GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 7, 2023

Herbert Stone
Twin Maples Inc.
158 Robinson Road
Jackson, MI 49203

RE: License #: AM380093368
Investigation #: 2023A0007022
Twin Maples Inc.

Dear Herbert Stone:

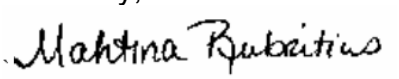
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0380.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
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Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM380093368
Investigation #:	2023A0007022
Complaint Receipt Date:	06/20/2023
Investigation Initiation Date:	06/21/2023
Report Due Date:	08/19/2023
Licensee Name:	Twin Maples Inc.
Licensee Address:	158 Robinson Road Jackson, MI 49203
Licensee Telephone #:	(517) 750-2968
Administrator:	Pam Griffith
Licensee Designee:	Herbert Stone
Name of Facility:	Twin Maples Inc.
Facility Address:	158 Robinson Road Jackson, MI 49203
Facility Telephone #:	(517) 750-2968
Original Issuance Date:	09/20/2000
License Status:	REGULAR
Effective Date:	10/08/2021
Expiration Date:	10/07/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a fall on 6/13/2023. He scraped his elbow, had a mark on his face on his cheek.	Yes
Second shift female staff refused to feed him but noted he ate dinner.	No
Additional Findings	Yes

III. METHODOLOGY

06/20/2023	Special Investigation Intake - 2023A0007022
06/20/2023	Contact - Face to Face with APS Supervisor #1. The referral was denied, and they won't be investigating.
06/21/2023	Special Investigation Initiated - On Site
07/19/2023	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1 and staff.
08/01/2023	Contact - Document Sent - Email to ORR Officer #1.
08/01/2023	Contact - Telephone call made to Employee #2. Message left. I requested a returned phone call.
08/01/2023	Contact - Telephone call made to Employee #3. Interview.
08/01/2023	Contact - Document Received - Email from ORR Officer #1. Status update provided.
08/01/2023	Contact - Telephone call made to Guardian A. Interview.
08/01/2023	Contact - Telephone call received - Interview with Employee #2.
08/02/2023	Contact - Telephone call made to Nurse #1. I requested a returned phone call.
08/02/2023	Contact - Telephone call received from Nurse #1. Message received.

08/03/2023	Contact - Telephone call made - Interview with Nurse #1.
08/03/2023	Inspection Completed On-site Unannounced - Face to face contact with Employee #6, staff, Resident A, Resident B, Resident C, and other residents.
08/04/2023	Contact - Telephone call made to Pam Griffith, Administrator. Interview and findings discussed.
08/04/2023	Contact – Telephone call made to Tim Stone, Licensee Designee. I requested a returned phone call to complete the exit conference.
08/07/2023	Exit Conference conducted with Tim Stone, Licensee Designee.

ALLEGATIONS:

Resident A had a fall on 6/13/2023. He scraped his elbow, had a mark on his face on his cheek. Second shift female staff refused to feed him but noted he ate dinner.

INVESTIGATION:

As a part of this investigation, I reviewed the written complaint, and the following information was noted:

On June 13, 2023, Resident A had a fall on second shift before dinner. Resident A utilizes a walker, and he tripped over his shoelace. He scraped his elbow. He has a mark on his face on his cheek that is about a half inch, above his nose between his eyes that is about a half inch, and elbow (unknown side or placement) that appears to be a rug burn. Because of the fall, the second shift staff member refused to feed Resident A dinner. The staff member wrote in Resident A's notes that he had dinner. No incident report was written for the fall when everyone can see that he fell. Resident A will tell people what happened. The manager/supervisor has not done anything about it. The owner is trying to retire and is not told about things that are happening in the facility. The manager/supervisor will hide incident reports or not give them to the owner. Nothing has been done to the employee that did this to Resident A and the other staff that was on shift did nothing either.

