC Vice President Kenneth Sledge who will have licensee designee Gladys Sledge call me to conduct the exit conference.
	Add exit conference with the LD

ALLEGATION:

- **On 10/11/2022 while DCW, Anthony Bass was assisting Resident A, with a shower, Resident A began to shake and fell hitting his cheek which caused bruising and swelling. There was a dollar size bruise on his cheek.**
- **On 10/24/2022, Resident B choked on a jumbo marshmallow while DCS Shelby Langowski and DCS Anthony Bass were on shift. Resident B's food must be cut into 1-inch by 1-inch pieces.**

INVESTIGATION:

On 10/25/2022, intake #191254 was referred by Oakland County Office of Recipient Rights (ORR) regarding Resident A had a seizure and fell in the bathroom with direct care staff (DCS) Anthony Bass on 10/11/2022. During this investigation, another intake #191306 was received from Adult Protective Services (APS) regarding Resident B

choked on marshmallows that were left out on the counter and 911 had to be contacted on 10/22/2022. Resident B's food must be cut in one-half inch size.

On 10/25/2022, I initiated this special investigation by discussing these allegations with ORR worker Aaron Winston. Mr. Winston will be investigating these allegations. He will email me Resident A's crisis plan and Resident B's IPOS. On 10/25/2022, I received a telephone call from ORR Arron Winston regarding the allegations. Mr. Winston advised he will be conducting an on-site investigation on Friday 10/28/2022 along with APS.

On 10/25/2022, I received an email from ORR Aaron Winston with Resident A's crisis plan completed by Macomb-Oakland Regional Center (MORC) effective date of 02/01/2022. According to the crisis plan, "Resident A requires hands-on assistance during bathing to ensure his body is clean and washed appropriately. Staff need to assist in drying him and to ensure the water is adjusted. In addition, before a seizure, Resident A's gait may become unsteady or will become louder, family has also reported that his breathing will sound louder, and he gets a dazed look on his face. Resident A's seizures can last up to two-minutes. Staff should utilize Nayzilam nasal spray in one nostril. If seizures las longer than 10-minutes, administer a second nasal spray."

On 10/26/2022, I conducted an unannounced on-site investigation. Present was the HM Cora Smith, DCS Shelby Langowski, Resident A and Resident C. Residents B, D, and E were at workshop. Resident A is non-verbal and was not interviewed regarding these allegations. I observed Ms. Langowski assisting Resident A in walking as his gait was unsteady. Resident A was observed to have good hygiene and dressed appropriately for the day. Resident C is verbal, but when attempting to interview him, he was unable to provide any details to the allegations.

I interviewed the HM regarding the allegations pertaining to Resident A. The HM began working for this corporation on 08/08/2022. She works the first shift. She stated that Resident A is a full-assist in the shower and there is a shower chair in the shower that is utilized for all the residents. The HM stated whenever she showers Resident A, she has Resident A hold onto the bar in the shower with both of his hands. The HM will grab one arm while Resident A is holding the bar with his other hand and begin to wash him. She will then place that hand back onto the bar and grab his other arm and wash his other side. The HM stated she will sit him on the shower chair, grab the towel and dry him off. She reported therefore she does not know how Resident A fell on 10/11/2022 while DCS Anthony Bass was showering Resident A.

The HM received a telephone call from DCS Shade Twinny who was on shift with Mr. Bass on 10/11/2022. Ms. Twinny told the HM that Mr. Bass came out of the bathroom running to Ms. Twinny stating that Resident A had a seizure and fell on his face in the shower. The HM advised Ms. Twinny to notify Resident A's mother who is the guardian. Ms. Twinny called Resident A's who told Ms. Twinny that Resident A, "will be ok," and that "Resident A did not need to go to the hospital." The HM stated that the mother came to Woodward Group Home the next day and picked Resident A up but did not take Resident A to the hospital even though Resident A had a large bruise on the left

