GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 31, 2023

Theresa Bursley
AH Jenison Subtenant LLC
6755 Telegraph Rd Ste 330
Bloomfield Hills, MI 48301

RE: License #: AL700397750
Investigation #: 2024A0467003
AHSL Jenison Cherrywood

Dear Mrs. Bursley:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against the license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Anthony Mullins

Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397750
Investigation #:	2024A0467003
Complaint Receipt Date:	10/18/2023
Investigation Initiation Date:	10/18/2023
Report Due Date:	12/17/2023
Licensee Name:	AH Jenison Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Theresa Bursley
Licensee Designee:	Theresa Bursley
Name of Facility:	AHSL Jenison Cherrywood
Facility Address:	798 Oak Crest Lane Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/12/2019
License Status:	REGULAR
Effective Date:	09/12/2023
Expiration Date:	09/11/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's safety was not attended to on the night of 10/13/23, resulting in his death.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/18/2023	Special Investigation Intake 2024A0467003
10/18/2023	Special Investigation Initiated - Telephone Spoke to Detective Adam Hill with the Ottawa County Sheriff's Department
10/18/2023	Inspection Completed On-site
10/18/2023	APS Referral APS Denied the complaint for investigation
10/30/2023	Exit Conference Licensee designee, Theresa Bursley

ALLEGATION: Resident A's safety was not attended to on the night of 10/13/23, resulting in his death.

INVESTIGATION: On 10/17/23, I spoke Detective Adam Hill with the Ottawa County Sheriff's Department. Detective Hill informed me of Resident A's death, after he reportedly eloped from the facility and was found deceased outside face down in the grass at 2:19 am on the morning of 10/14/23. Detective Hill stated that it was 49 degrees and raining and Resident A was found wearing pajama pants and a hunting jacket.

Per Detective Hill, Resident A pulled the fire alarm at approximately 7:02 pm on 10/13/23. Staff redirected Resident A to the hall area and away from the door. At approximately 7:18 pm, Resident A can be seen on video leaving the facility through the front door and he never returned. Per Detective Hill, Resident A was outside of the facility from 7:18 pm on 10/13/23, until he was found at 2:19 am on 10/14/23 in the grass just outside of the facility, approximately 25 feet away from his walker. Per Detective Hill, staff member Simona Martinez found him lying outside in the grass. Detective Hill stated that the nursing manager, Jennifer Hicks informed him that staff have not been doing routine checks on residents.

On 10/18/23, I made an unannounced onsite investigation at the facility. Upon arrival, I spoke to the executive director, Theresa Bursley. Present in the room for

part of the interview was Rhonda Hieber, Regional Vice President of Operations. Ms. Bursley confirmed that Resident A resided at AHSL Jenison Cherrywood at the time of his death. Prior to that, Resident A lived at AHSL Jenison Willowood for a couple of weeks, which is less than a half mile down the road from Cherrywood. Ms. Bursley confirmed that Resident A eloped from Willowood on 10/4/23 around 10:30 pm - 11:00 pm. He was found by staff and brought back inside. Resident A's family was notified. The following day (10/5/23) Resident A was moved to AHSL Jenison Cherrywood due to it being a memory care/locked facility to prevent him from eloping.

Ms. Bursley confirmed that on 10/13/23, Resident A pulled the fire alarm at approximately 7:02 pm. Staff redirected him back to the hallway in the building where he began to wander. Ms. Bursley confirmed that Resident A was captured on video at approximately 7:18 pm leaving the facility through the front door. Ms. Bursley confirmed that the door alarm did not sound because the pull station on the wall was not reset after Resident A pulled the fire alarm at 7:02 pm. Ms. Bursley confirmed that Resident A never returned to the facility, and he was found outside by staff member Simona Martinez although she was not searching for him. Ms. Bursley stated that Resident A was independent with a lot of his care needs and able to ambulate with his walker. Ms. Bursley stated that Resident A had only eloped from AHSL Jenison one time prior to his elopement on 10/13/23.

Ms. Bursley stated that although Resident A had only eloped from the facility one previous time, he does have a history of wandering through the facility. Ms. Bursley provided me with a copy of Resident A's assistant plan, which states that Resident A has, *"extensive wandering issues. Resident currently wanders outside and leaves immediate area. Resident may leave immediate area, get lost, or become combative about returning. Requires supervision."* Ms. Bursley stated that Resident A had some delusions/hallucinations that led to him looking for an unknown baby and/or his mother. Ms. Bursley stated that Resident A also had a history of aggressive behaviors towards staff as he reportedly punched a staff member during his first night in the facility. Ms. Bursley provided me with a copy of a "rounding sheet" from 10/1/23 to 10/7/23 that staff use to document that they've completed nightly rounds every two hours on residents per the facility's internal policy. From 10/1/23 through the morning of 10/5/23, Resident A resided at AHSL Jenison Willowood. From 10/5/23 through 10/7/23, there were no staff initials to confirm that Resident A had been checked every two hours. Ms. Bursley confirmed that there was no completed rounding sheet from 10/8/23 through present for Resident A. Ms. Bursley confirmed that staff members Ghyslaine "Gigi" Mapendo and Simona Martinez admitted that they did not check on Resident A on the night of 10/13/23 into the morning of 10/14/23. Ms. Bursley shared that Resident A signed onto hospice on 10/11/23, which was two days prior to this incident.

On 10/19/23, I spoke to AFC staff member, Ghyslaine "Gigi" Mapendo via phone. Ms. Mapendo confirmed that she was working at the facility during 2nd shift on 10/13/23. Ms. Mapendo stated that second shift is from 3:00 pm to 11:30 pm. Ms.

Mapendo stated that her mother, Mbula “Alice” Bitondo, and Linda Claude were working with her during second shift. Ms. Mapendo confirmed that Resident A pulled the fire alarm sometime around 7:00 pm on the day in question. After the fire alarm was pulled, all residents, including Resident A were accounted for in the building. Ms. Mapendo stated that she silenced the alarm and continued passing medications to residents. While passing medications and caring for approximately 14 residents, Resident A was able to get outside. Ms. Mapendo stated that she was not trained on what to do or how to respond when the fire alarm goes off. Ms. Mapendo stated, “if the door was locked, he (Resident A) wouldn’t have been able to get outside.” Ms. Mapendo stated that the resident aides (Ms. Bitondo and Ms. Claude) were supposed to be doing rounds as opposed to her since she was the med tech. Ms. Mapendo stated that she was responsible for training Ms. Bitondo and Ms. Claude during this shift, in addition to caring for the residents. Ms. Mapendo stated, “it was a lot for me and there should have been another person working to train staff.” After she finished passing medications, Ms. Mapendo stated that she went to the door/window to make sure no one was outside. It was raining and starting to get dark. Ms. Mapendo did not see anyone when she looked outside.

Ms. Mapendo confirmed that 3rd shift staff member, Simona Martinez found Resident A outside sometime after 2:00 am on 10/14/23 lying in the grass and notified her of this. Ms. Mapendo stated that Ms. Martinez called 911 and they attempted CPR, but Resident A was already deceased. Ms. Mapendo stated that Ms. Martinez was reportedly leaving the building after 2:00 am to go pick-up her children when she found Resident A lying in the grass. Ms. Mapendo stated that Ms. Martinez never ended up leaving due to this horrific incident.

Ms. Mapendo was asked about 2-hour checks being completed on the residents. Ms. Mapendo confirmed that checks occurred at 10:00 pm on 10/13/23 because she assisted Ms. Bitondo and Ms. Claude during this time. However, Ms. Mapendo confirmed that she and her colleagues never checked on Resident A at 10:00 pm because he was independent with a lot of his care needs. Ms. Mapendo stated that at approximately 11:45 pm, she left the facility to take her mother/colleague, Ms. Bitondo home. Ms. Mapendo stated that she met her brother at a Subway restaurant, and he was able to take her mother home. Ms. Mapendo did not know the location of the Subway restaurant, but she did not believe it to be close to the facility. Ms. Mapendo stated that she returned to the facility sometime after midnight. When she returned, Ms. Martinez and an agency staff member (name unknown) were working. Ms. Mapendo stated that the agency staff member told her that “everyone was good” when she returned to the facility, but she is unsure if the agency staff completed rounds on the residents.

After speaking to Ms. Mapendo, she gave the phone to her mother, Mbula Bitondo. It should be noted that I attempted to interview Ms. Bitondo individually. However, she stated that her primary language is Swahili and she will need to answer questions in her language. Therefore, Ms. Mapendo agreed to translate for her.

