GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 12, 2024

Monica Flagg
Elite Alternatives, Inc.
3330 Primary Rd.
Auburn Hills, MI 48326

RE: License #: AS630012646
Investigation #: 2024A0605014
Warick Group Home

Dear Monica Flagg:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your 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 (248) 975-5053.

Sincerely,

Frodet Dawisha

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 #:	AS630012646
Investigation #:	2024A0605014
Complaint Receipt Date:	01/10/2024
Investigation Initiation Date:	01/10/2024
Report Due Date:	03/10/2024
Licensee Name:	Elite Alternatives, Inc.
Licensee Address:	3330 Primary Rd Auburn Hills, MI 48326
Licensee Telephone #:	(248) 852-2065
Administrator/Licensee Designee:	Monica Flagg
Name of Facility:	Warick Group Home
Facility Address:	3127 Warick Royal Oak, MI 48073
Facility Telephone #:	(248) 288-6902
Original Issuance Date:	09/05/1990
License Status:	REGULAR
Effective Date:	03/29/2023
Expiration Date:	03/28/2025
Capacity:	2
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was observed to have bruising on 12/31/2023. Both eyes were swollen shut, with bruising on his face and head area.	Yes
Resident A was admitted into the hospital for failure to thrive, dehydration, and hypothermia.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/10/2024	Special Investigation Intake 2024A0605014
01/10/2024	Special Investigation Initiated – Telephone Discussed allegations with APS Marcie Fincher
01/10/2024	APS Referral Adult Protective Services (APS) made referral
01/10/2024	Contact - Telephone call made Discussed allegations with Oakland County Office of Recipient Rights (ORR) