GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 25, 2024

Gagandeep Mann
JP Managed Services, Inc.
Suite A
2316 John R
Troy, MI 48083

RE: License #: AL630295441
Investigation #: 2024A0605007
Sun Valley Senior Living

Dear Gagandeep Mann:

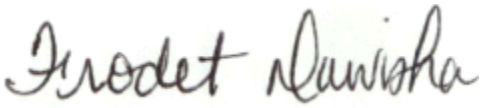
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AL630295441
Investigation #:	2024A0605007
Complaint Receipt Date:	12/08/2023
Investigation Initiation Date:	12/11/2023
Report Due Date:	02/06/2024
Licensee Name:	JP Managed Services, Inc.
Licensee Address:	Suite 3 2710 Rochester Road Rochester Hills, MI 48307
Licensee Telephone #:	(248) 497-4391
Administrator/Licensee Designee:	Gagandeep Mann
Name of Facility:	Sun Valley Senior Living
Facility Address:	2316 John R Troy, MI 48084
Facility Telephone #:	(248) 689-7755
Original Issuance Date:	09/13/2010
License Status:	REGULAR
Effective Date:	10/11/2022
Expiration Date:	10/10/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B was observed with a bruise on the corner of her left eye. The HM, Hilary Shattuck hit Resident B's cheek on the railing while in care.	Yes
Home manager (HM) Hilary Shattuck said to Resident A, "Resident A is grumpy today, you must be on your period."	Yes
Additional Findings	Yes

III. METHODOLOGY

12/08/2023	Special Investigation Intake 2024A0605007
12/11/2023	APS Referral Adult Protective Services (APS) denied referral
12/11/2023	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
12/12/2023	Inspection Completed On-site Conducted unannounced on-site investigation
12/21/2023	Contact - Telephone call made Discussed allegations with Compassus Hospice aide, Shalong (Monique) Hunt and DPOA A, DPOA B, and DPOA C. Left message for Compassus Hospice registered nurse (RN) Nanette Williams
12/29/2023	Contact - Telephone call received Message left by DPOA A
01/02/2024	Contact - Telephone call made Returned DPOA A's call regarding concerns of no food at the facility
01/02/2024	Contact - Document Sent Made another APS referral via email

01/05/2024	Contact - Telephone call received Compassus Hospice RN Nanette Williams left message
01/16/2024	Contact - Telephone call made Discussed allegations with RN Nanette Williams
01/16/2024	Contact - Telephone call made Discussed allegations with licensee designee Gagan Mann
01/17/2024	Contact - Face to Face Conducted another unannounced on-site visit
01/17/2024	Contact - Telephone call received APS denied referral made on 01/02/2024
01/17/2024	Contact - Telephone call received Text messages received from the HM and Dr. Dhillon
01/22/2024	Contact - Document Sent Email to Susan Carroll
01/23/2024	Contact - Document Received Email from Susan Carroll
01/24/2024	Exit Conference Conducted exit conference via telephone with licensee designee Gagan Mann with my findings

ALLEGATION:

Resident B was observed having a bruise on the corner of her left eye. The HM, Hilary Shattuck hit Resident B's cheek on the railing while in care.

INVESTIGATION:

On 12/11/2023, intake #198779 was referred by Adult Protective Services (APS) regarding the home manager (HM), Hilary Shattuck making inappropriate comments to Resident A. Also, Resident B has a bruise to the corner of her eye. ~~The HM reported that~~ when the HM was turning Resident B over, Resident B hit her eye on the bed rails.

On 12/11/2024, I interviewed the RP regarding the allegations. The RP was informed by DCS Brandi Brooks that the HM told Ms. Brooks that the bruising on Resident B's eye was because the HM turned Resident B over to change her and Resident B hit the bed rails. The RP was concerned because while at the facility, the Compassus Hospice aide was bathing Resident C and noticed a bruise on Resident C's forehead. When RP

asked the HM what happened to Resident C's forehead, the HM stated, "I don't know." The HM told the RP that the bruise was noticed after the hospice aide bathed Resident C.

On 12/12/2023, I conducted an unannounced on-site investigation. Present were the HM Hilary Shattuck, DCS Monique Appleba and her mother who is also a DCS Brandi Brooks. Also present were Residents A, B, C, D, E, F, and G.

I interviewed Resident A who stated she does not know anything about the other residents. Resident A had good hygiene.

I attempted to interview Resident B in her bedroom, but Resident B was holding her doll and kissing it. She was not responding to my questions. There was a bruise on her left eye near her temple. It was purple and yellowish in color. Resident B was unable to state how she sustained the bruise. Resident B had good hygiene.