Ms. Mbula confirmed that she worked at AHSL Jenison Cherrywood on 10/13/23 during second shift with Ms. Mapendo and Ms. Claude. During this shift, Ms. Mbula confirmed that one of the residents pulled the fire alarm. Ms. Mbula was unsure of the resident's name that pulled the fire alarm as she is new to the facility, but Resident A's name sounded familiar to her. Ms. Mbula was able to say that the resident who pulled the fire alarm was using a walker. After the fire alarm was pulled, Ms. Mbula confirmed that Resident A and all other residents were still inside the building. Ms. Mbula confirmed that she completed rounds on residents and changed their briefs between 8:30 and 9:00 pm and 10:30 and 11:00 pm. However, her last time seeing Resident A in the facility was around 7:10 pm on 10/13/23.

Ms. Mbula confirmed that rounds were not completed on Resident A because he was independent with his care needs and often, he would go to his room around 7:00 or 8:00 pm and remain inside for the rest of the night. Ms. Mbula stated that she did not check on Resident A because he has previously told her to leave him alone or refused to come out of his room. Ms. Mbula stated that she was trying to respect Resident A's wishes of not bothering him while in his room. Ms. Mbula stated, "I just didn't want to break his emotions." Ms. Mbula confirmed that none of the staff working completed rounds on Resident A after the fire alarm was pulled as it was assumed that he was in bed asleep. Ms. Mbula also stated that the agency staff member (name unknown) told her that "everyone was good." Ms. Mbula left the facility after her shift was done and was not present when Resident A was found deceased. Prior to concluding my interview with Ms. Mbula, I asked her how she planned to care for residents needs if she was unable to speak English fluently. Ms. Mbula stated that she can understand what people say to her in English, but it is hard for her to speak in English. When she assists residents, she does so with one of her colleagues since she is still new and only on the job for four days.

On 10/19/23, I spoke to AFC staff member, Linda Claude via phone. Ms. Claude confirmed that she worked at the facility on 10/13/23 during second shift, which is from 3:00 pm to 11:30 pm. Present at the facility with her was Ms. Mapendo and Ms. Mbula. Ms. Claude stated that the resident in room 4 pulled the fire alarm during her shift. She was unsure of Resident A's name as this was reportedly her first day training at the facility and she was being trained by Ms. Mapendo. Ms. Claude stated that after the fire alarm was pulled, Ms. Mapendo sent all residents to their room, and she did not see Resident A after that. Ms. Claude confirmed that she and her colleagues did not do 2-hour rounds (resident checks) during her shift as she believes this was done prior to her shift starting. Ms. Claude stated that she left the facility at 11:30 pm. When she returned to work for her next shift, Ms. Claude stated that she was told by her coworkers that "someone passed away". Ms. Claude stated that she was told that "someone's boyfriend" found Resident A lying in the grass and informed them. Ms. Claude stated during her shift on 10/13/23, "I did everything I was told to do," including changing and cleaning people. Ms. Claude stated that she finished changing residents at approximately 11:10 pm and she never went to Resident A's room due to Ms. Mapendo reportedly stating, "he doesn't sleep at this time." Ms. Claude again shared that she was just doing what she was told, and she

is unsure as to how Resident A was able to get out of the building or what time he left.

On 10/19/23, I spoke to AFC staff member, Simona Martinez via phone. Ms. Martinez confirmed that she has been employed by AHSL Jenison since May or June 2023 and she did work at AHSL Jenison Cherrywood on 10/13/23. Ms. Martinez was scheduled to work from 11:30 pm on 10/13/23 until 7:00 am on 10/14/23. Ms. Martinez stated that she arrived at the facility for work at approximately 11:50 pm. When she arrived, an agency staff member (name unknown) was present and stated that she was a resident aide. This prompted Ms. Martinez to ask the agency staff member where the med tech was. Ms. Martinez stated that she was supposed to be working with Ms. Mapendo. However, she was not there when she arrived as she reportedly gave someone a ride home. Ms. Martinez stated that Ms. Mapendo arrived at the facility around 12:30 pm. Ms. Martinez stated that when Ms. Mapendo returned to the facility, the agency staff member left as she was reportedly not feeling well.

