GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

Artesia McNeal
Irvine Head Injury Home Inc
30066 Ponds View Dr
Franklin, MI 48025

RE: License #: AL630094857
Investigation #: 2023A0605030
Irvine Neuro Rehabilitation Center

Dear Artesia McNeal:

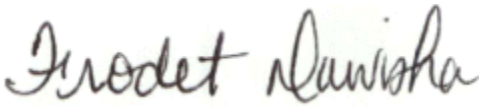
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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. 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
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 #:	AL630094857
Investigation #:	2023A0605030
Complaint Receipt Date:	05/24/2023
Investigation Initiation Date:	05/24/2023
Report Due Date:	07/23/2023
Licensee Name:	Irvine Head Injury Home Inc
Licensee Address:	30066 Ponds View Dr Franklin, MI 48025
Licensee Telephone #:	(248) 415-2500
Administrator:	Artesia McNeal
Licensee Designee:	Charlene McNeal and Artesia McNeal
Name of Facility:	Irvine Neuro Rehabilitation Center
Facility Address:	25700 Lahser Southfield, MI 48034
Facility Telephone #:	(248) 415-2500
Original Issuance Date:	05/29/2002
License Status:	REGULAR
Effective Date:	09/29/2022
Expiration Date:	09/28/2024
Capacity:	18
Program Type:	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A is missing from the facility.	Yes
The staff hit residents with a fist and gloves.	No
The staff do not change the residents. Residents are left in wet diapers and wet clothes.	No
Additional Findings	Yes

III. METHODOLOGY

05/24/2023	Special Investigation Intake 2023A0605030
05/24/2023	Special Investigation Initiated - Telephone Left message for reporting person (RP)
05/24/2023	APS Adult Protective Services (APS) denied the referral
05/24/2023	Contact - Telephone call received Discussed allegations with RP
05/25/2023	Contact - Telephone call made Discussed allegations with direct care staff (DCS) #1 and case manager (CM) #1 and CM #2
05/25/2023	Contact - Telephone call made Discussed allegations with Southfield Police Department Detective Bibbs
05/30/2023	Inspection Completed On-site Conducted unannounced on-site investigation
06/20/2023	Contact - Telephone call made Discussed allegations with Resident A's legal guardian
06/20/2023	Contact - Telephone call made Left messages for DCS #5 and manager Lisa Taylor

06/22/2023	Contact - Telephone call made Discussed allegations with DCS #6
06/22/2023	Contact - Telephone call received Discussed allegations with manager Lisa Taylor
06/22/2023	Contact - Telephone call made Discussed allegations with Resident B and DCS #7
06/22/2023	Contact - Telephone call made Left message for Detective Bibbs
06/22/2023	Contact - Telephone call made Discussed allegations with licensee designee Charlene McNeal
06/23/2023	Contact - Telephone call received Message left by Detective Bibbs
06/28/2023	Contact - Telephone call made Discussed allegations with DCS #5
07/10/2023	Exit Conference Conducted with licensee designee Artesia Washington with my findings

ALLEGATION:

Resident A is missing from the facility.

INVESTIGATION:

Intake #195404 was referred by Adult Protective Services (APS) which had received the complaint on 04/24/2023 but APS did not make the referral to adult foster care (AFC) licensing until 05/24/2023. The complaint was regarding Resident A was missing from the facility and the manager Lisa Taylor was telling staff to write statements that they saw Resident A sleeping. No one contacted Resident A's family until hours later.

On 05/24/2023, I interviewed the reporting person (RP) via telephone regarding the allegations. The RP reported they arrived at the facility around 1PM and observed Southfield Police at the facility. The officers advised the RP that Resident A was missing since 11:45AM and that staff did not call police until around 1PM. The RP immediately began searching for Resident A but was unsuccessful in locating him. The RP stated that Resident A required a one-to-one staff and was receiving a one-to-one staff until the staff that was assigned to Resident A "got fired." The RP cannot recall when the staff was fired but indicated since that staff was fired, Resident A did not have a one-to-one staff assigned to him. The RP expressed concerns that Resident A had been

missing for over an hour and none of the three staff were aware of it. Resident A had wondered off several times in the past and a couple of times during RP's shift, so staff were aware that Resident A was a wonderer.

On 05/25/2023, I interviewed DCS 1 regarding the allegations via telephone. DCS 1 was not working the day Resident A eloped from the facility; however, they were assisting in locating Resident A but were unsuccessful. DCS 1 advised that Resident A had eloped in the past from the facility as other DCS reported this to DCS 1. DCS 1 stated they do not have any other information.

On 05/25/2023, I interviewed case manager (CM) 1 via telephone regarding the allegations. On 04/23/2023, CM 1 was informed that Resident A walked out of the facility around 11:45AM while three DCS were working during that shift. CM 1 stated that they arrived at the facility around 1PM to take three other residents to church that day. CM 1 stated that they were never told by any of the DCS working that day that Resident A had been missing. CM 1 picked up the three residents and left for church. While at church, CM 1 received a text message around 4:30PM from the RP stating that "Resident A was missing." CM 1 texted RP back asking, "Did you contact Artesia (licensee designee) and the police?" RP advised CM 1, "yes." CM 1 returned to the facility with the three residents. CM 1 asked staff, "did you call Resident A's guardian?" Staff (unknown which staff) stated, "No." CM 1 then contacted Resident A's guardian around 5:45PM advising the guardian that Resident A was missing. CM 1 began searching for Resident A but was unsuccessful in locating him. CM 1 stated days later, CM 1 received a call from an outside supervisor advising them that Resident A was found deceased. CM 1 advised that Resident A had eloped before and was found at the facility next to Irvine Neuro Rehabilitation Center. Resident A's paperwork stated that "Resident A is a wonderer." CM 1 expressed concerns about three DCS being on shift and Resident A walked out without their knowledge when all staff were aware that Resident A was a wonderer. CM 1 stated any resident can walk out without anyone's knowledge unless staff is sitting at the front desk. There is an alarm on the door, but if staff are in the back of the facility, staff may not hear the alarm. CM 1 stated that a one-on-one staff was recommended in January 2023 or February 2023 for Resident A due to Resident A walking out of the facility more than once. CM 1 does not know if the one-on-one staff was assigned to Resident A.