side of his face underneath his eye. The HM stated that Ms. Twinny also advised the HM that Ms. Twinny administered the Nayzilam spray in one of Resident A's nostril as indicated to do so in Resident A's IPOS. The HM stated that Ms. Twinny did not inform the HM how long the seizure was. The HM stated whenever Resident A has a seizure, the policy is to document the seizures length of time on the "Seizure Calendar," form in Resident A's book. The HM asked DCS Anthony Bass what happened, and Mr. Bass stated, "I was standing right there with Resident A, he started shaking and fell." The HM does not believe that Mr. Bass utilized the shower chair; therefore, when Resident A had the seizure, it was too late for Mr. Bass to catch Resident A. The HM stated that Resident A does not have a script for the shower chair. She stated that the shower chair had been in the shower since she began working at Woodward Group Home and was advised by the previous HM to utilize the shower chair for all the residents. The HM stated that she was also informed by the previous HM that whenever any of the residents fall, their guardians and/or family is contacted and that the guardian and/or family will make the determination if the resident needs to go to the hospital. The HM stated that Mr. Bass has been suspended and removed from the staff schedule pending this investigation.

I reviewed the "Seizure Calendar," form and there was no documentation on 10/11/2022 as to the length of Resident A's seizure. I also reviewed Resident A's medication log on 10/11/2022 and there was no initial in the box or a reason recorded of Ms. Twinny administering the Nayzilam spray to Resident A.

During the onsite, I went into the bathroom where Resident A had his seizure and fell and saw that the shower floor did not have a non-skid surface and there was a shower chair sitting inside the shower. The HM stated the staff use a rubber mat which was sitting on the shower bar.

I interviewed DCS Shelby Langowski regarding the allegations pertaining to Resident A. Ms. Langowski has been working for this corporation since 08/09/2022. She works first shift from 7AM-11PM. Ms. Langowski was not present on 10/11/2022 when Resident A had a seizure and fell in the shower with DCS Anthony Bass. Ms. Langowski stated whenever she showers Resident A, she has Resident A hold the shower bar with both hands and takes one of his arms and puts it on her shoulder while she washes him. She then puts Resident A's arm back on the bar and removes his other arm placing it on her shoulder and washes his other side. She stated that she never leaves Resident A unattended and that he has never fallen with her. Ms. Langowski is unsure how Resident A fell because if Mr. Bass had been fully assisting Resident A with the shower, Resident A would not have fallen. Ms. Langowski stated whenever Resident A has a seizure, policy is to document the length of the seizure in the "Seizure Calendar," form. She stated she reviewed the "Seizure Calendar," form and there is no documentation noted of a seizure for Resident A on 10/11/2022. Ms. Langowski stated she and the rest of the staff have been trained on documenting all seizures on the form which is in the medication book.

Ms. Langowski stated on 10/22/2022, she worked with DCS Anthony Bass from 7AM-11PM. Around 8:15PM, Resident B was sitting at the dining room table. Ms. Langowski pulled out the jumbo marshmallow bag and placed it on the counter. She stated she was going to cut the marshmallows in small pieces for both Resident A and Resident B. However, she went to help Resident A up from the recliner in the living room and left the bag of marshmallows on the counter. Ms. Langowski stated that Mr. Bass was in the front room "probably," watching TV. Ms. Langowski stated as she was helping Resident A, she saw Resident B get up from the dining room table and walk towards the front room. Ms. Langowski stated then she heard something "fall." Mr. Bass came to the kitchen advising Ms. Langowski that Resident B fell. Ms. Langowski told Mr. Bass that Resident B was "just having a behavior/tantrum," because "Resident B did not get what she wanted immediately, the marshmallow." Ms. Langowski had advised Resident B to "wait," until she (Ms. Langowski) was done helping Resident A. Ms. Langowski stated that Resident B's behavioral plan states that, "staff must allow Resident B to "ride out the behaviors." Ms. Langowski stated after she was done helping Resident A, she went to the hallway, turned on the light and saw that Resident B was choking and her face was blue. Ms. Langowski stated she took out the marshmallow from her mouth and that Mr. Bass began CPR. Ms. Langowski then called 911. She stated that dispatch told her to do begin CPR which she did and then the paramedics arrived. Ms. Langowski stated that the paramedics took Resident B to the hospital. Ms. Langowski then called the HM and informed her what happened. Ms. Langowski stated that Residents C and D were in their bedrooms and Resident E was sitting in the living room with Resident A. Ms. Langowski stated Resident B's food must be cut into one-inch by one-inch pieces and that the jumbo marshmallow left on the counter was not cut into one-inch by one-inch pieces therefore, resulting in Resident B choking when she grabbed one from the counter and ate it without Ms. Langowski's knowledge. She reported this was an isolated incident.

