GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 8, 2023

Sulayman Aninure
Anikare AFC
323 E Glenguile
Parchment, MI 49004

RE: License #: AM030412015
Investigation #: 2023A0581025
Anikare's Home

Dear Mr. Aninure:

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 feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030412015
Investigation #:	2023A0581025
Complaint Receipt Date:	03/13/2023
Investigation Initiation Date:	03/15/2023
Report Due Date:	05/12/2023
Licensee Name:	Anikare AFC
Licensee Address:	323 E Glenguile Parchment, MI 49004
Licensee Telephone #:	(269) 254-0241
Administrator:	Sulayman Aninure
Licensee Designee:	Sulayman Aninure
Name of Facility:	Anikare's Home
Facility Address:	328 E Morrell St Otsego, MI 49078
Facility Telephone #:	(269) 254-0241
Original Issuance Date:	06/30/2022
License Status:	REGULAR
Effective Date:	12/31/2022
Expiration Date:	12/30/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's family hired a direct care staff to work with Resident A; however, licensee designee Sulayman Aninure did not obtain a background check prior to the staff working in the home.	No
The facility is short staffed.	No
Facility direct care staff allow Resident B to elope from the facility when she takes her scooter on the main roads.	No
Resident A had sores on his buttocks, which facility direct care staff were not addressing. Resident A was not having his incontinence briefs changed.	No
Additional Findings	Yes

III. METHODOLOGY

03/13/2023	Special Investigation Intake 2023A0581025
03/14/2023	APS Referral- APS received the allegations but denied investigating.
03/15/2023	Special Investigation Initiated - On Site Interviewed residents, staff, licensee designee, and obtained documentation.
03/16/2023	APS Referral- Made referral to Adult Protective Services via email.
03/16/2023	Contact - Telephone call made- Interview with Resident B's case manager of Case Management of Michigan, Laura Boylan.
03/16/2023	Contact - Telephone call made- Interview with Relative A1
03/16/2023	Contact - Document Received- Text message from Licensee Designee.
03/24/2023	Contact - Document Received- Email correspondence from Relative A2
04/17/2023	Contact - Document Received- Home help's wound notes received.
04/17/2023	Contact - Document Sent- Contacted BFS regarding inspection of the home. Received plan review number.

04/17/2023	Inspection Completed On-site- Obtained documentation and interviewed residents.
04/17/2023	Contact - Document Received- April staff calendar from licensee
05/08/2023	Exit conference with licensee designee, Sulayman Aninure

ALLEGATION:

Resident A's family hired a direct care staff to work with Resident A; however, licensee designee did not obtain a background check prior to the staff working in the home.

INVESTIGATION:

On 03/13/2023, I received this complaint through the Bureau of Community Health System (BCHS) online complaint system. The complaint alleged Resident A's family hired a direct care staff "outside of the facility" to come and help with Resident A's care. The complaint alleged the direct care staff did not have a background check completed.

On 03/15/2023, I conducted an unannounced inspection at the facility. I interviewed direct care staff members Alease Terry and Kip Pike. Both Ms. Terry and Mr. Pike stated Mr. Walker's family hired Staff A to come into the facility during the evenings to sit with Resident A in his bedroom. Ms. Terry had little information regarding Staff A as she stated she works only one to two days per week. Mr. Pike was unaware of the reason Staff A was working with Resident A, but stated Staff A had been coming to the facility for approximately one month and would come during the evenings on the weekdays and stay for approximately one hour. He stated Staff A would assist Resident A with getting out of bed, feeding him, and getting him cleaned up.

I interviewed Resident C who stated Resident A had a "nurse" who came "most evenings" for approximately one hour to sit with and feed him. Resident A was not interviewed as he passed away on 03/12/2023.

Licensee designee Sulayman Aninure's, statement to me was consistent with Ms. Terry's and Mr. Pike's statements to me. Mr. Aninure stated Staff A was Resident A's "assistant", who had been hired by Resident A's family. He also stated he was unsure why the family hired Staff A. Mr. Aninure stated Staff A came into the facility for approximately 30 minutes in the evenings to talk or feed Resident A. He stated Resident A did not need any assistance from direct care staff with eating unless a spoon was needed as he indicated Resident A had difficulty holding onto the utensil. He stated Staff A had come into the facility for approximately two or three weeks.

Mr. Aninure stated a background check had not been completed for Staff A as Staff A was not hired by Mr. Aninure.