On 05/25/2023, I interviewed CM 2 via telephone regarding the allegations. CM 2 stated that they were not present when Resident A walked out of the facility, but that CM 2 was aware that Resident A was a "wonderer." CM 2 stated that all DCS were aware that Resident A is a wonderer, and that Resident A has walked out of the facility multiple times. CM 2 stated that they had meetings with staff regarding the care and supervision of Resident A and that staff must ensure that Resident A is supervised always, and that staff are always aware of Resident A's whereabouts. CM 2 stated that they were informed that Resident A walked out because there were no staff sitting at the front desk on 04/23/2023. There were three DCS on shift, but the CM 2 is unsure what staff were doing and all CM 2 knows is that Resident A walked out. CM 2 stated they do not have any further information.

On 05/25/2023, I contacted Detective Bibbs with Southfield Police Department. Detective Bibbs has been assigned to the case regarding Resident A. Resident A went missing on 04/23/2023 and found on Wednesday 04/26/2023 deceased. There was no foul play. Detective Bibbs stated that there were no security measures in place to ensure residents cannot leave the facility without staff's knowledge. Detective Bibbs advised that the facility initially did not want to show the camera but eventually did. She is waiting on the cause of death.

On 05/30/2023, I conducted an unannounced on-site investigation. The door is locked at Irvine Neuro Rehabilitation Center, so I had to ring the doorbell. However, the door is not locked when someone walks out of the facility, but there is an alarm on the door that sounds when the door is opened from the inside. During this visit, I was informed that there are a total of 10 residents residing at this facility, but that Residents H, I, J, and K are from Newport that is currently being remodeled and that once the remodel is complete, these residents will be moving back to Newport. There were three DCS present during this visit and the licensee designee Artesia Washington.

I interviewed DCS 2 regarding the allegations. DCS 2 was present on 04/23/2023 with DCS 5 and DCS 7. They worked the day shift from 7AM-3PM. DCS 2 stated that residents are not assigned to specific staff on shift and that Resident A was not assigned to any DCS that day. There were nine residents present on 04/23/2023. Resident A was not assigned to any DCS. Around 11AM-11:15AM, Resident A ate lunch at the dining table and DCS 2 went into the kitchen and began cleaning. DCS 2 stated that DCS 5 came to DCS 2 asking, "Have you seen Resident A?" DCS 2 stated, "Resident A usually goes to bed after lunch so check his bedroom." DCS 5 stated, "I did and he's not there." DCS 2 does not recall the time that DCS 5 approached her asking where Resident A was. DCS 2 and DCS 5 combed the entire inside of the building and did not locate Resident A. DCS 5 then went outside and looked around the building and went next door to their other facility and were unable to locate Resident A. DCS 5 contacted upper management, Lisa Taylor, and licensee designee Charlene McLean first and then called the police. Again, DSC 2 stated they do not recall the time that the police were called. DCS 2 stated that they did not contact the guardian. The police arrived and began searching for Resident A but was unable to locate him. DCS 2 stated that they were then informed days later that Resident A was found deceased. DCS 2 stated that she was in the kitchen and believes that both DCS 5 and DCS 7 were helping other residents but is only assuming this because DCS 2 never observed DCS 5 and DCS 7 assisting the residents because DCS 2 was in the kitchen. DCS 2 stated, "I don't know if Resident A wonders, but then stated, whenever Resident A goes outside with staff, he takes a long time to return as he wants to stay outside." DCS 2 stated there was no staff at the front desk and that whenever someone walks out of the front door, the door chimes. DSC 2 does not recall hearing the chime that day. If DCS 2 had heard the chime, then they check the camera to see who walked out the door. DCS 2 stated that Lisa Taylor never advised DCS 2 to write statements that they saw Resident A sleeping when he was in fact missing.

I interviewed DCS 3 regarding the allegations. DCS 3 advised that they are responsible for Residents H, I, J, and K as DCS 3 is from Newport and so are these residents. DCS 3 does not know Resident A and stated that they have no information regarding Resident A as they were not hired until 05/23/2023. DCS 3 stated that Lisa Taylor nor any other upper management has asked them to do anything unethical.

I interviewed DCS 4 regarding the allegations. DCS 4 advised they were not working on 04/23/2023. Residents are not assigned to specific staff and staff are responsible for the care of all the residents. DCS 4 was informed by staff (unknown which staff) that Resident A walked out of the door Sunday morning and staff were not aware that he had left the building. Resident A has lived here for over a year and during that time, Resident A has wondered off several times, but there were no safety precautions put in place. Upper management and all staff were aware that Resident A was a wonderer because it had been documented by staff and by CM 1 and CM 2 that Resident A is a wonderer. DCS 4 stated they have no other information to offer but did report that Lisa Taylor nor any other manager has advised DCS 4 to falsify documents.

I interviewed Dr. Ruza, the psychiatrist and medical director at Irvine Neuro Rehabilitation Center who was present during this visit. Dr. Ruza provides services to Resident A. Dr. Ruza advised that Resident A walked out of the building the beginning of April and was found next door as Resident A gets physical therapy (PT) there. Staff found him and brought him back. Dr. Ruza stated it should be in Resident A's treatment plan that Resident A "wonders." He was informed by staff that Resident A walked out on 04/23/2023 and was found deceased days later. Dr. Ruza is unsure what the plan was supposed to be for Resident A regarding his wondering. Dr. Ruza stated that when Resident A moved into this facility, Resident A could not ambulate and because of staff and the care that Resident A received, Resident A had a "remarkable recovery." Resident A began ambulating and making progress because of this facility.

I interviewed licensee designee Artesia Washington regarding the allegations. Ms. Washington stated on 04/23/2023, DCS 5 called Ms. Washington around 12:30PM saying, "Resident A is missing." Ms. Washington asked DCS 5, "Did you check all the rooms and the bathrooms?" DCS 5 stated, "Yes, he's not there." She advised DCS 5 to call the police. The police arrived at the facility and viewed the camera. Ms. Washington saw that DCS 2, and Resident A were standing at the front desk around 11:30AM. DCS 2 then walked away from Resident A leaving Resident A alone in front of the front door. DCS 2 was observed going into the kitchen, DCS 5 was in the room where I was conducting the interviews that was empty on 04/23/2023 as the resident had passed away. Ms. Washington stated its unclear why DSC 5 was in this room. DCS 7 was in room #1 assisting Resident D. The police brought dogs to assist in locating Resident A but was unsuccessful. Ms. Washington stated there is a door alarm/chime that sounds off whenever the door opens. This should alert staff who are responsible for checking the cameras to see who left the facility. Ms. Washington asked DCS 5 what she was doing and DCS 5 stated, "it was lunchtime, and I was getting everybody to eat and Resident A left." Ms. Washington tried to interview DCS 7, but

DCS 7 refused and then never returned to work. DCS 7 told Ms. Washington, “I have my whole life to live.”

Ms. Washington stated that “Resident A was not a wonderer and that she was never told that he had left the facility multiple times in the past.” Ms. Washington stated the chime on the door should have alerted the staff working that day to see who walked out, but evidently, staff were not alerted. Ms. Washington stated protective measures are being put in place. She will be looking into getting “alert bracelets,” for the residents so that if they try to walk out of the building, a loud alarm sound would go off, alerting staff that someone is trying to leave the building. A DCS will be posted at the front desk to ensure no resident leaves the building without staff’s knowledge. Ms. Washington will be in servicing staff on making sure this incident does not happen to another resident at this facility.

Note: I reviewed Resident A’s “exceptional charting,” dated 02/19/2023 completed by DCS 6 regarding Resident A left the building and went next door because Resident A wanted to do PT. Staff found Resident A and brought him back. Ms. Washington stated she never received this report and was never advised that Resident A walked out of the building.

I reviewed Resident A’s assessment plan dated 02/10/2022 that was incomplete and never signed by Resident A’s designated representative. Also, the assessment plan had minimal information regarding Resident A’s needs and how staff will be providing care for those needs.

I reviewed Resident A’s “quarterly report,” which is a care plan that was completed for 01/17/2023-03/21/2023 stated “Resident A often wanders off and needs consistent redirection, protective supervision, and safety cues to complete all tasks. Resident A could benefit from a one-on-one staff regarding these behaviors.” This plan was completed on 03/21/2023.

I reviewed Resident A’s “charting notes”, dated from 02/28/2022-04/26/2023.

- 02/10/2022, Resident A tried to walk out of the facility multiple times, staff grab client and assisted back to room. Resident A had a one-on-one that day.
- 08/30/2022, Staff could not locate client. Client was in the parking lot on the other side of the other building.
- 11/01/2022 (9:32AM), Therapy informed staff that client wheelchair was being removed. Wanted client to move more and he would need to be monitored for elopement risks. Client was observed with coat on ambulate in hallway.
- 11/01/2022 (3:03PM) Client ambulating in hallway. Attended therapy, continue to monitor for elopement.
- 11/11/2022, Resident A went out the back patio door but was quickly brought back in by staff.
- 12/12/2022 (12:35PM), client eloped next door to the Manor indicating he went for PT. Client reminded that he cannot leave the facility without informing staff. Escorted back to facility by nurse Jones. Will continue to monitor closely.

- 12/12/2022 (1:18PM), client ambulatory at liberty in facility. Continues to answer questions in English and Arabic. Client must be monitored closely. Left out of front door and went over to therapy building. Escorted back to facility.
- 12/16/2022, he walked out the front door today. Client did take a shower and put on clean pajamas. Client is in bed resting.
- 04/16/2023, DCS 6 noticed that client was not sitting at the table, doing a sweep of the building. I went out back and client was at the Manor looking in the window. I asked him what he was doing, he said PT. We walked back to the building client started laughing.
- 04/26/2023, client left facility without permission on 04/23/2023 at approximately 11:45AM. Missing person protocol followed. Informed by administrator client found deceased.

I interviewed Registered Nurse (RN) Brenda Jones regarding the allegations. Resident A loves to go next door for PT. One time the RN was in the kitchen and Resident A was sitting at the dining room table one minute and the next minute he was gone. The RN checked Resident A's room and he was not there. Resident A was found trying to leave the facility to go to PT. On 04/23/2023, DCS 7 called the RN at 1:04PM saying that Resident A was missing. The RN asked, "Did you check the building?" DCS 7 stated, "Yes." The RN advised that DCS 5 needs to get into her car and drive around to try to locate Resident A and that the police need to be called. DCS 7 stated they already contacted the police. The RN stated to DCS 7 you need to have Resident A's CM 1 call the guardian. DCS 7 told the RN that CM 1 was present because she was taking residents to church. The RN stated that she arrived at the facility to assist in locating for Resident A. The guardian arrived around 6PM and informed them that CM 1 called him at 5:30PM. The police brought dogs to assist in locating Resident A but was unsuccessful. They learned on 04/26/2023 that Resident A was found deceased only 1.5 miles away from this facility. The RN advised that staff were aware of Resident A wondering away and that DCS 2, DCS 5, and DCS 7 should have supervised Resident A closely on 04/23/2023. There were no specific protective measures in place for Resident A other than close supervision by staff.