On 11/02/2022, I interviewed DCS Anthony Bass via telephone regarding the allegations. Mr. Bass stated he began employment with this corporation on 09/30/2022. He stated he had not completed any of his trainings; however, he has had experience in the intensive care unit at a hospital and had been working with a home health care agency for about five years. Mr. Bass stated he worked on 10/11/2022 with DCS Shade Twinny. This was his first-time assisting Resident A in the shower. Mr. Bass stated the shower went well as Resident A had both hands on the shower bar while Mr. Bass was washing Resident A's body. Mr. Bass stated he was done washing Resident A and turned off the shower. Mr. Bass stated he leaned over to grab the towel and that's when Resident A had a seizure and fell forward on his face. Mr. Bass checked Resident A all over and stated, "he (Resident A) was fine, but had a bump on his left cheek." Mr. Bass stated he picked Resident A up off the floor, took Resident A into his bedroom, dried him up and put his clothes on. Mr. Bass stated he then informed Ms. Twinny what happened. Mr. Bass stated that Ms. Twinny asked him if he completed a safety check on Resident A and Mr. Bass stated, "Yes." Mr. Bass stated that Ms. Twinny contacted Resident A's mother who is the guardian and that the mother advised Ms. Twinny that since Mr. Bass conducted a safety check and that Resident A was "fine," there was no need to seek medical treatment. Mr. Bass stated that he monitored Resident A

throughout his shift and that Resident A was "Ok." Mr. Bass stated that he did not witness Ms. Twinny administer any spray inside Resident A's nostril and stated that the seizure only lasted one minute. Mr. Bass stated he was never informed to document Resident A's seizure on the "Seizure Calendar," because, "I haven't completed any of the trainings."

Mr. Bass stated that he and DCS Shelby Langowski worked on 10/22/2022 when Resident B choked. Mr. Bass stated that he still had not completed any of his required trainings and was responsible for the male residents, Residents A, C, E and Ms. Langowski was responsible for the female residents, Residents B and D. Mr. Bass stated that Resident A and Resident B were sitting in the living room and Resident C was in his bedroom. Mr. Bass stated he went to the front room to grab something and when he came out of the front room, he saw Resident B on the floor and Ms. Langowski standing in the hallway. Ms. Langowski told Mr. Bass that "Resident B was having one of her tantrums." Mr. Bass stated the light was off. He stated he then left Ms. Langowski with Resident B and went to the living room to check on Residents A and E. He stated a few minutes later, he returned to the hallway, Resident B was still on the floor and Ms. Langowski was asking Resident B to "get up." Mr. Bass stated the light was still off, so he turned the light on and noticed that Resident B's face was blue. Mr. Bass stated he told Ms. Langowski to call 911 and then he immediately turned Resident B on her side to assist in getting whatever she had in her mouth out and then began chest compressions. Mr. Bass stated that Ms. Langowski was panicked as he was attending to Resident B and he told Ms. Langowski to calm down and call 911. Mr. Bass stated while Ms. Langowski was on the phone with 911, she was advised by the dispatcher to continue chest compressions. Mr. Bass stated Ms. Langowski took over chest compressions and minutes later, the paramedics arrived. When the paramedics arrived, the paramedics continued chest compressions and Resident B began responding and then was given oxygen. Mr. Bass stated that Ms. Langowski left with paramedics who transported Resident B to the hospital.

Mr. Bass stated afterwards he noticed a chewed marshmallow on the floor and figured that is what Resident B was choking on. Mr. Bass stated that Ms. Langowski left the bag of marshmallows on the counter after she gave Resident A some marshmallows. Mr. Bass stated that to his knowledge, Resident A did not have a seizure on 10/22/2022 and that Ms. Langowski was never attending to Resident A as Ms. Langowski was standing in the hallway watching Resident B on the floor. Mr. Bass stated that Ms. Langowski is aware that he had not had any of his trainings completed, but left Mr. Bass unsupervised with Residents A, C, D, and E. Mr. Bass stated he was with the residents unsupervised until 11PM when another staff arrived at the home. Mr. Bass stated he has been suspended but that Ms. Langowski has not.