I was unable to interview Resident C who was alert but unable to respond to any questions. When she spoke, she mumbled making it difficult to understand her. I observed a bruise in the healing stages on the right side of her forehead that was greenish/yellow in color. Resident C had good hygiene.

I was unable to interview and observe Resident D as she was in the shower with Compassus Hospice aide.

I was unable to interview Resident E because she is non-verbal; however, I observed her sleeping in her Geri chair. Resident E had good hygiene.

I attempted to interview Resident F and Resident G who were eating lunch at the dining room table, but both refused to speak with me. Resident G had good hygiene.

On 12/12/2023, I interviewed DCS Brandi Brooks regarding the allegations. Ms. Brooks was told by the HM that Resident B "bumped her head on the railing." Ms. Brooks was not present but observed the bruise when she came into work. The HM called Resident B's DPOA (B) and told her what happened. Ms. Brooks stated whenever there is an incident or staff observe marks/bruising on residents, then it must be written in the staff communication log. Ms. Brooks did not see anything in the staff communication log regarding Resident B's bruise. Ms. Brooks does not know how Resident C obtained the bruise on her forehead. One day last week she arrived at Sun Valley and Resident C was sitting at the dining room table having lunch. The HM brought the bruise on Resident C's forehead to Ms. Brooks' attention. The HM told Ms. Brooks that the HM does not know how Resident C obtained the bruise. Ms. Brooks has never seen any marks/bruises on Resident B or Resident C in the past.

On 12/12/2023, I interviewed DCS Monique Appleba regarding the allegations. The HM was changing Resident B in bed when the HM rolled Resident B over and Resident B's face hit the bedrail. Ms. Appleba stated the process regarding any incident related to a

resident must be followed by an incident report (RP), notify family, and then staff must document it in the staff communication log. Ms. Appleba did not see an IR written by the HM nor did she see anything in the staff communication log. Ms. Appleba stated a few weeks ago, Resident B also had a bruise on her forehead and was informed by the afternoon shift, that when Erica was transferring Resident B from the Geri chair to the commode, Erica bumped Resident B's head on the corner of the wall. Ms. Appleba was not present when Resident C sustained the bruise on her forehead but was informed by the HM that the bruise on Resident C's forehead was noticed after Compassus Hospice Aide showered Resident C. Again, Ms. Appleba did not see an IR for Resident C's bruise on her forehead, nor did she see anything in the staff communications log.

On 12/12/2023, I interviewed the HM regarding the allegations. The HM stated that about four days ago, Resident B was in her bed and the bedrail was down. The HM did not realize the bedrail had a hoop so when the HM turned Resident B over towards the rail, Resident B's face bumped the rail. The HM informed DCS Ms. Appleba and Ms. Brooks, as well as Resident B's DPOA (B). The HM never completed an IR even though that is their policy and stated she wrote the incident in the staff communication log, but when I reviewed the log with the HM, we both were unable to locate it. The HM does not know how Resident C obtained the bruise on the right side of her forehead but stated she observed the bruise after Compassus Hospice aide showered Resident C. The HM brought Resident C into the dining room for lunch and noticed the bruise. The HM asked the hospice aide, Monique Hunt, "Did you notice the bruise?" The hospice aide said, "I did." The HM never completed an IR or wrote in the staff communication log Resident C's bruise. There are four residents that receive services with Compassus Hospice, Residents A, B, C, and D. The protocol is that anytime a mark/bruise is observed on a resident, it must be documented in the staff communication log, which the HM has not been following.

On 12/12/2023, I interviewed Dr. Gursharan Dhillon co-home manager and licensee's husband regarding the allegations. Dr. Dhillon does not know anything about Resident B's and Resident C's bruising's. He stated, "No one mentioned it to me or Gagan." The protocol regarding any marks/bruises is to let the HM or the administrator which is Susan Carroll know, then inform hospice, then the family and then complete an IR and document in the staff communication log. Dr. Dhillon was advised that the HM never completed an IR regarding Resident B's nor Resident C's bruising's nor did she write them in the staff communication log. He stated, "I will address that with her."

On 12/21/2023, I interviewed Compassus Hospice aide Monique Shalong Hunt regarding the allegations. Ms. Hunt saw the bruises on both Resident B and Resident C. the HM brought Resident C's bruise to Ms. Hunt's attention. Ms. Hunt stated that both residents "constrict," themselves when Ms. Hunt and this facilities staff try to transfer and/or turn them during care. Ms. Hunt cannot say for sure if the bruise on Resident C did not occur during showering or care provided to Resident C. However, the HM reported that the bruise to Resident B was due to Resident B bumping the bedrail when the HM was turning Resident B over to change her. Ms. Hunt has not observed any past marks/bruises on Resident B or Resident C.

On 12/21/2023, I interviewed Resident B's DPOA (B) regarding the allegations. The HM called DPOA (B) and told her that when the HM went to change Resident B who was lying in bed, Resident B hit her face on the bedrail when the HM turned Resident B over towards the bedrail. The DPOA (B) stated a couple of weeks ago that Resident B fell out of bed when staff were transferring her into her Geri chair. The DPOA (B) did not receive a call from anyone at this facility. Instead, Compassus Hospice called her and informed her that Resident B had a bump on her head. Resident B is non-weight bearing and requires two-people to assist her with the Hoyer lift for all transfers. The DPOA (B) visited yesterday with Resident B and noticed that there were two staff members, the HM and DCS Monique Appleba, but the only one providing care to the residents was Ms. Appleba. The HM was in the office the entire time.

The DPOA (B) stated that Resident B also had an eye infection, and her eyes were filled with crust. There was oatmeal on the side of Resident B's mouth from breakfast that no one wiped off. The DPOA (B) took a wet rag and wiped Resident B's face. Also, the same day the DPOA (B) smelled urine coming from Resident B. She looked at Resident B's chair and there was pee on the chair. Resident B was soiled because she was sitting too long in her wet brief. The DPOA (B) asked DCS Ms. Appleba to clean Resident B up which she did, but then when the DPOA B asked to put Resident B back into her chair, Ms. Appleba stated, "I'm just gonna have her stay in bed because of her eye even though her eye is getting better. I'll have her stay in bed until 4:30PM. The DPOA (B) advised Ms. Appleba that hospice did not want her in bed this long and Ms. Appleba said, "someone will take her out at 4:30PM," and she left the room. The DPOA (B) reported other concerns about staff sitting in the living room watching TV instead of caring for the residents. One time the DPOA (B) had to inform staff who were watching TV that the DPOA (B) was leaving and to make sure they check on Resident B. The DPOA (B) is concerned about Resident B when the DPOA (B) is not present. The DPOA (B) stated that since the previous HM and several staff walked out, this home has not been the same. The previous HM and staff were caring properly for all the residents and there were hardly any concerns, but now with this HM and this staff, there are concerns.

On 12/21/2023, I interviewed DPOA (C) regarding the allegations. The DPOA (C) was visiting with his mom when the hospice nurse brought the faint bruise on Resident C's forehead to his attention. The bruise was noticed after Compassus Hospice aide showered Resident C. He stated, "it's he said, she said," so he is not sure how the bruise occurred. The six years that Resident C has been living at this facility, he has not had significant red flags, but due to new management, this could result in inadequate care, but based on his numerous unannounced visits, he has not observed any concerns. He has not seen a pattern of marks and/or bruises on Resident C to state something is going on. He stated, "I don't think there is any physical or verbal abuse happening to mom."

On 01/16/2024, I interviewed Compassus Hospice RN, Nanette Williams regarding the allegations. The HM told the RN that as she was changing Resident B, turned her over

towards the bed rails, Resident B's face hit the bedrail resulting in the mark/bruise on her left eye. The RN stated that since the incident, the bedrail hoop where Resident B hit her left side of her face has not been covered nor have any protective measures taken to ensure it does not happen again. Resident C's bruise on her forehead was faint and the HM stated she does not know what happened, but then the HM stated that she noticed the bruise after Compassus Hospice aide Monique Hunt showered Resident C. It's unclear how Resident C sustained the bruise.

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, the HM Hilary Shattuck did not take any protective measures to ensure the protection and safety of Resident B when providing care. The HM was turning Resident B over in her bed to change her when Resident B hit the side of her face on the bed rail. The bed rail has two hoops that stick up on both sides of the bed rail. Resident B sustained bruising to her left eye. I observed the hoop on the bedrail to still be exposed and not covered with anything to prevent further incidents. In addition, it was reported that around Halloween, the previous HM and staff walked out of this facility leaving only Compassus Hospice staff at the facility. The residents' personal needs, including protection and safety were not attended to at all times. Compassus Hospice remained in the facility until the husband of licensee designee Gagan Mann, Dr. Gursharan Dhillon arrived and called additional staff to the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0465012 dated 01/05/2022, CAP dated 04/11/2022**

ALLEGATION:

Home manager (HM) Hilary Shattuck said to Resident A, "Resident A is grumpy today, you must be on your period."

INVESTIGATION:

On 12/11/2023, I contacted the reporting person (RP) via telephone and discussed the allegations. The RP heard the HM say to Resident A, “you must be grumpy because you’re on your period.” The HM left the room and Resident A told the RP, “I don’t like her. She’s condescending.” The RP also reported a time that they overheard DCS Monique Appleba cursing, using the “F,” word at this facility. The RP was unsure if Ms. Appleba was on the phone or if Ms. Appleba was speaking with another staff member. There were no residents present, but the RP was concerned that this is how staff are speaking to and in front of the residents.

On 12/12/2023, I interviewed Resident A regarding the allegations in her bedroom. Resident A is wheelchair bound and verbal. Resident A does not like the HM because the HM, “yells at you. One day she’s nice and the next day she snaps at you. I tried so hard to be kind to her, but she yells. I don’t know how she is with others because I usually stay in my room.” Resident A is not afraid of the HM, but she does not know how the HM speaks to her.

On 12/12/2023, I interviewed DCS Brandi Brooks regarding the allegations. Ms. Brooks has only been working for this company for about a month. She works first shift from 7AM-3PM. Ms. Brooks has worked with the HM and stated, “I cringe when Hilary speaks.” Ms. Brooks has heard the HM “yell and be harsh,” with the residents, especially Resident A. Ms. Brooks was not present when the HM told Resident A “you’re grumpy today so you must be on your period.” Ms. Brooks stated I heard her say to Resident D, “you shit in your pants, you shit all over the place and now I have to clean it.” Ms. Brooks told the HM, “What did you say? You can’t talk to them like that.” The HM responded, “I’ve been doing this for 34 years, so I know what I’m doing.” Ms. Brooks believes the HM is “too comfortable around the residents and says things without thinking.” Ms. Brooks has not reported these concerns to anyone.

On 12/12/2023, I interviewed DCS Monique Appleba regarding the allegations. Ms. Appleba has been with this company for about one and a half years. She too works the morning shift from 7AM-3PM. Ms. Appleba is Ms. Brooks’ daughter. Ms. Appleba was not present when the HM spoke inappropriately to Resident A but stated that there was a time when the HM did not know that Ms. Appleba had arrived at her shift at 7AM and Ms. Appleba heard the HM saying to Resident C, “shut the hell up,” when Resident C was singing. Resident C likes to sing, but each time Resident C sings, the HM yells for Resident C to “shut up.” Ms. Appleba has also heard the HM speak rudely to all the residents and stated, “she’s always yelling and screaming at them.” Ms. Appleba has never reported these concerns to anyone.

On 12/12/2023, I interviewed the HM Hilary Shattuck regarding the allegations. Ms. Shattuck has been working here for 11 years but has a total of 34 years of experience in this field. She works the midnight shift from 11PM-7PM but has been promoted to the HM so she now works the morning shift. The HM stated, “I don’t yell. Some of the residents are hard of hearing so I have to raise my voice.” The HM stated, “I admit I did

say to Resident A you're grumpy today, you must be on your period. I understand it's inappropriate and I regret it after I said it." The HM then stated, "I'm joking with the residents to make them laugh and smile. I pat Resident A on her butt, and she pats me on the butt."

While I was interviewing the HM, Dr. Gursharan Dhillon, the licensee designee (LD) Gagan Mann's husband arrived at the facility. I interviewed him regarding the allegations. Dr. Dhillon has not received any complaints or concerns about the HM speaking inappropriately to Resident A or any other resident. He stated that the LD would have told him about these issues if she was aware of them. He will inform the LD of these issues as he agrees that the HM should never speak to Resident A or any other resident the way she has. He then stated, "Hilary was just made the HM. I will have to reassess that because maybe she shouldn't be the HM."

On 12/21/2023, I interviewed Compassus Hospice aide Monique Shalong Hunt regarding the allegations. Ms. Hunt has no knowledge or information about the HM speaking inappropriately to the residents. She stated, "if Hilary has spoken inappropriately, it must have happened when I'm not there because I would have said something to her."

On 12/21/2023, I interviewed Resident A's DPOA (A) regarding the allegations. Resident A brought to his attention how the HM was speaking to her. The DPOA (A) stated he spoke with the HM and told her that it is not appropriate to speak to Resident A that way and that behavior was unacceptable.

On 12/21/2023, I interviewed Resident B's DPOA (B) regarding the allegations. DPOA (B) has never heard the HM speak inappropriately to Resident B whenever the DPOA (B) has been present. However, the HM was working the midnight shift so that is why the DPOA (B) was never present during her shifts. Currently, there have not been any reports of the HM speaking inappropriately to Resident B by anyone at this home.

On 12/21/2023, I interviewed Resident C's DPOA (C) regarding the allegations. There has not been any time where DPOA (C) has heard the HM, or any other staff speak inappropriately to Resident C or any other resident. He stated, "I personally have never heard her speak that way to Resident C."

On 01/16/2024, I interviewed Compassus Hospice RN, Nanette Williams regarding the allegations. Ms. Williams has been providing hospice care to this facility for a long time. Prior to this new management, things were great with no issues regarding the care of the residents. Since the HM took over, there have been concerns about the way the HM speaks with the residents. The HM is not the only one as other staff have been heard speaking inappropriately either in the vicinity of the residents or to the residents. The staff are "cranky and patronizing." Resident B likes to sing and when she starts jabbering, the HM will grab Resident B by the face, squeeze her cheeks and say, "shut up Resident B shut up, we're talking here." The RN has spoken to the HM several times about the way she speaks with the residents and the HM says, "I've been doing this job

for 34 years, and I know what I'm doing." These concerns were reported to Compassus Hospice management but when they reached out to Dr. Dhillon, he had the HM call them back instead of himself. Compassus Hospice management advised the HM that they needed to speak with Dr. Dhillon, not her since the complaint was about the HM. The RN stated, "Dr. Dhillon is so far removed that he only becomes involved when there is a complaint."

On 01/16/2024, I interviewed LD Gagan Mann via telephone regarding the allegations. Ms. Mann stated she was informed of the allegations by Dr. Dhillon whom she referred to as "co-manager." She was informed that the HM was "not speaking properly." Ms. Mann addressed this by "having a conversation with the HM about how to speak with residents." There was no training provided to the HM, just a "conversation." Ms. Mann was asked about the marks/bruises on Residents B and C. She stated, "Dr. Dhillon being a physician is following up with the patient." She was unable to provide any further details as to the bruising or why Dr. Dhillon was following up as a "physician," with the residents when this is a "conflict of interest," with him being as the "co-manager." Ms. Mann stated the last concern was about "food being cold." I advised her that the concern was that there was very minimal to no food at the facility. Ms. Mann stated, "there is always food and there has never been a time there wasn't enough food." She said, "the menu wasn't available, but the food is always available." Ms. Mann stated she will review these allegations and call me back with how they have been addressed.

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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	Based on my investigation and information gathered, the HM Hilary Shattuck has subjected Resident A, Resident C, and Resident D to mental/emotional cruelty and verbal abuse when the HM yells, screams, and makes inappropriate comments towards the residents. The HM has been heard yelling and patronizing the residents by multiple individuals. Resident A informed me that the HM yells at her and the HM confirmed she told Resident A, "you're grumpy today so you must be on your period."
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my on-site investigation on 12/12/2023, several DCS, Compassus Hospice RN, and Dr. Dhillon reported that the previous HM and staff walked out and quit working at this facility around Halloween 2023. Compassus Hospice was on-site during the time and remained with all the residents until Dr. Dhillon arrived at the facility finding additional staff to cover the shift. Compassus Hospice staff are not employed by Sun Valley Senior Living; therefore, they do not have the proper training, nor their criminal background checks to provide for the care of these residents. The was insufficient staff on duty to provide for the care of the residents.

On 01/17/2024, I conducted another unannounced on-site visit. Present were the HM, the cook Kyle Ralston and Residents A, B, C, D, F, and G. Also present was DPOA (C) who was observed feeding Resident C and Compassus Hospice RN Nanette Williams. The RN was present visiting Residents A, B, and C whom she provides hospice services too.

The HM stated she is working alone today because DCS called in sick. The HM does not know how many DCS should be on shift because she does not have the staff schedule ready yet. She believes it's one DCS per shift but sometimes there are two DCS per shift. The HM stated that Residents B, C, and F use a Hoyer lift for transfers, but she is unsure if their assessment plans reflect if they are a two-person assist or not. The RN was present during this conversation in the dining room and stated, "there must be two-persons during transfers while using the Hoyer lift. This was part of the Hoyer lift training." The HM stated, "Oh I didn't know that." The HM stated she was trained on using a Hoyer lift, but she cannot recall if there must be two persons because she has always used the Hoyer lift during transfers alone.

I reviewed Residents B's, C's, and F's assessment plans and found the following errors:

- **Resident B's** assessment plan completed on 09/06/2023 was incomplete as boxes were checked but no "needs," were described and how they will be met were not identified throughout the assessment. It is unclear what Resident B's needs are and how staff are supposed to meet those needs.
- **Resident C's** assessment plan was completed and expired on 11/10/2021. I did not see an updated assessment plan in Resident C's file. The assessment plan was also incomplete with needs not identified and/or how staff will be meeting those needs.
- **Resident F's** assessment plan was completed and expired on 12/08/2021. I did not see an updated assessment plan in Resident F's file. The assessment plan was also incomplete with needs not identified and/or how staff will be meeting those needs.

During this visit, I observed Resident B and Resident F sitting in the dining room with their food trays sitting in front of them. The HM stated she is supposed to feed them but

was assisting Resident D in the bathroom. Resident F was in her Geri chair sleeping and slumped over in her chair almost hitting the dining room table. I called out Resident F's name and she woke up and adjusted her head. I was at this facility for about 45 minutes and during this entire time, Resident B and Resident F were still not fed their food that had been sitting on the dining room table for that long.

On 01/17/2024, I spoke with Dr. Dhillon who stated that they are short staffed today because a couple of DCS called in sick. He will call staff to come to the facility and begin their shifts early to ensure there are sufficient staff on shift. Staff called off, and they are short staffed, and the HM is alone working her shift. He was advised that there should always be at least two DCS per shift always due to Residents B, C, and F being two-person assists for all transfers according to the RN. He stated that he will call the other staff working the afternoon shift and have them come into work.

On 01/17/2024, I received a text message from Dr. Dhillon stating that he is at the facility as well as two other DCS that arrived at their shifts.

On 01/17/2024, I received a text message from the HM sending me a copy of January staff schedule. I reviewed the staff schedule and there are only one DCS per shift on many of the days. For example, 01/01/2024, 01/03/2024, 01/08/2024, 01/09/2024, 01/11/2024, 01/13/2024-01/15/2024, and on 01/17/2024 there was only one DCS scheduled to work per shift. There are three shifts: 7AM-3PM, 3PM-11PM, and 11PM-7AM. There is always only one DCS during the midnight shift for the entire month of January 2024.

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 on-site investigation on 01/17/2024, there were insufficient DCS on duty to provide for the supervision, personal care, and protection of Residents A, B, C, D, F, and G. The HM was the only DCS on shift this day when according to the Compassus Hospice RN, Nanette Williams, there should always be two DCS per shift. Residents B, C, and F require two persons assist during transfers because they use a Hoyer lift for all their transfers. The RN stated that during the Hoyer lift training, DCS are informed that two-persons must assist during transfers using the Hoyer lifts. The HM did not know that there should be two-persons when using the Hoyer lift as she does not recall that in her training. Also during the onsite, Residents

	B and F were observed sitting at the dining room table with their lunch trays in front of them for over 45 minutes which is how long I was at this visit that no one fed them. Both residents must be fed by another person. I reviewed January 2024 staff schedule and according to the schedule, there is only one DCS per shift on many of the days. For example, 01/01/2024, 01/03/2024, 01/08/2024, 01/09/2024, 01/11/2024, 01/13/2024-01/15/2024, and on 01/17/2024 there was only one DCS scheduled to work per shift. There are three shifts: 7AM-3PM, 3PM-11PM, and 11PM-7AM. There is always only one DCS during the midnight shift for the entire month of January 2024.
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 review of Resident B's, Resident C's, and Resident F's assessment plans to obtain information on their needs I found the following errors: **Resident B's** assessment plan completed on 09/06/2023 was incomplete as boxes were checked but no "needs," were described and how they will be met were not identified throughout the assessment. It is unclear what Resident B's needs are and how staff are supposed to meet those needs. **Resident C's** assessment plan was completed and expired on 11/10/2021. I did not see an updated assessment plan in Resident C's file. The assessment plan was also incomplete with needs not identified and/or how staff will be meeting those needs. The assessment plan was not completed annually for 2022 and 2023. **Resident F's** assessment plan was completed and expired on 12/08/2021. I did not see an updated assessment plan in

	Resident F's file. The assessment plan was also incomplete with needs not identified and/or how staff will be meeting those needs. The assessment plan was not completed annually for 2022 and 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 12/12/2023, during my interview with Resident A, she reported that there is not enough food here and that she is only given a can of soup and a sandwich for dinner.

On 12/12/2023, DCS Brandi Brooks was interviewed regarding the food. She reported that the residents are eating canned chicken noodle soup, a sandwich and ice cream for dinner. There is no menu for the cook, Frances Garland to follow and there are times, there is not enough food for the residents.

On 12/12/2023, I interviewed DCS Monique Appleba regarding the food. Ms. Appleba confirmed that sometimes there is not enough food for the residents. There were times when she had to use her own money to purchase food and the essentials needed for this facility. She stated, Dr. Dhillon who is the owner of this facility went grocery shopping recently because there was no food. There used to be a menu, but not anymore after the last HM Desiree Peter's "walked out." Residents B, C, and E are on a pureed diet, but there is no menu reflecting that. She is unsure who is responsible for the grocery shopping, but Dr. Dhillon gives money to the HM, so she believes it is the HM's responsibility. She stated there is enough food today.

On 12/12/2023, I interviewed the HM regarding the food. Dr. Dhillon gave the HM money, and she recently went shopping for groceries and the essentials. She did the shopping around Thanksgiving. The cook, Frances also does the grocery shopping when there's something missing such as eggs, milk, and so forth. The cook makes a "hefty," lunch but for dinner residents are served a sandwich with soup. The menu was taken down as the HM has been working on it. However, she was unable to produce the menu for me during this visit. In the past, there have been minimal food, but when there is no food, she informs Dr. Dhillon who then gives her money to go grocery shopping.
I interviewed the cook, Frances Garland regarding the allegations pertaining to the food. Ms. Garland has been working for this corporation for eight years. She stated there has not been a menu since the previous HM, Desiree Peters walked out during Halloween. She was in the process of making lunch for the residents. There was tuna noodle casserole with a biscuit along with juice and water for a drink. Ms. Garland stated there is enough food now, but there has not been enough food in the past. Ms. Garland also has spent her own money purchasing groceries for the residents when there was minimal food in the home. She did get reimbursed for the groceries she bought. Dr. Dhillon is responsible for giving money to the HM who then does the grocery shopping.

On 12/12/2023, I observed the refrigerator in the kitchen, as well as the two refrigerators and a separate freezer in the pantry room and there was enough food.

On 12/12/2023, I interviewed Dr. Gursharan Dhillon regarding the food. Dr. Dhillon was informed of the food situation when he received a call from the HM saying that Resident A's sone was complaining about the food. Dr. Dhillon did the grocery shopping about two-three weeks ago from Costco. The HM went shopping last week. He stated he gives money to the HM to purchase food and the essentials and that he will assure there is always enough food at this facility for the residents. The cook, Frances Garland is supposed to give the HM a shopping list for groceries needed and then the HM goes shopping. Dr. Dhillon stated he spoke with Ms. Garland about the food concerns and to inform the HM whenever there is a food shortage in the home. He stated that there was a menu, but since the previous HM Desiree Peters walked out around Halloween, there has not been a menu as the administrator Susan Carroll is working on it. He stated he hired Ms. Carroll to take on the administration responsibilities for this home and to work closely with the HM.

On 12/21/2023, I interviewed the DPOA (B) regarding the food. The food has not been great here either. Resident B is on a pureed diet so when the DPOA (B) was present during lunch, the HM was asked what the food was. The HM told the DPOA (B) "it's pureed pizza." Yesterday when the DPOA (B) was present they pureed cabbage rolls, but then gave it hole to the other residents who appeared to have issues with eating it because they were too big.

On 12/21/2023, I interviewed DPOA (C) regarding the food and he has no concerns to report about the food.

On 12/29/2023, I received a detailed voice mail message from DPOA (A) stating that they were at the facility and there was no food. The owner needs to fulfil their obligations of making sure there is enough food in this facility for all the residents and they are not.

On 01/02/2024, I returned DPOA (A) call who stated that there currently is enough food now but are concerned about the continuous lack of food at the home. They are also concerned that Dr. Dhillon is not doing anything to resolve the issues regarding the food.

On 01/16/2024, I interviewed Compassus Hospice RN, Nanette Williams regarding the food. Last week, 01/09/2024 when the RN was at the home, she observed Resident A eating a pack of instance oatmeal and water only because there was no food in the facility. The RN has been receiving multiple complaints from family members about no food and the type of food being fed to the residents. The facility has the menu but are not following it. One of the DCS, Monique Appleba was complaining about the cook not following the menu and that Dr. Dhillon is not doing anything to address these issues. The RN stated that because of all these issues, Resident E has moved out of the home.