On 03/16/2023, I interviewed Relative A1, via telephone. Relative A1's statement to me was consistent with Ms. Terry's, Mr. Pike's, and Mr. Aninure's statement to me. Relative A1 stated he hired Staff A, who was a direct care staff at a neighboring nursing facility, to come sit with Resident A a couple evenings a week to check in with Resident A while Relative A1 was out of town for approximately one month. Relative A1 stated Staff A visited with Resident A after she completed work at the nursing home and stayed with Resident A anywhere from one hour to two hours. Relative A1 stated Staff A was extra support to Resident A; she sat with him while he ate, talked to him, and helped or assisted Resident A in any way in which she was comfortable. Relative A1 stated Staff A informed him on how Resident A was doing while he was out of town such as providing updates on Resident A's bowel movements and talking to staff about Resident A's incontinence brief changes. Relative A1 stated Staff A also assisted in changing Resident A's incontinence briefs. Relative A1 stated Mr. Aninure was spoken with about Staff A coming into the facility, but Relative A1 indicated Staff A was not expected to act in the capacity of a direct care staff. Relative A1 also stated Staff A was not expected to work with any of the other residents within in the facility.

On 04/06/2023, I interviewed Staff A, via telephone. Staff A's statement to me was consistent with Relative A1's statement to me. Staff A stated she did not work with any of the other residents in the facility and did not have access to any of their information.

APPLICABLE RULE	
MCL 400.734b	**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 this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). 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.

	On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section 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 (14). 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 but may transfer to another adult foster care facility, mental health facility, or covered health facility. 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 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on my interviews with direct care staff members Alease Terry and Kip Pike, Resident C, licensee designee Sulayman Aninure, Relative A1 and Staff A, Staff A was hired by Relative A1 to sit with Resident A in the evenings for approximately one to two hours during weekdays while Relative A1 was out of town. Staff A visited with Resident A for approximately one month prior to Resident A passing away on 03/12/2023. Though Staff A fed Resident A and changed his incontinence briefs while visiting with him there was no indication Staff A was acting in the capacity of direct care staff, but rather as a companion. Additionally, Staff A neither accessed resident documentation while in the facility or worked with the other residents. As a result of the relationship between Staff A, Relative A1 and Resident A, there was no need for Staff A to have fingerprints completed through the Workforce Background Check.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

The complaint alleged the facility is short staffed and does not have direct care staff members awake during the overnight shifts. No additional information was provided.

Direct care staff members Ms. Terry and Mr. Pike both stated only one direct care staff works 1st shift (7 am until 3 pm); however, Ms. Terry stated she will work as a second staff on Wednesdays during the day to provide additional assistance for residents and licensee designee Sulayman Aninure. Both Ms. Terry and Mr. Pike stated Mr. Aninure resides in the home and will both work during the day and the overnight shift to assist staff as needed. They stated there is an assigned overnight staff, Veronica Johnson, who works the overnight shift three nights a week (Monday, Tuesday, and Wednesday). Mr. Pike stated Resident B requires two direct care staff to transfer her in and out of her bed and into her wheelchair. He stated he assists Mr. Aninure in the morning with Resident B's transfer into her wheelchair. He stated he's able to transfer Resident B by himself; however, he stated it's "easier" with two direct care staff members. Mr. Pike also stated Resident C has assisted him with transferring Resident B by Resident C pressing the button on the Hoyer lift to lift it up and down.

I interviewed Resident B who stated Mr. Aninure sleeps at night, but she can wake him up, if needed; however, she was unable to indicate "how" she would alert him if she needed to. Ms. Hoskins stated she requires the use of a Hoyer to be transferred from her bed into her wheelchair and vice versa. She stated a sling is used during the process. This sling was observed draped over her wheelchair indicating she was sitting on it. She stated it takes two direct care staff to transfer her and indicated it was usually Mr. Pike and Mr. Aninure who assist her with this task.

I interviewed Resident C whose statement to me was consistent with Mr. Pike's statement to me regarding her assistance in and involvement with operating the Hoyer lift with direct care staff. Resident C stated Mr. Aninure sleeps at night if there is not another staff working. She stated if she needs Mr. Aninure at night then she would knock on the door to his living area.

I attempted to interview Resident D; however, due to her impaired mental status she was unable to answer my questions. Resident D's *Health Care Appraisal*, dated 07/29/2022, identified Resident D's diagnoses as "cognitive deficiency" and "forgetfulness". I did not interview Resident E as she was sleeping. I also attempted to interview Resident F and Resident G; however, they also appeared to have impaired mental statuses and were unable to answer my specific questions.

I reviewed Resident B's *Assessment Plan for AFC Residents*, dated 08/16/2022; however, it did not indicate the number of staff needed to transfer Resident B; however, it identified Resident B requiring the use of a wheelchair and Hoyer lift.

I reviewed Resident B's Individual Plan of Service (IPOS), dated 07/23/2022; however, nothing was noted or indicated in this IPOS regarding the number of direct care staff needed to assist Resident B in transferring.

I reviewed Resident B's *Health Care Appraisal (*HCA), which was not dated. The HCA established Resident B requires the use of a wheelchair for ambulation and mobility; however, it did not establish the number of direct care staff in transferring Resident B.

I also reviewed Resident C's, D's, E's, F's and G's assessment plans as well; however, none of them established any of the residents required additional monitoring during the day or night or required the assistance of more than one direct care staff in transferring.

Mr. Aninure's statement to me about working the overnight night and having Ms. Johnson work three nights a week was consistent with Mr. Pike's statement to me. Mr. Aninure stated he is not awake the entire night when he's working with Ms. Johnson but is accessible. Mr. Aninure stated two direct care staff typically transfer Resident B; however, he stated he can transfer her by himself, as well. Additionally, Mr. Aninure's statement regarding Resident C assisting with using the Hoyer lift to transfer Resident B was consistent with Mr. Pike's statement to me. Mr. Aninure stated if Ms. Johnson was working the overnight shift and needed assistance with transferring Resident B then he would assist her.

During the inspection, I reviewed the facility's March 2023 staff schedule that was displayed on a bulletin board. According to the schedule, only one direct care staff, either Mr. Pike or Mr. Aninure, was on the schedule to work the 1st shift throughout the entire month, except Wednesdays when Ms. Terry was on the schedule as a second 1st shift staff. The scheduled identified two direct care staff working the 2nd shift. Mr. Aninure was the only staff on the schedule to work the overnight shift every Thursday through Sunday night except Thursday, March 2, 2023, where it identified both him and Ms. Johnson as working.

On 03/16/2023, I interviewed direct care staff, Veronica Johnson. Ms. Johnson stated she works at the facility approximately three nights per week during the overnight shift, which is 11 pm until 7 am. Ms. Johnson stated Mr. Aninure resides in the facility. She stated when she's working, Mr. Aninure is sleeping, but she remains awake during her shift. She stated if she needs assistance with any of the residents then she wakes Mr. Aninure up by either messaging or calling him or knocking on the door to his living area.

She stated when she's not working the overnight shift, Mr. Aninure is working by himself because there aren't any other staff who work the overnight schedule. She stated it was communicated to her by Mr. Aninure in February 2023 that he was cutting her shifts to "curb expenses." Ms. Johnson stated when she's working the overnight shift, she is completing hourly checks on residents, cleaning, meal prepping, and preparing breakfast for the morning. She stated she also assists residents in the middle of the night if they need to use the bathroom, be rotated, or changed, for example. Ms. Johnson stated when Resident B was admitted to the facility she was informed by Mr. Pike and Mr. Aninure that Resident B required the assistance of two direct care staff when transferring. Ms. Johnson stated she would be unable to move Resident B by herself.

Ms. Boylan, Resident B's case manager through Case Management of Michigan, stated Resident B required two direct care staff to transfer her at her previous placement. Ms. Boylan stated it was not indicated in Resident B's assessment plan about needing two staff for transferring.

On 04/17/2023, I completed a follow up inspection at the facility. Resident B again stated it takes two direct care staff to get her out of bed because she's a "fall risk". She stated staff use a Hoyer to get her out of bed, which was observed in her bedroom.

I reviewed Resident B's Evacuation Score (E-score) information related to Life Safety, dated 08/25/2022, which was completed by Mr. Aninure. The explanatory remarks on the E-Score Worksheet for Rating Residents stated, "[Resident B] is a two people assist because of the use of Hoyer lift. For an effective transfer during emergency she is encouraged to sleep on luer[*sic*] sling. This would make the transfer[*sic*] faster".