On June 21, 2023, I conducted an unannounced on-site investigation, and made face to face contact with Home Manager #1 (HM #1), Resident A, and staff. When I arrived at the facility, HM #1 stated that she knew why I was there, as ORR Officer #1 had recently contacted her as well. HM #1 stated that Nurse #1 stopped in to see Resident A. HM #1 was not at the facility at that time. Employee #1 called HM

#1 and informed that an incident report needed to be written. HM #1 contacted Nurse #1. According to HM #1, the staff (Employee #2) that witnessed the incident said that Resident A did not fall. The staff that witnessed the incident said Resident A was walking with his walker too far out, away from his body, and staff has to remind him to move the walker closer to his body. Resident A lowered himself to the floor. When Nurse #1 saw him, Resident A complained of hip pain. Resident A has a history of not being compliant. According to HM #1, Nurse #1 wanted Resident A medically examined; therefore, Guardian A took him to the walk-in clinic. Resident A did not complain of hip pain at the medical examination, and when asked if he wanted an x-ray, Resident A said no, because he did not have any pain.

According to HM #1, Resident A has OCD, and he picks at his skin. He was seen at the walk-in clinic due to picking, to prevent an infection. Resident A often starts picking at his legs.

HM #1 reported that she was not aware of Resident A having a fall. It was dinner time when the incident occurred and one staff had eyes-on Resident A. HM #1 informed that if a resident had a fall, an incident report would be written.

HM #1 informed me that Pam Griffith was doing good, and she was not planning to retire. In addition, that Pam Griffith is in the facility once or twice a week and kept informed as to what's going on in the home. HM #1 also reported that Tim Stone, Licensee Designee, plans to retire.

I interviewed Resident A, and he informed me that he had been falling a lot. He recalled that he had fallen about five days ago. He stated he was by the couch when he tripped over his shoelace and fell. Resident A stated, "I go too fast sometimes." As a result from the fall, his side was hurting, and he was taken to the doctor. The doctor asked him if he wanted an x-ray and Resident A told the doctor he did not want the x-ray.

I observed, what appeared to be a small rug burn on Resident A's face, it was about the size of a dime, and red in color. I asked about the mark and Resident A stated it was from the fall. Resident A also reported that he scraped his elbow when he fell. Regarding the fall, Resident A stated that he did not remember the specific staff on duty, but there were three staff there. He stated that it's hard for him to get up off the floor. The staff put a chair next to him and he got up by himself. Resident A stated, "I did want help, but they didn't help." The staff told him that they didn't want him to hurt them, due to back pain. Therefore, he got up by himself. He did not know how long it took for him to get himself off the floor. Resident A stated that this happened around supper time. When asked if he received supper he stated, "No, it was too late." Resident A stated they gave him snacks, not dinner. Resident A stated, "I went out to dinner with my sister because I did not get dinner." Resident A stated they went to McDonalds, and he had two McDoubles. When asked if the staff refused to give him dinner, Resident A stated he did not know.

I followed up with HM #1 and she stated that the staff sat Resident A at the table, but he refused dinner. He did have snacks with his medications at 8:00 p.m. HM #1 further reported that she spoke with Guardian A. Sometimes Resident A eats more food when on an outing and he's not hungry when returning to the facility. HM #1 stated that Resident A went to the doctor on Friday and Guardian A drove him through the McDonald's drive-thru but that was not the day of the incident. Guardian A usually takes Resident A out in the community on Wednesdays. At the end of the conversation, HM #1 informed me that Resident A is a tall guy, and staff tried to do arm & arm, and staff were not able to get him up. So, they brought over a chair and prompted him to get up.

HM #1 provided me with copies of the staff notes and medical notes from the visit to the doctor.

The staff notes documented that on June 13, 2023, Resident A had a good day with lots of prompts. It was also noted that Resident A was "very rude" with staff. It was also noted that Resident A "put himself on the floor (He did not fall). Staff saw him go down very slowly and he told staff that he did it for attention. This was during dinner time. Staff prompted many, many times to try to help him up. He was very uncooperative, not helping at all. At times very demanding. Finally, staff got [Resident A] up with prompts in the end, it just took lots of time. He was offered dinner but refused but he did eat a snack."

The office visit notes documented that Resident A is a 65-year-old male with a history of neurological disorder and developmental delay. Resident A was brought in by his guardian (Guardian A) on June 16, 2023, for an evaluation of a fall that occurred three days ago. The visiting nurse requested that he get an x-ray of his hip for the fall. Resident A reported that he was no longer having pain in the hip or flank, where he initially was painful. Resident A has been walking since the injury without pain. There has been no change to his gait since the injury. Resident A denied pain when standing, weight-bearing, or walking. Resident A and Guardian A declined to get an x-ray at that time.

On August 1, 2023, I interviewed Employee #3. She stated that there were three staff on duty, and she was downstairs. When she came upstairs, she saw Resident A on the floor. She did not see how he got on to the floor. She was told that he put himself on the floor. Staff placed a chair next to Resident A and prompted him to help himself up. Employee #3 did not know how long Resident A was on the floor, but she thought it was about ½ hour. After prompting him, Resident A got up and staff had him sit in the chair to gather himself. I inquired if Resident A had dinner and Employee #3 stated that he went to the table but said he wasn't hungry. She stated that Resident A said he was sorry for putting himself on the floor. I inquired if Resident A had any other behaviors, and she stated that he picks at his skin and causes sores. When asked specifically if staff denied Resident A dinner, Employee #3 stated they did not. In addition, after the incident, Resident A did not appear to be in any pain.

On August 1, 2023, I interviewed Guardian A. She reported that Resident A has been placed at the home for the past two years, and she loved the facility. She stated that she has visited the home both announced and unannounced. Guardian A recalled that she received a phone call from her older brother who reported that Nurse #1 was trying to get a hold of her, as she had been calling all day. Guardian A's older brother informed her that Resident A had a fall, no-one helped him up, and they did not feed Resident A dinner. Nurse #1 wanted Resident A to be seen by the doctor. When Guardian A contacted Nurse #1 she informed her that her number had changed twenty years ago, and Nurse #1 stated that case management needed to update the information. Once Guardian A picked up Resident A, she asked him what happened. Resident A informed her that he fell and when asked if they helped him up, he proudly stated, "Nope, nobody helped me up." Guardian A stated, "You mean they let you lay there?" Resident A replied, "No, they got me a chair." She asked if he hurt, and he said it hurt (3 days ago) when he fell. While at the appointment, the doctor assessed Resident A. His gait was fine, and it was determined that he would not get an x-ray. Guardian A also informed that Resident A has OCD, and he has behaviors, which includes picking. The psychiatrist has been helpful. She stated that Resident A also sees an occupational therapist, and he's been getting stronger since working with the therapist. Resident A is encouraged to do things on his own.

Guardian A expressed frustration with the complaint and stated she was upset. Guardian A stated that Resident A was proud of himself (for getting up off the floor alone) and that the nurse jumped to the conclusion. Guardian A stated that she did not want Nurse #1 to see Resident A again.

Guardian A stated that Resident A has a "lazy side" sometimes and he does not want to do his exercises. He gets mad if redirected. Staff will try to encourage him to do things on his own.

Guardian A also informed me that Resident A said he did not eat dinner, but he got his snack. She stated that when she takes him out, she spoils him. He will eat half his sandwich or meal because he wants to eat the desserts. Then when he returns to the home, he's not hungry. Guardian A stated that the staff did not refuse to feed him. She reiterated that she has visited the home both announced and unannounced and found that the staff took good care of the residents. Guardian A stated that she would recommend them for placement as this is a good home.

On this same day, Guardian A called me back informed that Nurse #1 said she was filing a report; overall it's a great facility but it's probably one person who's the problem. She also informed me that Resident A's driver takes him out on Tuesday's, and the day she took him to get McDonalds, was when he went to the doctor for the fall (three days later).

On August 1, 2023, I interviewed Employee #2. She stated she did not recall contacting HM #1 and telling her that an incident report needed to be written. She

stated that she was the employee that observed Resident A put himself down slowly on the floor. I asked if she observed him trip and fall over his shoelace and she stated she did not. She stated that sometimes Resident A is afraid he's going to fall so he will just put himself on to the floor. She stated that they have been working with OT. While Resident A was on the floor, they were prompting him to get up. They assisted by moving furniture and prompting. I asked if they tried to assist by helping arm & arm and she stated "no." Employee #2 stated that Guardian A stated that Resident A was working on building his strength. Employee #2 stated that they didn't ignore Resident A when he was on the floor. They just wanted to get him in a position to help. I inquired if she had back problems and she stated, "I'm old." She stated that she lifts people and assists daily. Employee #2 stated she did not know how long Resident A was on the floor. She stated they asked him to sit a few minutes to get his bearings.