Ms. Martinez stated that she began doing rounds on residents around 2:00 am. She did not start sooner because the agency staff member informed her that she completed “rounds” when she first arrived at the facility. While completing her 2:00 am rounds, Ms. Martinez stated that she did not notice that Resident A was missing. Ms. Martinez stated that during her last time working at the facility, she was told that Resident A “is violent so if his door is shut, don’t go in there.” Therefore, Ms. Martinez followed the directions she was previously given and never checked Resident A’s room. Ms. Martinez stated that the resident in room 10 (name unknown) was another resident that she did not check either due to his history of aggression. When asked who told her about Resident A and the resident in room 10 being violent and to avoid doing rounds on them, Ms. Martinez stated that this was “word of mouth at shift change.”

Ms. Martinez then shared that she had a 30-minute break after 2:00 am. While on break, Ms. Martinez stated that her boyfriend came to the facility to visit her since he gets off work at 2:00 am. Ms. Martinez stated that she went outside to meet her boyfriend. While walking outside, Ms. Martinez stated that she noticed a walker outside and her boyfriend spotted a person lying on the ground in the grass, which turned out to be Resident A. Ms. Martinez stated that she ran inside the facility and informed Ms. Mapendo and she was able to identify the person in the grass as Resident A. Ms. Martinez stated that Resident A was “soaking wet and his whole body was freezing.” Ms. Martinez stated that Ms. Mapendo told her that she did not know the last time she saw Resident A prior to being found deceased in the grass. Ms. Martinez stated that she called the police, and they pronounced Resident A dead. Ms. Martinez stated that Resident A was face down lying on his stomach. 911 dispatch instructed her to roll Resident A over and she could tell that he was deceased. Ms. Martinez stated that dispatch wanted her to do CPR, but it was clear that he was deceased as he had no pulse. Per Ms. Martinez, the police arrived at the facility and did not try to resuscitate him after checking and not finding a pulse.

Ms. Martinez had no knowledge as to how Resident A was able to get outside. However, she did share that when she arrived at work, she noticed the door that normally opens after pushing a button, was not operating correctly. Ms. Martinez stated that it, “slipped my mind” to ask Ms. Mapendo about the door because she was not at the facility when she first arrived at 11:50 pm. Ms. Martinez stated that this was only her second time at the facility since Resident A was admitted. Ms. Martinez stated that the second shift supervisor (Julie – last name unknown) arrived at the facility to help them prepare everything needed for first responders. Ms. Martinez also stated that the executive director, Mrs. Bursley also arrived at the facility to assist.

On 10/19/23, I spoke to agency staff member, Claudette Deschemins-Toussant via phone and she agreed to discuss case allegations. Ms. Deschemins-Toussant confirmed that she is employed through IntelyCare agency, and she was scheduled to work 3rd shift at the facility on 10/13/23. Ms. Deschemins-Toussant confirmed that she was at the facility from 11:30 pm until 1:00 am on 10/14/23. Ms. Deschemins-Toussant stated that she was sick and not feeling well. Therefore, she left the facility and went to the hospital. Ms. Deschemins-Toussant stated that Ms. Mapendo worked the rest of her shift for her due to not feeling well. During her time at the facility, Ms. Deschemins-Toussant stated that she did rounds on residents. However, she denied checking on Resident A due to his bedroom door not having a name on it. Ms. Deschemins-Toussant stated that no one told her to check on Resident A and due to being an agency staff member, she was not familiar with Resident A. Due to only being at work for an hour and a half, Ms. Deschemins-Toussant denied any knowledge of a resident being found deceased outside. Ms. Deschemins-Toussant did not have any additional information to add, and this interview concluded.

On 10/30/23, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and aware of the recommendation for revocation.

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:	Resident A has a known history of wandering per Mrs. Bursley and his assessment plan. Despite this, no rounds/checks were completed on him on the night of 10/13/23 or the early morning of 10/14/23. Video footage confirmed that Resident A left the facility at approximately 7:18 pm on 10/13/23 and he never returned. He was later found outside of the facility face down in the grass approximately 25 feet away from his walker deceased.