On 06/20/2022, I interviewed Resident A's legal guardian regarding the allegations. Resident A was in a severe car accident that caused his traumatic brain injury (TBI). Resident A required care with all his needs because of his TBI. On 04/23/2023, around 5:40PM, the guardian received a call from CM 1 stating that Resident A left the facility and cannot be located. CM 1 told the guardian that she was not present at the facility but that she was heading there now. The guardian arrived at the facility at 6:05PM and saw police and multiple staff present. The guardian asked, "What time he left, five minutes ago?" Staff (name unknown) responded, no he left at 11:47AM. The guardian was extremely upset that no one contacted him as he could have assisted in locating Resident A soon after Resident A wondered off and there might have been a chance of locating Resident A. The guardian stated this was not the first time Resident A wondered off from this facility. He stated that Southfield Police Department (SPD) called him last year saying, "We found Resident A." The guardian asked SPD, "was he missing?" SPD stated, "Yes." The guardian was never contacted when Resident A went

missing and expressed his concerns to staff about needing to be contacted if/when Resident A wonders off. The guardian stated again Resident A went missing and he was never contacted and now Resident A is deceased. The guardian and his friends along with staff were searching for Resident A until 10PM that night and were unsuccessful in locating Resident A. He returned home to rest and received a telephone call from staff (name unknown) saying that Resident A was spotted at a gas station near the facility. The guardian left his home again, drove to the gas station and found out it was not Resident A. The guardian stated it was raining and cold that night, but he continued to search for Resident A until 1AM but again was unsuccessful in locating him. The next couple of days, police brought their dogs to assist in searching for Resident A, but the dogs were unable to locate him. On 04/26/2023, the police informed the guardian in person that Resident A was found 1.5 miles from the facility deceased. The guardian stated that Resident A's death certificate stated that Resident A died of hyperthermia. The guardian does not understand how Resident A left the facility with three DCS working that morning and none of the staff were alerted when he walked out the front door. The guardian does not understand how protective measures were not in place to ensure Resident A's safety even after staff were aware that Resident A wonders because he had wondered multiple times from this facility.

On 06/22/2023, I interviewed DCS 6 via telephone regarding the allegations. DCS 6 was not working on 04/23/2023 when Resident A walked out of the facility. DCS 6 was informed when they returned to work that Resident A had been missing and was later found deceased. DCS 6 reported that Resident A had left the facility before to go next door as Resident A believed he had PT, but that staff found him and escorted him back to the facility. DCS 6 stated, "all the staff knew that Resident A has left the facility more than once and everyone is supposed to keep an eye on him during their shift because he's a flight risk." DCS 6 denied that Lisa Taylor or any other member of upper management asked to falsify documents.

On 06/22/2023, I interviewed Lisa Taylor, the manager via telephone regarding the allegations. Ms. Taylor was not working the day Resident A left the facility on 04/23/2023. DCS 2 advised Ms. Taylor that she saw Resident A last in his bedroom. (this was incorrect as the camera showed that DCS 2 standing at the front desk which is in front of the facilities front door talking to Resident A and then DCS 2 walked away to go into the kitchen leaving Resident A alone at the front desk.) DCS 2 advised Ms. Taylor there were three DCS working that day when Resident A walked out of the facility. Ms. Taylor advised there are "bells," on the door and the door "rings," when it opens so she is unsure what happened that day and why all three DCS did not hear the bell or rings on the door when Resident A left the facility. DCS 7 told Ms. Taylor they were in room #3 assisting with another resident and DCS 5 advised Ms. Taylor that they too were assisting with another resident. (The camera showed DCS 5 in room # 6 which was empty.) Ms. Taylor recalled another incident when Resident A left the facility, but this time staff heard the bell/ring on the door and immediately went after him and brought him back to the facility. Ms. Taylor denied advising any staff members to falsify documents or say that Resident A was "last seen in his bedroom." Ms. Taylor stated this information was reported to her by DCS 2.

On 06/22/2023, I interviewed DCS 7 regarding the allegations via telephone. DCS 7 worked on 04/23/2023 when Resident A walked out of the facility. DCS 7 was working with DCS 2 and DCS 5 and stated they were not assigned to any specific resident including one-on-one for Resident A. There was a total of 15-16 residents that day. DCS 7 was busy in the medication room as she was responsible for administering all the medications. DCS 5 came up to her (time unknown) asking her, “Where’s Resident A?” DCS 7 asked, “What do you mean where’s Resident A? He just got done eating lunch.” DCS 7 began looking for Resident A inside and outside of the building but could not locate him. DCS 7 called the RN who advised to call the manager Lisa Taylor. Ms. Taylor advised DCS 7 to call the police. DCS 7 called the police. The police arrived at the facility and DCS 7 wrote out a statement of what happened. DCS 7 will text me the statements and can not talk right now as they are driving.