Mr. Aninure provided the facility's April staff schedule, which now identified two direct care staff working the overnight shift. Mr. Aninure stated his wife, who operates another licensed Adult Foster Care facility, would be providing him with assistance on the nights Ms. Johnson isn't working. Mr. Aninure also suggested making Resident B's doorway bigger so that direct care staff could just move her bed out of the facility in the event of an emergency. Mr. Aninure was informed he would need to contact the Bureau of Fire Services (BFS) to determine if the changes he wanted to make were compliant and approved by BFS.

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, which included a review of resident assessment plans, health care appraisals, Resident B's Evacuation Scores (e-score), staff schedules, and interviews with direct care staff and the licensee designee, the licensee designee has sufficient direct care staff on duty during both the day and the overnight shift to provide residents with the supervision, protection, and personal care they require per their assessment plans. Additionally, although Resident B's e-score identifies two direct care staff are required to transfer her from her bed to her wheelchair (and vice versa), the licensee designee has indicated there are two direct care staff available to assist Resident B in the event of an emergency, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility direct care staff allow Resident B to elope from the facility when she takes her scooter on the main roads.

INVESTIGATION:

The complaint alleged facility direct care staff let Resident B "elope from the building and go out into the community". The complaint alleged Resident B has driven a scouter on M-89 highway, which is a busy road near the facility.

Ms. Terry and Mr. Pike both stated there were several residents within the facility who have independent community access, including Resident B. They both stated Resident B utilizes a motorized wheelchair when accessing the community and visiting local stores. They stated Resident B has taken the main roads like M-89, despite the risks. They both stated if they were able and staffing allowed it, they accompany Resident B into the community. Neither Ms. Terry nor Mr. Pike indicated any concerns with other residents eloping from the facility.

Resident B stated she is allowed to go out into the community unattended and without direct care staff supervision. She stated she primarily visits local stores, like Dollar General. Resident B stated she will travel on main or busy roads and stated she doesn't have to practice any "rules of the road" such as going against traffic. She stated she has been both informed and encouraged by direct care staff and the licensee designee to stay primarily on sidewalks and is discouraged driving through snow or wet covered sidewalks to prevent her from getting stuck or tipping over. She stated she takes her cell phone with her when she goes into the community.

Mr. Aninure's statement to me was consistent with Resident B's statement to me. He stated he's discussed safety practices with Resident B like using the sidewalks and not taking the actual road; however, he stated he's unable to restrict her movement.

I reviewed Resident B's *Assessment Plan for AFC Residents* (assessment plan), dated 8/16/22, which indicated Resident B can move independently within the community.

I reviewed Resident B's *Individual Plan of Services* (IPOS), dated 07/22/2022, which identified an objective for Resident B was to "demonstrate appropriate behavior (i.e., weather appropriate clothing, staying within line of sight of staff to ensure safety, etc.) when walking outside the home, as evidenced by staff report/documentation which CSM will review at least weekly with a target date of 7/23/23". The IPOS identified multiple interventions for Resident B to obtain this objective which included the following:

> "1. AFC staff will encourage [Resident B] to stay around the home to ensure her safety. AFC staff will remind [Resident B] that it is unsafe for her to access the community independently due to the chances of her chair dying, her falling over in a chair, someone hitting her. AFC staff will try to make time to take a longer walk with [Resident B]. […]
> 2. [Resident B] agrees to stay within line of sight of the home when she wants to go on a walk. [Resident B] will ask staff politely if they have time to go for a longer walk with her. [Resident B] will wear appropriate clothing (less clothes in summer, more in winter) to avoid skin breakage. […]"

On 03/16/2023, I interviewed Resident B's case manager through Case Management of Michigan (CSM), Laura Boylan. Ms. Boylan stated Resident B has freedom of movement within the community. Ms. Boylan stated she was in the process of trying to get a Behavior Treatment Plan (BTP) for Resident B; however, she stated there were no plans restricting Resident B's movement. Ms. Boylan stated she educates Resident B about going out into the community and encourages her to not take her wheelchair onto main or busy roads. Ms. Boylan stated Resident B had a flag for her chair and has indicated Resident B would even be willing to wear a brightly colored jacket for visibility.

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 review of Resident B's assessment plan and IPOS, and my interviews with Resident B, her case manager of Case Management of Michigan, Laura Boylan, direct care staff, and the licensee designee, Sulayman Aninure, Resident B utilizes her motorized wheelchair when accessing the community independently. Resident B has no restrictions on her community access, but she is encouraged and reminded to exercise appropriate behaviors while in the community to prevent injury such as staying on the sidewalk, if able, but avoiding slippery or snow covered sidewalks, and taking her phone with her. Despite the risks of taking her motorized wheelchair to local stores via main roads, there are no restrictions preventing Resident B from doing so.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident A had sores on his buttocks, which facility direct care staff were not addressing.**

- **Resident A was not having his incontinence briefs changed.**

INVESTIGATION:

The complaint alleged on 03/12/2023, Resident A was taken to the local hospital only to pass away from sepsis. The complaint alleged Resident A was "very ill and had sores on his behind." The complaint alleged Resident A was not changed enough and medical treatment was not sought quick enough.

Neither Ms. Terry nor Mr. Pike were working when Resident A went to the ER on 03/12/23. Both Ms. Terry and Mr. Pike stated they worked the week before Resident A passed away and neither direct care staff indicated Resident A appeared particularly ill or acted ill during that time. They both reported they were "shocked" when they learned he had passed away at the hospital over the weekend. Both staff indicated Resident A had a medical diagnosis of multiple sclerosis, indicating his "normal" or "baseline" was already quite weak and ill. Mr. Pike indicated a "wound nurse" came to the home approximately once a week to address Mr. Walker's sores on his buttocks. Mr. Pike indicated in the interim of the wound nurse visiting then

staff were expected to treat the sores with cream and if there was "skin breakdown" then to put a bandage on the sores. Mr. Pike also indicated Visiting Physician's also visited the home approximately every 6 months. Mr. Pike, who acknowledged working day shifts during the week from approximately 7 am until 3 pm, stated Resident A wore incontinence briefs. He stated Resident A's incontinence briefs were changed in the morning around 7 am and then changed again prior to the end of his shift around 1:30 pm – 2 pm. Mr. Pike stated he had no direct knowledge of Resident A's care after he left the facility due to him not working 2nd of 3rd shifts. Mr. Pike stated Resident A could verbalize his needs and requests to be changed if he experienced incontinence.

I was unable to interview Resident B regarding the allegations as she was visually agitated with me asking questions.

I interviewed Resident C whose statement was consistent with Mr. Pike's statement to me. Resident C stated a wound nurse would come look at Resident A every "3-4 days". She stated there was nothing abnormal or unusual about Resident A the days leading up to this death or even the day of other than she indicated he threw up the morning he passed away but was taken to the Emergency Room (ER).

I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan), which was completed by licensee designee Sulayman Aninure, dated 07/12/2022; however, it was not signed or dated by Resident A, Resident A's designated representative, if applicable, Resident A's responsible agency, if applicable or the licensee. According to my review of the assessment plan, Resident A required the assistance of staff with eating/feeding, toileting, bathing, and grooming. The assessment plan indicated staff were to make meals, helping in cleaning Resident A when toileting, and help him with showering. The assessment plan also indicated Resident A could communicate his needs and understand verbal communication. There was no additional information provided in the assessment regarding these activities of daily living for Resident A.

I also reviewed Resident A's HCA, dated 07/22/2022, which indicated his diagnoses as multiple sclerosis. The HCA stated Resident A's mental and physical status is "Limited due to progressive MS. Needs assistance with ADL". His HCA also identified Resident A's skin was abnormal due to pressure sores on his buttocks.

I reviewed the facility's notes for Resident A starting 03/01/2023; however, nothing was indicated as abnormal in his notes as the only identifying behaviors for Resident A were eating and sleeping. Direct care staff did not take any notes pertaining to Resident A on 03/11 or 03/12.

I reviewed the *AFC Licensing Division Incident / Accident Report* (IR), dated 03/12/2023, relating to when Resident A was taken to the ER. The IR, which was completed by the licensee designee, Mr. Aninure, stated at approximately 2:08 pm on 03/12/2023, Resident A "called me for help to transfer her[*sic*] from bed to his

chair, I noticed that he was breathing with some hardship. I called 911 and they took him away". The IR provided additional information that Resident A's family contacted Mr. Aninure to inform him Resident A passed away at approximately 9 pm. There was no additional information provided in the IR.

Mr. Aninure statement to me was consistent with what was written in the IR. He stated Resident A had been "fine" the week and days prior to him being sent to the ER. He stated Resident A woke up that morning, threw up, but Resident A had breakfast and then was "stable". He stated Resident A also had lunch that afternoon and laid down for a nap afterwards. He stated when Resident A got up after lunch and he was getting him into his wheelchair Resident A was holding his head and neck in a concerning position, so he contacted 911. He indicated Resident A was having a difficult time breathing.