	Five staff members including Ghyslaine Mapendo, Mbula Bitondo, Linda Claude, Simona Martinez, and Claudette Deschemins-Toussant all worked between 2nd and 3rd shift on 10/13/23 into the morning of 10/14/23 and each denied completing rounds/checks on Resident A for various reasons. Resident A's protection and safety was not attended to and likely led to his demise. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegation listed above, I was informed that the facility has several residents who require a two-person assist. Ms. Bursley confirmed that Resident B, Resident C, Resident D, and Resident E all require two-person assists. She provided me with copies of their assessment plans, which also confirms this. Therefore, the facility must have two trained staff members working each shift to appropriately address resident's needs. However, during second shift on 10/13/23, Ms. Mapendo was the only trained staff member working and she was responsible for training Ms. Mbula and Ms. Claude.

On 10/30/23, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and aware of the recommendation for revocation.

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:	Ms. Mapendo confirmed that she was training two staff members while also being responsible for addressing residents' needs. Ms. Mbula and Ms. Claude both confirmed that they were new staff members training with Ms. Mapendo on the day in question. Ms. Bursley also confirmed this.

	Therefore, there is a preponderance of evidence to indicate the facility had insufficient staff working on the day that Resident A eloped from the facility and passed away.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While addressing the allegations listed above, Ms. Bursley stated that Ms. Mapendo was not trained on how to reset the pull station after a fire alarm is triggered. Ms. Bursley stated that maintenance provides this training to staff. If Ms. Mapendo would have reset the pull station, the door alarm would have triggered when Resident A eloped from the facility at 7:18 pm on 10/13/23. Ms. Mapendo also confirmed that she was not trained on what to do or how to respond when a fire alarm is pulled, which includes how to reset the pull station on the wall that would have triggered the door alarm when Resident A walked out the facility.

On 10/30/23, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and aware of the recommendation for revocation.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Ms. Mapendo was the only trained staff working second shift on 10/13/23. Despite this, she was not trained on safety and fire prevention. If Ms. Mapendo had been trained, she would have known how to reset the pull station and the door alarm would have triggered when Resident A eloped. Therefore, there is a preponderance of evidence to support this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegation listed above, Ms. Bursley informed me that Ms. Mapendo was seen on camera on 10/13/23 tying a gait belt around Resident F's waist and chair to prevent him from falling.

On 10/19/23, I spoke to Ms. Mapendo via phone, and she was asked about this incident. Ms. Mapendo stated, "I think I did that because he (Resident F) fell down a lot." Ms. Mapendo stated that Resident F fell at least four times and she tried to put him in bed. Due to this not working, Ms. Mapendo stated that she used a gait belt and tied it around his waist and a chair to prevent him from falling. Ms. Mapendo was adamant that she did this for Resident F's safety as she did not have any staff members to look after him since she was training two staff members and helping care for approximately 14 residents.

On 10/30/23, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and aware of the recommendation for revocation.

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.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R400.15102(1)(m).** **(i) Any electrical shock device.**

ANALYSIS:	Ms. Bursley stated that Ms. Mapendo used a gait belt to tie Resident F to his chair on 10/13/23. Ms. Mapendo confirmed that she did this for Resident F's safety as he fell approximately four times prior to this. Ms. Mapendo stated she was busy attending to other residents needs and training two staff members. Therefore, she was unable to give Resident F the care he needed. By Ms. Mapendo doing this, she restricted Resident F's movement. There is a preponderance of evidence to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

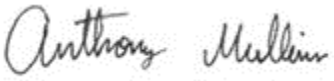
INVESTIGATION: While investigating the allegation listed above, I reviewed Resident A's Medication Administration Record (MAR). While reviewing the MAR, I noticed that Resident A did not receive his Carbidopa – Levodopa 10-100 MG tablet on 10/5/23 at 8:00 pm. The explanation provided on the MAR stated, "resident moved to different building." However, this is not an acceptable explanation for a resident not receiving his prescribed medication.

On 10/30/23, I conducted an exit conference with licensee designee, Theresa Bursley. She was informed of the investigative findings and aware of the recommendation for revocation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff did not provide Resident A with his prescribed medication at 8:00 pm on 10/5/23. Therefore, there is a preponderance of evidence to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

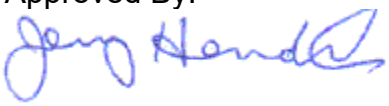
This investigation has led to the facility being cited for the above-referenced quality-of-care violations. Therefore, I recommend revocation of the license due to the facility failing to protect Resident A.



10/30/2023

Anthony Mullins — Date
Licensing Consultant

Approved By:



10/30/2023

Jerry Hendrick — Date
Area Manager