On 11/03/2022, I received a return call from Shade Twinny regarding the allegations. Ms. Twinny stated she has been with the corporation for five months and has completed all her trainings. Ms. Twinny stated on 10/11/2022, she worked her shift with DCS Anthony Bass. She began work at 3PM and checked on all the residents before getting on the telephone with the pharmacy. Ms. Twinny was sitting in the office when Mr. Bass

came to her and told her that Resident A had a bowel movement that spilled on Resident C's legs and that Mr. Bass wanted to shower Resident A. Ms. Twinny stated she put the pharmacy on hold and gathered Resident A's clothes and Resident A's towel and placed them in the bathroom and left to return to the office. Ms. Twinny stated there is a shower chair in the shower that is used for all the residents. Ms. Twinny stated she does not believe that Resident A has a written authorization script from Resident A's physician for the use of the shower chair. She stated, "all staff know to use the shower chair with Resident A because of his seizures." Ms. Twinny stated later Mr. Bass came to her saying that Resident A had a seizure and fell forward on his face. Ms. Twinny stated she immediately administered the Nayzilam nasal spray in one of Resident A's nostril and then called Resident A's mother/guardian. Ms. Twinny explained to the mother that Resident A had a seizure, fell, and there was a bump underneath his left eye. Ms. Twinny stated that the mother advised her that Resident A will be ok and not to take him to the hospital. Ms. Twinny stated that she and Mr. Bass monitored Resident A throughout the day and that Resident A was "fine." Ms. Twinny stated she was not aware that Mr. Bass was not trained because if she knew, she would not have allowed Mr. Bass to shower Resident A.

Ms. Twinny stated she was not present on 10/22/2022 when Resident B choked. Ms. Twinny stated she heard from staff many different versions of what happened to Resident B, but that the stories being told that were inconsistent. Ms. Twinny stated she had only worked with Mr. Bass once and did not know him well.

On 11/03/2022, I received a telephone call from APS Heather Goodin. Ms. Goodin stated she was advised that on 10/22/2022, regarding Resident C choking, that Ms. Langowski left to go to the hospital with Resident C leaving Mr. Bass alone unsupervised with the residents. Ms. Goodin stated that Mr. Bass had not completed any of his trainings. Ms. Goodin stated she will be substantiating her case for neglect.

On 11/07/2022, I receive an email from ORR Aaron Winston. Mr. Winston retrieved the 911 call from Bloomfield Hills Police Department due to conflicting stories of who did what during the event by both DCS Anthony Bass and DCS Shelby Langowski. I listened to the 911 call and according to the call I obtained the following information: "Ms. Langowski made the 911 call while Mr. Bass was in the hallway with Resident B. Dispatched asked what happened. Ms. Langowski stated, "I got my eyes off her just for a second to get something and then I heard a thump on the floor, and she started crawling and I thought she was having a behavior. I told her to lay on her back and she laid on her side. Dispatch advised Ms. Langowski to go by Resident B, which she did and then dispatch advised Ms. Langowski to complete chest compressions. Mr. Bass was heard stating that Resident B was bleeding from her mouth. Ms. Langowski began chest compressions and stated Resident B was trying to say something and face was still blue. Ms. Langowski stated she does not see anything in her mouth and breaths was still shallow. Ms. Langowski continued chest compressions until the paramedics arrived."