Mr. Aninure stated Resident A had pressure sores on his buttocks; however, he indicated a wound nurse was coming into the facility weekly to address the sores. Mr. Aninure stated Resident A required the use of incontinence briefs and the briefs would be changed every morning, afternoon, and evening prior to bed. He stated Resident A was verbal and was able to tell direct care staff if he'd been incontinent and needed assistance with being changed any other time.

Relative A1 stated he and Relative A2 shared power of attorney for Resident A. Relative A1 indicated Resident A also had a wound nurse visiting with him, which he indicated was visiting weekly. Relative A1 stated he observed a "bruise" or "chaffing" on Resident A's buttock area on or around January or February 2023. He stated at that time the pressure sore wasn't open or exposed. Relative A1 stated prior to 02/15/2023 he was visiting with Resident A once or twice a week in the facility; however, after 02/15/2023 he had to go out of town. To compensate for his lack of visitation, he hired Staff A to visit with Resident A several times per week for approximately four to five weeks.

Relative A1 stated he would drop off three to four packs of 40 count incontinence briefs to the facility, but Resident A was only going through one pack in approximately two weeks. Relative A1 stated he noticed a change in the amount of briefs the facility wasn't utilizing around December 2022. Relative A1 stated he had changed Resident A's incontinence briefs while visiting because he observed Resident A's briefs being soiled. He stated when he visited with Resident A, he asked direct care staff when Resident A had last been changed, but he only got "vague answers." Relative A1 stated Resident A did not vocalize his incontinence briefs were not being changed or that he was in pain; however, Relative A1 indicated Resident A's mental capacity appeared to be declining as he was making inaccurate statements to him.

Relative A1 stated he was not present prior to Resident A passing away, but indicated he touched base regularly with Staff A during his absence. On or around the Friday before Resident A passing away, Relative A1 stated he received a

message from Staff A relaying Resident A had a bowel movement, ate well, but Resident A complained of leg pain. Relative A1 stated Resident A passed away from "sepsis" on 03/12/2023, which the attending physician indicated could have happened suddenly.

Ms. Johnson stated she was not working at the time Resident A was taken to the ER as she only works the overnight shifts. She stated he seemed "fine" the week prior to passing away. She denied him complaining to her about feeling ill. Ms. Johnson stated Resident A was verbal and communicated to her if he was not feeling well or needed anything. Ms. Johnson stated Resident A typically slept throughout the entire night and did not require much assistance from her during that time unless he needed water or wanted his fan turned on. She stated there had been times when Resident A complained of his "bottom" being sore, but she denied ever seeing any type of pressure sores or ulcers on his buttocks. She stated if he complained of being sore in one position then she would assist him in changing his position. Due to the hours in which she worked at the facility, Ms. Johnson stated she had little information regarding who was visiting with Resident A on a regular basis. She stated she was aware of him having a visiting physician "every once in a while."

I interviewed Staff A whose statement to me was consistent with Relative A1's statement to me. She stated she had worked the Friday before Resident A passed away and indicated he had been "cranky." She stated she asked him if he was in any pain and he reported to her he was always in pain. Staff A stated when she visited with Resident A his incontinence briefs were always wet and usually soaked through to the bed pad. Staff A stated she would change Resident A's incontinence briefs when she visited with him. She stated he had a pressure ulcer on his buttock and needed to be turned every few hours.

On 04/05/2023, I reviewed Resident A's death certificate, which identified Resident A's cause of death as "septic shock" and "multi organ system failure", but the manner of death was listed as "natural". An autopsy was not completed, per the death certificate.

On 04/19/2023, I received Harmony Cares Medical Group Home Help documentation relating to Resident A's care by a visiting wound nurse. According to my review of this documentation, a wound nurse visited with Resident A on 12/29/2022, 01/13/2023, 01/20/2023, 01/26/2023, 01/31/2023, 02/09/2023, 02/27/2023, and 03/06/2023 to address wound care to the pressure ulcer on Resident A's coccyx. The documentation provided identified the onset of the pressure ulcer as 08/22/2022. Throughout the course of visits, the wound nurse did not identify any significant changes or worsening condition of the pressure ulcer.

Per the 03/06/2023 notes, there was no change in Resident A's chronic pressure ulcer. The documentation did not indicate any signs of infection of the pressure ulcer and Resident A did not complain of any pain. The wound nurse stated in her notes, "Patient alert and oriented to self and place, pleasant and cooperative, wound care

and assessment completed today. No signs or symptoms of wound infection. CG Kip instructed on wound care today".

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, which included interviews with direct care staff members Alease Terry, Kip Pike, and Veronica Johnson, Resident C, Relative A1, Staff A, and the licensee designee, Sulayman Aninure, and review of pertinent resident documentation, there is no evidence direct care staff were not assisting Resident A in changing his incontinence briefs, as required. Additionally, despite Resident A experiencing a chronic pressure ulcer on his coccyx or upper buttock area, the Harmony Cares Medical Group Home Help agency wound nurse did not identify any changes to the pressure ulcer from 12/2022 through 03/06/2023. In her 03/06/2023 visit documentation, she indicated there were no signs of infection of the pressure ulcer and Resident A continued to be alert and oriented to self and place. Subsequently, there is no documentation supporting Resident A's pressure ulcer on his coccyx or upper buttock area was worsening as a result of not having his incontinence briefs changed regularly. Consequently, there is no evidence supporting direct care staff or the licensee designee were not providing Resident A with the personal care he required while residing in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Interviews with direct care staff, the licensee designee, Resident C and Staff A were all consistent with Resident A not showing any signs of illness or change in behavior prior to 03/12/2023. Even on the morning of 03/12/2023, licensee designee, Mr. Aninure, stated that though Resident A threw up in the morning he continued to eat as normal and appeared "stable." It was only after Resident A awoke from his afternoon nap that Mr. Aninure discovered Resident A's change in status and immediately alerted emergency medical personnel. Though Resident A passed away suddenly on 03/12/2023, there is no evidence supporting the licensee did not obtain immediate medical care for him upon his sudden change in physical condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan), which was completed by the licensee designee, Sulayman Aninure, dated 07/12/2022; however, it was not signed or dated by Resident A, Resident A's designated representative, if applicable, Resident A's responsible agency, if applicable or the licensee.

APPLICABLE RULE	
R 400.14301	**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:	Upon review of Resident A's written assessment plan, there was no way to determine if the Licensee, resident, or his designated representative, and responsible agency participated in the development of the assessment plan, as required. Signatures of the licensee, resident and/or resident's representative and responsible agency, demonstrate all required persons have participated in the development of the written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my onsite inspections, I requested to review fire drills due to allegation of insufficient staffing. On 03/15/2023, licensee designee, Mr. Aninure, stated the facility's fire drills were not in the facility indicating they were a "bag" off site; however, he indicated fire drills had been completed. Direct care staff, Ms. Terry, Mr. Pike, and Ms. Johnson, all stated they had not completed a fire drill since the home changed ownership in July 2022. They indicated residents had resided in the home during the change in ownership. I reviewed the facility's *Resident Register*, which identified six residents residing in the home on 07/01/2022.

During my follow up onsite inspection on 04/17/2023, Mr. Aninure provided documentation fire drills had been completed during the daytime on 01/17/2023, during the evening on 02/12/2023, and during the overnight on 03/19/2023. There was no documentation confirming fire drills had been completed from July 2022 through January 2023.

APPLICABLE RULE	
R 330.1803	**Facility environment; fire safety.**
	(3) A facility that has a capacity of 4 or more clients shall conduct and document fire drills at least once during daytime, evening, and sleeping hours during every 3-month period.
ANALYSIS:	There was no documentation provided indicating fire drills had been completed during the 3rd quarter of 2022 (i.e., July, August, and September) or 4th quarter of 2022 (i.e., October, November, and December), as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my 03/15/2023 and 04/17/2023 onsite inspections, I observed bed rails on Resident B's bed; however, upon review of her assessment plan, there was no indication the bed rails were inputted into her assessment plan.

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:	Bed rails were observed on Resident B's bed; however, the use of bed rails was not identified in her assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/08/2023, I conducted my exit conference with the licensee designee, Sulayman Aninure, via telephone. Mr. Aninure acknowledged my findings. He stated he had been in contact with BFS and they reported to him he could widen Resident B's interior door frame. He stated he would update Resident B's assessment plan to reflect the use of her bedrails.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

05/08/2023

Cathy Cushman — Date
Licensing Consultant

Approved By:

05/08/2023

Dawn N. Timm — Date
Area Manager