On 06/22/2023, DCS 7 texted me the statement they wrote regarding Resident A leaving the facility. Here is the summary of the statement. “Yesterday around lunch at 11:45AM, Resident A left the building. I was doing a task as were the other staff. We were short staffed because there was no RN on the floor. DCS 7 had to administer medications to both buildings in addition to all the other tasks staff are responsible to do. Maybe around 12:15-12:20PM, DCS 5 came to DCS 7 stating they can’t find Resident A. Both looked inside and outside the building but could not locate him. DCS 7 called the RN Brenda Jones who insisted to call the manager Lisa Taylor. DCS 7 called Ms. Taylor who advised to call the police. The police arrived with their dogs but could not locate Resident A. DCS 7 spent around four hours searching for Resident A but was unsuccessful. DCS 7 was told to lie to the guardian by the licensee designee Charlene McNeal that DCS 7 went to Resident A's bedroom and Resident A was sleeping but that DCS 7 then returned an hour later and found Resident A gone. Did not sit well with DCS 7 about lying to the guardian as to when Resident A went missing. DCS 7 went home and later that evening, Ms. Taylor called DCS 7 asking DCS 7 to lie to Resident A’s guardian stating that DCS 7 saw Resident A sleeping when Resident A was missing. DCS 7 contacted Ms. Taylor advising Ms. Taylor that DCS 7 did not feel right lying to the guardian and that the issue was that they were short staffed because all the staff that day were responsible for both buildings. The clients can just walk out of the front door, and we cannot decipher between the chimes on the door as to who is leaving because there is no one at the front desk.”

On 06/22/2023, I contacted licensee designee Charlene McNeal regarding the allegations. Ms. McNeal was on her way back from out of town when she received a call from staff stating, “Resident A is missing.” Staff advised her they did a sweep of the inside and outside of the facility but could not locate him. Ms. McNeal arrived at the facility and DCS were out looking for Resident A as was Ms. McNeal. She was informed that Resident A had lunch and staff thought he was taking a nap, but then found out he had been missing. Ms. McNeal does not have any other information. Resident A has left the facility in the past as Resident A says, “I have PT and then tries to leave the facility to go next door.” Staff stop him and bring him back. Ms. McNeal stated that now they are in the process of getting a wrist band for the residents that will be connected to an

alarm so if the resident tries to leave from any of their doors or windows, the alarm will go off alerting staff immediately. Ms. McNeal is concerned that with three DCS on shift, how none of the staff knew that Resident A left the facility. Ms. McNeal believes Resident A's co-guardian was contacted soon after the police were contacted.

06/23/2023, I received a voice mail from message from Detective Bibbs. Detective Bibbs advised the police call from Irvine Neuro Rehabilitation was made "between 1:08-1:11PM." Detective Bibbs does not see reports in their system regarding "Resident A missing" in the past. There are two reasons why: there is a glitch in their system that is not pulling all the reports and the other possibility is that if he was located at the initial police call, a report may not have been done because it would have been a dispatch call and then they locate them.

On 06/28/2023, I interviewed DCS 5 via telephone regarding the allegations. DSC 5 was working with DCS 2 and DCS 7 but was not assigned specific residents including one-one-one for Resident A on 04/23/2023 when Resident A went missing. DCS 5 was packing up a resident belonging who was in respite care that day whose bedroom was in the back. DCS 5 stated they were notified by DCS 7 that Resident A was missing. DCS 5 checked the inside and outside of the building, but Resident A was not there. DCS 5 then went into their car and drove around looking for Resident A but could not find him. DSC 5 returned to the facility and saw police present with their dogs. DCS 5 does not know what DSC 2 or DSC 7 were doing at the time Resident A went missing. I advised DCS 5 that according to the cameras, DCS 5 was in room #6 which was empty. DCS 5 stated she was in room #10 packing belongings and not in room #6. DCS 5 stated, "to my knowledge this was the first time Resident A left the facility without staff's knowledge." DCS denied being told to lie about seeing Resident A sleeping when he was missing and denied being told to falsify documents.

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:	Based on my investigation and information gathered, there was insufficient direct care staff on duty at all times for the supervision, personal care, and protection of Resident A as specified in Resident A's quarterly report. Resident A had a history of eloping from this facility as reported in Resident A's charting notes (02/10/2022-04/16/2022) and quarterly report completed on 03/21/2023. On 03/21/2023, a one-on-one was recommended but never put in place for Resident A. On 04/23/2023, Resident A left the facility around 11:45AM without staff's knowledge. DCS 2, DCS 5, and DCS 7 were working but

	stated they were never assigned as a one-on-one to Resident A. DCS 7 stated there was a staff shortage that day because a RN was not scheduled to work; therefore, DCS 7 was responsible for administering medications to this facility and the facility next door in addition to all their other tasks they complete. Therefore, there was insufficient staff available to supervise Resident A. Resident A was found three days later deceased on 04/26/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on my investigation and review of Resident A's assessment plan dated 02/10/2022, the assessment plan was incomplete and never signed by Resident A's designated representative. The assessment plan had very minimal information and did not have any statements pertaining to Resident A's wondering/elopement needs and how staff were supposed to meet those needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**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, DCS did not attend to at all times the protection and safety of Resident A's needs on 04/23/2023. There were three DCS on duty that day, but Resident A left the facility through the front door without any of DCS 2, DCS 5, and DCS 7 knowledge. Resident A

	required one-on-one supervision due to his history of wondering/eloping from this facility. Resident A never had the one-on-one as reported by DCS 2, DCS 5, and DCS 7. Resident A was found deceased on 04/26/2023.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2020A0602029 dated 04/07/2020; CAP dated 09/17/2020**

APPLICABLE RULE	
R 400.15307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on my investigation and information gathered, interventions to address Resident A's wondering/elopement was not specified in Resident A's written assessment plan. Resident A had a history of wondering and eloping from this facility as reported in Resident A's quarterly report on 03/23/2023. Even though a one-one one was recommended, it was never adopted and there were no safety measures put in place for the supervision or protection of Resident A. Resident A left the facility on 04/23/2023 without DCS 2, DCS 5, and DCS 7 knowledge and then found deceased three days later.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The staff hit residents with a fist and gloves.