Employee #2 stated in her opinion, Resident A did not fall. An incident report was not done at that time because Resident A did not fall and the fact that they're trying to teach him how to get up, on his own. She stated that Resident A was on his knees, but then he started to go into other positions. She was not sure why. I inquired if she saw the rug burn on his forehead and stated she did not. She stated that she saw a spot on his forehead later that evening.

Regarding dinner, she stated Resident A refused supper. Employee #2 stated that she thinks Resident A was embarrassed. Resident A gets mad and does not like prompting. Employee #2 stated that Resident A does not chew his food and he has to be prompted to slow down. Employee #2 stated that he did have his snack that night. Employee #2 denied that staff refused to feed Resident A.

On August 1, 2023, ORR Officer #1 provided me with a status update. She informed me that Resident A's Guardian was very upset about the investigation and complained about the nurse (Nurse #1), saying that she doesn't know her patient well. Guardian A reported that Resident A fell, but she was proud that Resident A was able to get off the floor by himself; and Nurse #1 took that out of context when Resident A said, "staff didn't help me up." Guardian A has requested a new nurse on Resident A's case. The investigation is still pending.

On August 3, 2023, I interviewed Nurse #1. She stated that she stopped into the facility for a follow-up visit with Resident A. Resident A had some open sores, from picking and he was prescribed an antibiotic. During the follow-up visit, Resident A was observed sitting in his recliner. When asked how he was doing, Resident A informed her that he fell three or four days ago. Nurse #1 stated that homes are required to write incident reports and keep her informed of these situations. Nurse #1 asked Resident A if he got hurt and he said "yeah." She observed a wound on his forehead, his elbow was red and swollen (he could bend it), and his knees were skinned. Resident A reported to her that his hip hurts when he sits and walks or stands with his walker. She examined Resident A but did not observe bruising but

his hip area was a little tender. When asked how he fell, Resident A stated he thought he tripped over his shoelace. This happened out by the couch, when going to a meal. Resident A stated that nobody helped him. Resident A told Nurse #1 that the staff said “nope, you have to get up yourself.” Employee #5 walked in, and Nurse #1 asked if she knew Resident A had fallen. Employee #5 reported to hear about it, as she had been off. Nurse #1 asked Employee #5 if the staff helped Resident A up and she stated she did not know. Nurse #1 asked if HM #1 knew about it. Staff then told Resident A it was time for lunch. Nurse #1 observed Resident A, and he grimaced when he stood up with his walker. Nurse #1 stated that Resident A does have history of saying that he can’t get up and that he needs help. Staff have been instructed to prompt him and not to jump right up and assist. Nurse #1 asked Employee #1 if she knew he fell and she replied, “um hum.” She was not able to get direct information from Employee #1. Employee #5 went and checked and ended up telling Nurse #1 that the fall occurred 3 days prior.

Nurse #1 stated that Resident B and Resident C observed the fall. Nurse #1 stated that Resident B said he saw Resident A fall, and staff would not help him up. In addition, that Resident C stated that she had more common sense and knew that the staff needed to help Resident A up. The staff told Resident C that Resident A was too big, and they couldn’t help him up. Resident C also stated to Nurse #1 that Resident A was bleeding after the fall.

Nurse #1 was concerned as Resident A reported to have pain and he could have fallen on his walker. She thought it was best that he be examined by the doctor. Nurse #1 told Employee #1 to ask HM #1 if he could go and get checked out. Employee #1 hung up the phone. Nurse #1 asked Employee #1 if that was HM #1 on the phone, and Employee #1 said it was, and that HM #1 would contact the guardian about having him seen. Nurse #1 stated that Employee #1 didn’t let her speak with HM #1. Nurse #1 questioned where the incident report was. In addition, that if HM #1 knew about the fall, why didn’t she follow up. Nurse #1 contacted her boss and was told to contact the guardian to make sure Resident A was seen. The number listed for the guardian was not correct or busy. HM #1 then called Nurse #1 and stated that Resident A already had an appointment scheduled for the following week and if he could go then. HM #1 was told no, as he needed to be seen. Nurse #1 was trying to get a hold of the guardian and the number was busy. HM #1 told Nurse #1 that she got a hold of Guardian A, and she would take him to the doctor. Nurse #1 ended up contacting the second guardian, due to difficulties with contacting Guardian A.

Nurse #1 stated that Guardian A called her and was yelling at her. She asked if she really thought Resident A was being abused. Nurse #1 stated she did not but that she was just trying to make sure he was taken care of properly. Nurse #1 asked if Guardian A noticed the scab on his forehead or the injury to his elbow. Guardian A informed Nurse A that OT stated that staff are not to help Resident A out of the chair. Nurse #1 stated yes, but staff should help Resident A up from the floor, especially after falling. Nurse #1 stated that the home usually has excellent staff, and

she did not know if it was just one person who would not help him up or what. Nurse #1 questioned why staff would let him lay on the floor while he was bleeding. Nurse #1 stated that Guardian A requested a different nurse.

Regarding dinner, Nurse #1 stated that Resident A said he couldn't have his dinner because he got to the table too late. Guardian A said to Nurse #1 that Resident A eats too much when he goes out into the community, and that he gets a snack. Nurse #1 stated that Resident A was going to the table for dinner when he fell. He got there too late. Guardian A told her he did get a snack to take his pills.

On August 3, 2023, I conducted an unannounced on-site investigation and made face to face contact with Employee #6, staff, Resident A, Resident B, Resident C, and other residents.

I interviewed Resident C. She informed me that Resident A fell and "nobody did anything about it." I inquired if he appeared to have any injuries, and she stated Resident A said his hip was hurting. She did not confirm that Resident A was bleeding. Resident C stated staff put a chair by him, so he could get up and do it by himself. Resident C informed me that Resident A asked staff for help. She also wanted to help him, but the staff would not let her. Resident C stated the staff were rude. She stated that Resident A did not get dinner that night.

I interviewed Resident B. He talked about being hypnotized. In addition, that he was storing stuff in his last home, and he had to dig his way out. Once on the topic, I inquired about Resident A falling, and Resident B stated that Resident A may have fallen. Resident B stated that Resident A was outside his door and Resident A said he fell. Resident B did not provide any additional information regarding Resident A's fall or what he may have observed.

On August 4, 2023, I spoke with Pam Griffith, Administrator, and discussed the investigation, findings, and my recommendations. She informed me that they would submit a written corrective action plan to address the established violations.

On August 7, 2023, Tim Stone, Licensee Designee, returned my phone call and I conducted the exit conference with him. He reported to be aware of what was going on regarding the investigation but was happy to hear it firsthand from licensing. Regarding retiring, he stated that they are trying staff in new positions, as they would like to ensure that Twin Maples will continue with the same standards. He reported to be working less but is still involved with the business. He agreed to submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be

	attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Regarding the fall, Resident A stated that it's hard for him to get up off the floor. The staff put a chair next to him and he got up by himself. Resident A stated, "I did want help, but they didn't help." The staff told him that they didn't want him to hurt them, due to back pain. Therefore, he got up by himself. He did not know how long it took for him to get himself off the floor. Resident A informed Guardian A that he fell and when asked if they helped him up, he proudly stated, "Nope, nobody helped me up." Guardian A stated, "You mean they let you lay there?" Resident A replied, "No, they got me a chair." She asked if he hurt, and he said it hurt (3 days ago) when he fell. While at the appointment, the doctor assessed Resident A. His gait was fine, and it was determined that he would not get an x-ray. Employee #3 was told that Resident A put himself on the floor. Staff placed a chair next to Resident A and prompted him to help himself up. Employee #3 did not know how long Resident A was on the floor, but she thought it was about ½ hour. After prompting him, Resident A got up and staff had him sit in the chair to gather himself. Employee #2 reported that she observed Resident A put himself down slowly on the floor. I asked if she observed him trip and fall over his shoelace and she stated she did not. She stated that sometimes Resident A is afraid he's going to fall, so he will just put himself on to the floor. She stated that they have been working with OT. While Resident A was on the floor, they were prompting him to get up. They assisted by moving furniture and prompting. I asked if they tried to assist by helping arm & arm and she stated, "No." Employee #2 stated that Guardian A stated that Resident A was working on building his strength. Employee #2 stated that they didn't ignore Resident A when he was on the floor. When asked how he fell, Resident A stated to Nurse #1 that he thought he tripped over his shoelace. This happened out by the couch, when going to a meal. Resident A stated that nobody helped him. Resident A told Nurse #1 that the staff said, "Nope, you have to get up yourself." Resident C informed me that Resident A fell and "nobody did anything about it." I inquired if he appeared to have any injuries, and she stated Resident A said his hip was hurting. She did not