On 11/16/2022, I contacted Resident A's mother via telephone and discussed the allegations. Resident A's mother stated she is also Resident A's legal guardian. Resident A is prone to seizures and if his seizures are longer than five-minutes, then staff must administer Nayzilam nasal spray in one of Resident A's nostril. On 10/11/2022, Resident A's mother received a telephone call from DCS Shade Twinny stating that Resident A had a seizure in the shower and fell. Ms. Twinny stated that Resident A was not bleeding, nor did he appear to have any broken bones; however, the mother was advised that Resident A hit his cheek bone on the shower floor. Resident A's mother stated to keep an eye on Resident A and if the cheek bruises to apply ice which staff did. Resident A's mother picked Resident A up the next day and stated he appeared fine with minor bruising under his eye. Resident A's mother did not ask DCS Mr. Bass what happened and stated that when Resident A is given a shower, staff must be in the shower with Resident A who requires full assistance. Resident A's mother stated she assumed Resident A had the seizure and that is why he fell. Resident A's mother stated she has not had any issues from staff and that staff have been great about keeping her abrupt of all issues pertaining to Resident A. Resident A's mother stated that Resident A had a seizure at her home on 11/13/2022 that required him to go to the hospital. Resident A's mother had the hospital check Resident A's face and the physician informed her that there are no concerns. Resident A's mother stated she will work with MORCs supports coordinator to update Resident A's plan to include seeking immediate medical attention if Resident A falls and hits his head and/or face.

On 11/16/2022, I received the following email from ORR Arron Winston: "Resident B has very limited expressive communication skills beyond what staff/family that know her well. Her communication is mostly gesturing/seeking out items she wants, and some limited vocalizations. I have not completed my investigation yet, but as of now I had a feeling that both staff (DCS Shelby Langowski and Anthony Bass) would be substantiated, given they were both on shift and her getting into food that did not meet her mealtime guidelines."

On 11/16/2022, I followed up via telephone with DCS Shelby Langowski. Ms. Langowski stated on 10/22/2022, she was attending to Resident A while Resident B was on the floor in the hallway because Resident A was having a seizure. Ms. Langowski stated Mr. Bass was in the front room and did not attend to Resident A. Ms. Langowski stated she did accompany Resident B to the hospital because Resident B was more responsive to Ms. Langowski than Resident B was to the paramedics. Ms. Langowski stated she left the other residents with Mr. Bass. Ms. Langowski stated she "assumed Mr. Bass had completed his training," but she does not know if he had because she had only worked with him twice.

On 11/16/2022, I followed up via telephone with the HM Cora Smith. Ms. Smith stated she has received conflicting stories of what happened on 10/22/2022 from DCS Shelby Langowski and Anthony Bass. Ms. Langowski told the HM she was "dealing with Resident A having a seizure," and, "Anthony was in the front room." Ms. Langowski stated, "she (Shelby) turned on the lights in the hallway and noticed that Resident A's

face was blue," and that "Anthony called 911 while she did chest compressions." The HM stated Mr. Bass told the HM that "Shelby was in the hallway with Resident B," and "Shelby told Anthony that Resident B was having a behavior." Mr. Bass told the HM that, "he (Anthony) turned on the hallway light and noticed Resident B's face blue." Mr. Bass then told the HM that, "he (Anthony) did chest compressions," and that, "Shelby called 911." The HM sated she does not know what exactly happened because of the conflicting stores. The HM stated that Mr. Bass had not completed any of his trainings but because "Anthony worked at the hospital, he must have completed training." The HM stated that Mr. Bass did remain unsupervised with the residents when Ms. Langowski left with the paramedics accompanying Resident B to the hospital.

On 11/30/2022, I left message with Packard Group's Vice President Kenneth Sledge to have licensee designee Gladys Sledge return my call to conduct the exit conference. Mr. Sledge stated he will have Ms. Sledge call tomorrow.

On 12/01/2022, I conducted the exit conference via telephone with licensee designee Gladys Sledge and the Regional Manager Dana Pikula regarding my findings. Ms. Sledge advised that she has terminated DCS Anthony Bass' employment with Packard Group and that Ms. Pikula is currently conducting trainings with staff regarding Resident A's seizure protocol. Ms. Sledge stated she and Ms. Pikula will be meeting with all staff regarding Resident B's IPOS and the importance of making sure all items are stored away to prevent Resident B from getting these items and having another choking incident. Ms. Sledge and Ms. Pikula will also be training staff on how to utilize the seizure logs and documentation within Woodward Group Home regarding the residents. Ms. Pikula stated she will complete the trainings with staff and forward the signed in-service sheets to me once completed. Ms. Sledge stated she will submitted a corrective action plan.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based on my investigation and information gathered, DCS Anthony Bass stated he had not completed his reporting requirements, personal care, supervision, and protection,

	resident rights, safety, and fire pretraining but was working unsupervised on 10/11/2022 when he showered Resident A and on 10/22/2022 when he was left unsupervised with Residents A, C, D, and E after DCS Shelby Langowski accompanied Resident B to the hospital after her choking incident.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal Licensing Study Report (LSR) dated 01/12/2022, CAP dated 02/09/2022**