INVESTIGATION:

On 05/24/2023, the RP stated that Resident F is sexually inappropriate, so DCS 6 hit his mouth with a glove after Resident F said something inappropriate to them. The RP witnessed this but cannot recall the date. There were no injuries, and do not know if this was an isolated incident.

On 05/25/2023, DCS 1 stated that DCS 1 and the RP were working with DCS 6 hit Resident F with their glove on his mouth. Resident F make inappropriate sexual comments because of his TBI so when DCS 6 was getting Resident F ready for a shower, he said something sexual to DCS 6 and that's when she turned around and hit his mouth with the glove. DCS 1 stated Resident F said, "why you hit me with the glove?" DCS 6 then punched Resident F in the arm when DCS 6 thought that DCS 1 and the RP left the room. Resident F then said, "Why did you hit me. I'm getting in the shower." There were no injuries and unsure if this was an isolated incident.

On 05/25/2023, CM 1 stated they never witnessed DCS 6, or any other staff hit Resident F or any other resident. They are a mandated to report any abuse or neglect; therefore, if they would have witnessed it, then they would have reported it. They have not received any complaints from Resident F or any other resident regarding DCS 6 hitting them.

On 05/30/2023, DCS 2 stated they have not heard that Resident F had been hit by DCS 6 or any other staff. They have never received any complaints from Resident F or any other staff that DCS 6 hit them. DCS 2 reported that they have never seen any injuries on Resident F or any other resident.

On 05/30/2023, DCS 3 stated they have never assisted staff in caring for Resident F. Resident F has never reported being hit by DCS 6 or any other staff member. DCS 3 has never received any reports from Resident F or any other resident that they have been hit by DCS 6 or any other staff member. DCS 3 has not seen any injuries on Resident F.

On 05/30/2023, DCS 4 stated they too have never witnessed DCS 6, or any other staff member hit Resident F or any other resident. Resident F has not reported to DCS 4 that DCS 6 or any other staff member hit them. DCS 4 has not seen any injuries on Resident F.

On 05/30/2023, Dr. Ruza stated he provides services to Resident F. Resident F never reported any concerns to him regarding DCS 6 or any other staff member hitting him. Dr. Ruza has never observed any injuries to Resident F or any other resident at this facility.

On 05/30/2023, Artesia Washington stated that Resident F would not allow anyone to hit him because he would hit back. Staff are afraid of Resident F and would never hit Resident F with a glove or a fist. Resident F makes very sexual inappropriate remarks to staff, but staff understand that Resident F has a TBI and cannot control what he says. Resident F is easily redirectable by staff, so Ms. Washington believes these allegations are false. She has never seen any injuries on Resident F and there have never been any reports made by Resident F or any other resident or staff member that any DCS has hit a resident.

On 05/30/2023, the RN stated that she too has never heard that a staff member hit Resident F. Resident F is very vocal and would tell someone if this happened. Resident F makes sexual remarks to staff, but staff can easily redirect him and would never hit Resident F or any other resident as all staff understand that these residents cannot control their behaviors sometimes because of their TBI. The RN has never observed injuries on Resident F or any other resident.

On 05/30/2023, Resident C has never witnessed staff hitting Resident F or any other resident. Resident C would tell someone if they had witnessed staff hitting a resident.

On 05/30/2023, I was unable to interview Resident F during my on-site visit because he was at work.

On 06/22/2023, DCS 6 stated, “I would never put my hands on any client. I’ve worked in this field over 20 years.” Resident F makes inappropriate sexual remarks, but DCS 6 would never hit him with a glove or their fist. DCS 6 understands that Resident F has a TBI and that he cannot control what he says so DCS 6 would never harm him in any way. Resident F is easily redirectable; therefore, whenever he makes an inappropriate statement, DCS 6 redirects him and that works.

On 06/22/2023, Lisa Taylor never received any reports of DCS 6 or any other staff member hitting Resident F or any other resident. Resident F is vocal and would tell someone if a staff or anyone hits him. Ms. Taylor has never observed an injury on Resident F.

On 06/22/2023, Charlene McNeal stated that Resident F is the type of resident that if someone hits him, Resident F will “beat the crap out of them.” Ms. McNeal advised that policy is that if there are any verbal or physical complaints regarding residents to report them to her. She has not received any complaints from staff stating that a resident was verbal or physical towards them nor has she received any complaints from residents regarding staff being verbal or physical with them. Ms. McNeal stated there is zero tolerance for any verbal and/or physical abuse towards residents at this facility. She too has never witnessed any injuries on Resident F.

On 06/28/2023, DCS 5 stated that she has not heard of any concerns regarding DCS 6 or any other staff hitting Resident A or any other resident. DCS 5 stated, “the owner does not condone that and if that were to happen, that staff member would be fired immediately.” DCS 5 has never observed any injuries to Resident F and nor has Resident F reported being hit by DCS 6 or any other staff member.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.**
ANALYSIS:	Based on my investigation, I have insufficient information to determine if Resident F was hit by DCS 6 with a glove or their fist. Resident F makes inappropriate sexual remarks but according to staff is easily redirectable. He is vocal and would not allow anyone to hit him. Upper management have not received any complaints from Resident F or any other resident or staff that DCS 6 hit Resident F in the mouth with a glove or punched Resident F with their fist. Staff and upper management have not observed any injuries on Resident F.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The staff do not change the residents. Residents are left in wet diapers and wet clothes.

INVESTIGATION:

On 05/24/2023, RP stated that residents are sitting soiled in their briefs for long periods of time as staff are not changing them. The resident RP was referring to has since passed away but due to him not being changed, he has open wounds. RP advised that policy is to conduct 2-hour checks, but staff were not doing that because they were short staffed. There are currently no residents who have bedsores at this facility.

On 05/25/2023, DCS 1 stated that Resident D is wheelchair bound and left soiled because Resident D is “aggressive,” so “staff leave him soiled.” Policy is to check residents every 2-hours and change them if needed. Staff do not change Resident D because of his aggressiveness; however, Resident D does not have any bedsores.

On 05/25/2023, CM 1 stated that there was a resident that had bedsores, but that resident has passed; however, the bedsores were not from the facility, but when the resident was in the hospital. CM stated that staff are checking and changing residents’ briefs and that residents are never left soiled. There are no residents that currently have any bedsores due to being left soiled.

On 05/30/2023, DCS 2 stated that policy is conducting checks every 2-hours and if a resident is soiled then they get changed, but if not, then they continue to conduct checks every 2-hours. DCS 2 reported that some residents toilet themselves and do not wear briefs, so those residents let staff know they need to go to the bathroom. DCS 2 has never left a resident soiled in their briefs and residents have never told her that staff have left them soiled and did not change them. DCS 2 stated there was a resident with

bedsores, but that resident has since passed away. The resident returned from the hospital with bedsores and did not get the bedsores while at this facility.

On 05/30/2023, DCS 3 stated that the residents they are responsible for are Residents H, I, J, and K and the only resident who wears briefs is Resident H. DCS 3 has never left Resident H soiled. Resident H is verbal and would inform DCS 3 whenever he needed to be changed. DCS 3 has never seen any other resident sitting soiled in their briefs as DCS 3 would report that to management.

On 05/30/2023, DCS 4 stated that there is a 2-hour check policy on all residents either toileting or checking their briefs. There have not been any complaints from residents that their briefs have not been changed when they are soiled or that staff have not assisted them to the bathroom. DCS 4 advised that the only resident who had bedsores was a resident that recently passed away, but that resident had bedsores while at the hospital and not from this facility. DCS 4 have never observed residents soiled or staff refusing to change residents when they are soiled.

On 05/30/2023, Dr. Ruza stated he has never observed any resident soiled or smelling of urine because they have not been changed. He stated, “this is the cleanest place ever. I’ve seen other facilities and Charlene McNeal keeps this place and the residents clean.”

On 05/30/2023, Artesia Washington stated that only a few residents wear briefs at this facility. Resident D, Resident E and Resident F as well as Resident H. She reported that policy is a 2-hour check and if soiled to change them. She has never received any complaints from residents or staff that residents are sitting soiled and not changed. Ms. Washington advised there are no residents with bedsores, and it is due to staff making sure residents are not sitting soiled for long periods of time. The only resident that had bedsores was a resident that recently passed away. That resident was at the hospital for a long time and returned to this facility with bedsores.

On 05/30/2023, the RN stated that the residents who wear briefs are getting changed if soiled every 2-hours and staff never leave them sitting soiled for long periods of time. The RN advised that she conducts skin assessments on all the residents and currently no resident has any bedsores. The RN advised that there was a resident with bedsores, but he has since passed. The bedsores were from the hospital and not this facility. She stated that residents will complain to her if they are soiled and not getting changed by staff.

On 05/30/2023, Resident C stated he does not wear briefs and can toilet himself. He does not know about anyone else.

On 05/30/2023, I attempted to interview Resident D who was sitting in his wheelchair, but he did not want to speak with me. Resident D appeared to have good hygiene and did not smell of urine.

On 05/30/2023, I observed Resident E eating his lunch while sitting in his wheelchair. He too did not want to speak with me. He had good hygiene and did not smell of urine.

On 05/30/2023, I observed Resident H in bed being changed by staff. Resident H is non-verbal; therefore, he was not interviewed.

On 05/30/2023, I attempted to interview Resident I who was getting his blood pressure checked, but he did not want to speak with me. Resident I appeared to have good hygiene.

On 05/30/2023, I attempted to interview Resident J who stated he did not want to talk. He too had good hygiene.

On 05/30/2023, I observed Resident K sleeping in his bedroom. The bedroom was clean and did not smell of urine. Resident K was covered with a blanket that appeared to be clean.

On 06/22/2023, DCS 6 stated that most of the residents get toileted and the residents that wear briefs are checked and changed if soiled every 2-hours. DCS 6 has never left a resident soiled nor has she observed any other staff leaving residents soiled for long periods of time. DCS 6 advised there are no residents that currently have any bedsores and that is because staff change and/or toilet the residents regularly.

On 06/22/2023, Lisa Taylor stated that policy is to check and change residents if soiled every 2-hours. She has never received a complaint from residents or staff that residents are left soiled. Ms. Taylor reported that if residents were left soiled for longer periods of time, then the RN would notify upper management after the RN's skin assessment. Ms. Taylor has never observed any resident sitting soiled in their wheelchair or their bed because staff did not change them.

On 06/22/2023, Charlene McNeal stated policy is that residents must be checked every 2-hours and changed if they are soiled and checked immediately upon returning to the facility from outside appointments. Ms. McNeal has never received a complaint from staff stating that residents were observed soiled because a staff member did not change their briefs. Ms. McNeal advised that currently there are no residents with bedsores, and it is due to staff changing residents regularly and not leaving them soiled in their briefs. Ms. McNeal has never observed any resident sitting soiled nor has she smelled urine from any resident.