	confirm that Resident A was bleeding. Resident C stated staff put a chair by him, so he could get up and do it by himself. Resident C informed me that Resident A asked staff for help. She also wanted to help him, but the staff would not let her. Resident C stated the staff were rude. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A had a fall and staff put a chair next to him, so he could get up on his own, instead of physically assisting him off the floor. Based on these findings, it's concluded that Resident A was not treated with dignity and his personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Resident A stated that the fall happened around supper time. When asked if he received supper her stated, “No, it was too late.” Resident A stated they gave him snacks, not dinner. When asked if the staff refused to give him dinner, Resident A stated he did not know. I inquired if Resident A had dinner and Employee #3 stated that he went to the table but said he wasn’t hungry. She stated that Resident A said he was sorry for putting himself on the floor. Regarding dinner, she stated Resident A refused supper. Employee #2 stated that she thinks Resident A was embarrassed. Resident A gets mad and does not like prompting. Employee #2 stated that he did have his snack that night. Employee #2 denied that staff refused to feed Resident A. Resident C stated that Resident A did not get dinner that night. Staff documented in the daily notes that they prompted many, many times to try to help him up. He was very uncooperative, not helping at all. At times very demanding.” Finally, staff got [Resident A] up with prompts in the end, it just took lots of time. He was offered dinner but refused but he did eat a snack.” While it’s unknown how long Resident A was on the floor, once off the floor, staff reported that Resident A was not hungry and refused dinner. When asked if the staff refused to give him dinner, Resident A stated he did not know. Based on the information gathered during this investigation and provided above, it’s concluded that there is not a preponderance of the evidence to support the allegations that he was not provided with three regular and nutritious meals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the course of this investigation, it was also reported that staff don’t keep toilet paper or soap in the bathrooms. This is due to concerns with residents flushing too much tissue down the toilet. Residents are given toilet paper rolls to carry into the bathroom with them.

While at the facility (on 8/3/2023), I observed each of the bathrooms. The first bathroom did not have toilet paper and there was a very small amount of liquid soap on the sink. There were wipes observed in the bathroom as well. The bathroom closet was full of towels.

The back bathroom sink had weak water pressure and there was no tissue, soap, or paper towel observed in the bathroom. It was also noted that the water did not get hot in the bathrooms unless the hot water was turned on in the kitchen. Staff stated that the administrative staff were aware of this issue and had been working to address the problem with aging plumbing system.

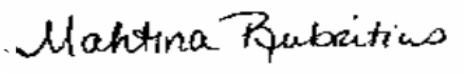
On August 4, 2023, I spoke with Pam Griffith, Administrator. She stated that the residents who are independent have toilet paper in their rooms. In addition, that for residents who are more low functioning and require assistance with toileting, the tissue is kept on the top shelf in the bathroom (out of sight/out of mind). They have had many issues with residents flushing rolls of toilet paper and other items down the toilet. I asked Ms. Griffith if the guardians signed the assessment plans, agreeing to keeping tissue in the rooms or on the top shelf and she stated they did not. I explained that the residents must have access to tissue, soap, and paper towels in the bathroom. In addition, they may have to review the supervision levels of the other residents to address issues with them flushing toilet paper rolls down the commode. Regarding the plumbing issue, she stated that she has been working on this issue and has gotten an estimate. She also applied for some assistance but just learned that she was denied. Pam Griffith told HM #1 that they may have to pay for the expensive plumbing repairs. Pam Griffith informed me that they would provide a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	The first bathroom did not have toilet paper and there was a very small amount of liquid soap on the sink. The back bathroom sink had weak water pressure and there was no tissue, soap, or paper towel observed in the bathroom. It was also noted that the water did not get hot in the bathrooms unless the hot water was turned on in the kitchen. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence that the home is not being maintained to provide adequately for the health, safety, and well-being of the occupants.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



8/04/2023

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

08/07/2023

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Ardra Hunter Date
Area Manager