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:	Based on my investigation and information gathered, there was insufficient staff on shift on 10/22/2022 after DCS Shelby Langowski accompanied Resident B to the hospital after her choking incident leaving DCS Anthony Bass who had not completed his training unsupervised with Residents A, C, D, and E.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and information gathered, DCS Anthony Bass did not provide supervision, protection, and personal care of Resident A during his shower on 10/11/2022, resulting in Resident A falling on his face after having a seizure. According to Resident A’s IPOS, Resident A requires hands-on assistance during showers. In addition, DCS Anthony Bass and DCS Shelby Langowski did not provide supervision, protection, and personal care to

	Resident B when Resident B took a jumbo marshmallow from the bag that was sitting on the counter and choked on the marshmallow. According to Resident B's IPOS, her food must be cut into small pieces.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report (SIR) #2022A0605011 dated 12/22/2021, CAP dated 01/11/2022**

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:	Based on my investigation and information gathered, Resident A's and Resident C's protection and safety were not attended to at all times. On 10/11/2022, DCS Anthony Bass who had not completed his personal care, supervision, and protection training showered Resident A. Resident A is a hands-on assist during showers as stated in his IPOS. Mr. Bass stated he turned to grab the towel and Resident A had a seizure and fell on his face in the shower. According to the HM Cora Smith, Resident A would not have fallen on his face during the seizure if Mr. Bass was fully assisting Resident A in the shower. On 10/22/2022, Resident B choked on a marshmallow that was left on the kitchen counter by DCS Shelby Langowski. According to Resident B's IPOS, her food must be cut into bite size and the marshmallow was not cut into bite size when Resident B put it in her mouth.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2022A0605011 dated 12/22/2021, CAP dated 01/11/2022** **SIR #2021A0989005 dated 06/04/2021, CAP dated 06/09/2021**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based on my investigation and information gathered, the HM Cora Smith, DCS Shelby Langowski, and DCS Shade Twinny reported using a shower chair in the shower for Resident A, but the shower chair was not in Resident A's IPOS completed by MORC.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on my investigation and information gathered, there was no written authorization for Resident A to use a shower chair; however, the HM Cora Smith, DCS Shelby Langowski and DCS Shade Twinny stated they use the shower chair whenever they shower Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

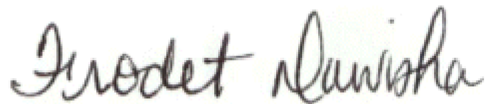
ANALYSIS:	Based on my investigation and review of Resident A's medication log on 10/11/2022, Resident A was given Nayzilam 5MG Nasal Spray; instill one stray into nostril as needed for seizure may repeat in 10 minutes as needed by DCS Shade Twinny, but she did not initial the medication log.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal LSR, dated 01/13/2020, CAP dated 02/21/2020**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	Based on my investigation and review of Resident A's medication log on 10/11/2022, Resident A was given Nayzilam 5MG Nasal Spray; instill one spray into nostril as needed for seizure may repeat in 10 minutes as needed by DCS Shade Twinny, but the reason for this as needed medication was not recorded.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(11) Handrails and nonskid surfacing shall be installed in showers and bath areas.
ANALYSIS:	During the on-site investigation on 10/26/2022, I observed the shower that Resident A used on 10/11/2022 and the shower did not have nonskid surfacing. There was a rubber bathmat sitting on the grab bar in the shower.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend modification of the license to a six-month provisional license.



12/01/2022

Frodet Dawisha
Licensing Consultant

Date

Approved By:

12/01/2022

Denise Y. Nunn
Area Manager

Date