On 06/28/2023, DCS 5 stated that there is a 2-hour check policy on residents to ensure they do not need to be toileted or changed. If soiled, then staff change them immediately. DCS 5 has never observed a resident soiled during her shift nor has a resident complained to her about being soiled and another staff member did not change them. DCS 5 advised currently there are no residents with bedsores, and this is attributed to staff making sure residents are changed regularly.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on my investigation and information gathered, residents are being toileted and changed at least every 2-hours or as needed. On 05/30/2023 during an unannounced on-site visit, I observed residents to be clean and having good hygiene. All DCS reported that they have never left any resident soiled for long periods of time and this is evident by all residents being free of any bedsores.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/30/2023, I received a video from the RP of Resident B sitting on the floor requesting to get into his wheelchair while a female staff (later learned it was DCS 6) had licensee designee Charlene McNeal on the speaker phone. I could hear Resident B asking to be put into his wheelchair, but Ms. McNeal is telling him he had to go back into bed. Resident B said he did not wake up early because he did not have any physical therapy (PT) this morning and wanted to sleep in a little longer and because he slept in, he now wants to get into his wheelchair. Ms. McNeal kept telling him he needed to get back into bed, but Resident B was refusing. Then I heard Ms. McNeal saying, “then you can stay on the floor.” The RP told me that they then picked Resident A up off the floor and put him in bed.

On 05/30/2023, I showed the video to DCS 4 who recognized the voice of the person holding the phone to be DCS 6 and the voice of the person on speaker phone was Charlene McNeal. DCS 4 advised that midnight shift staff are responsible for getting residents up, dressed, and into their wheelchairs. Resident B refuses often to get up out of bed and sometimes slides himself off the bed onto the floor. Resident B is heavy; therefore, staff who are typically female work the midnight shift and cannot pick Resident B up so the fire department must be contacted. DCS 4 stated they have never refused to put Resident B in his wheelchair when Resident B asks to be put in his wheelchair. DCS stated “as long as what the resident asks of me is safe, then I do what the resident asks.’

On 05/30/2023, I showed the video to both Artesia Washington and the RN, Brenda Jones. Both confirmed the voices on the video and stated that Resident B can stand, but often slides off the bed. Resident B's wheelchair cushion was "probably," being washed that day and that is why Charlene McNeal wanted Resident B to return to bed. I advised them that I never heard Ms. McNeal or DCS 6 state that the wheelchair cushion was being washed and because it was being washed, Resident B needed to go back into bed. Both Ms. Washington and the RN advised they have never denied a resident's request regarding wanting to go into their wheelchair or back into bed unless there is a valid reason.

On 06/22/2023, DCS 6 does not recall refusing Resident B to be put into his wheelchair. DCS 6 does not recall that day nor does she recall having Charlene McNeal on the phone while Resident B was on the floor. DCS 6 stated, "I never refused Resident B to get into his wheelchair. I don't recall that day." DCS 6 advised that whenever Resident B slides onto the floor, DCS 6 requests assistance from another staff member to pick Resident B off the floor and place him either into bed or onto his wheelchair.

On 06/22/2023, Lisa Taylor stated that she has never heard about a video regarding Resident B on the floor and both DCS 6 and Charlene McNeal refusing Resident B to get into his wheelchair. Ms. Taylor stated she has never had any issues with staff refusing to put Resident B into his wheelchair or any other resident.

On 06/22/2023, I interviewed Resident B via telephone regarding the allegations. Resident B has a TBI, and he does not recall what happened the day he was on the floor while DCS 6 had Charlene McNeal on speaker phone. Resident B reported he has been on the floor a couple of times before, but he is not sure if anyone assisted him or not. He was unable to provide any information as to the video.

On 06/22/2023, Charlene McNeal stated that DCS 6 called her saying that Resident B was on the floor. Resident B often slides on the floor and the female staff cannot lift him, so the fire department must be contacted. Ms. McNeal believes the cushion on the wheelchair was wet and that is why he could not get into his wheelchair. I advised her that I did not hear her inform Resident B that his wheelchair cushion was wet, and he could not get into his wheelchair because it was wet. Ms. McNeal stated, "We've told him many times about his cushion being wet so he should have remembered." Ms. McNeal stated, "this video was probably cut and pasted because of a disgruntled employee."

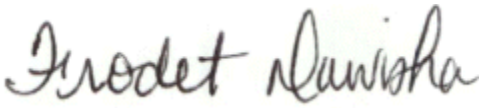
On 06/28/2023, DCS 5 stated they do not know of a video regarding Resident B on the floor and DCS 6 or Charlene McNeal refusing Resident B to get into his wheelchair. DCS 5 stated they have never refused to put Resident B or any other resident into their wheelchair. DCS 5 stated, "that's not my character. I would never do that."

On 07/10/2023, I conducted the exit conference with licensee designee Artesia Washington with my findings. Ms. Washington acknowledged my findings and did not have any questions.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.
ANALYSIS:	Based on my investigation and the video I reviewed, Resident B was not treated with consideration and respect, with due recognition of personal dignity, individuality when he was refused to get into his wheelchair. Resident B woke up late that morning because he did not have PT. When he was ready to get out of bed and into his wheelchair, DCS 6 called Charlene McNeal because Resident B slid on the floor. I could hear Ms. McNeal advising Resident B to get back into bed and that he could not get into his wheelchair. I did not hear Ms. McNeal or DCS 6 say that the wheelchair cushion was wet. According to Ms. McNeal, “Resident B should have remembered that his cushion was wet because this was told to him before.” Resident B has a TBI and should have been told again about his cushion being wet or should have been put into his wheelchair instead of refusing to put him into the wheelchair. In addition, I heard Ms. McNeal say to Resident B, “You can stay on the floor.” RP advised that they along with another staff picked up Resident B off the floor and put him back into bed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

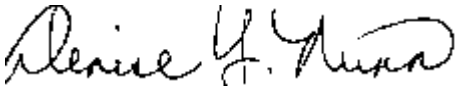
Contingent upon receiving an acceptable corrective action plan, I recommend modification of the license to a six-month provisional license.



07/10/2023

Frodet Dawisha — Date
Licensing Consultant

Approved By:



07/31/2023

Denise Y. Nunn — Date
Area Manager