On 01/17/2024, I interviewed the cook Kyle Ralston who stated he began working here middle of December 2023 to “help out.” He was making spaghetti but that was not on the menu. I observed the menu on the refrigerator, but Mr. Ralston stated, “I’m not following the menu because we don’t have what’s on their here.” I opened the refrigerator in the kitchen and observed very minimal food. I also observed in the right corner of the shelf a bin full of spoiled food of cucumbers, meat, and other vegetables. Pictures were taken. Mr. Ralston stated, “Oh yeah, I have to throw that away.” I went into the pantry and opened two refrigerators and one freezer and observed extremely minimal amount of food in the home.

On 01/17/2024, the HM stated there was minimal to no food because she had not gone shopping because she is the only staff member working today as a couple DCS called in sick. Dr. Dhillon gave her $400 to grocery shop but she has not had an opportunity to get groceries for the facility. The HM stated that she is also responsible for feeding Resident B and Resident F their food that has been sitting on the dining room table, but she has not had the chance to because she was assisting another resident, Resident D to the bathroom.

APPLICABLE RULE	
R 400.15313	**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 hours.
ANALYSIS:	Based on my investigation and information gathered, several family members have complained to Compassus Hospice that there is minimal food in the home for all the residents. Dr. Dhillon stated that Resident A’s family called complaining about the food being provided at this facility. During my unannounced on-site visit on 01/17/2024, there was minimal to no food in the facility. The HM acknowledged there was minimal food and stated she had yet gone shopping to purchase groceries.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.

ANALYSIS:	During my unannounced on-site investigation on 12/12/2023, there was no menu written at least 1 week in advanced and posted in this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome, and free from spoilage, adulteration, and misbranding.
ANALYSIS:	During my unannounced on-site visit on 01/17/2024, I observed a bin full of spoiled food; vegetables and meat in the refrigerator located in the kitchen.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 01/17/2024, I spoke with the HM who stated that the furnace stopped working about three days ago and Resident A's family brought in the space heater because Resident A was complaining about being cold. I looked at the thermostat and it was, 63° Fahrenheit when the heat was set to 80° Fahrenheit. The HM informed Dr. Dhillon this morning and was informed by Dr. Dhillon that someone will come out to look at the furnace. The HM did not inform Dr. Dhillon immediately because she thought the furnace not working was due to the "outside wind." I advised the HM that the residents should not be staying at this facility without any heat and that she should have contacted Dr. Dhillon when she first noticed it not working. The HM stated she did not know.

On 01/17/2024, I stopped in Resident A's bedroom and observed a space heater being used. Resident A stated it was very cold in her bedroom and needed the space heater.

On 01/17/2024, I attempted to call the LD, Gagan Mann but there was not answer so I left a message. I contacted Dr. Dhillon who advised that the furnace was being repaired today and he will forward me the invoice. Dr. Dhillon was just informed by the HM about the furnace. If he would have known, he would have had it fixed immediately.

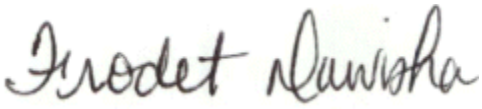
On 01/17/2024, I received a text message from Dr. Dhillon with the invoice to the furnace repair that was now working.

On 01/24/2024, I conducted the exit conference with licensee designee Gagan Mann and her husband Dr. Gursharan Dhillon regarding my findings. Ms. Mann stated that they have addressed some of the issues at the facility. They have spoken with the HM regarding appropriate etiquette in speaking with the residents and will be sending her to training. They have also reassessed the staff schedule and will hire additional staff to ensure there are two DCS per shift always to meet the needs of the residents. The furnace is working so they have removed the space heater from Resident A's bedroom. In addition, they had the HM go grocery shopping and understand the importance of ensuring there is adequate amount of in the home and that the food is not spoiled. Ms. Mann will review all assessment plans to ensure they are updated and current.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of the occupants.
ANALYSIS:	During my on-site investigation on 01/17/2024, there was a space heater being used in Resident A's bedroom because the furnace was not operating properly. The furnace was repaired this same day, and the space heater has been removed per licensee designee Gagan Mann.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



01/24/2024

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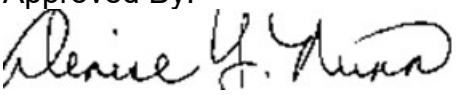
Frodet Dawisha Date
Licensing Consultant

Approved By:



01/25/2024

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Denise Y. Nunn Date
Area Manager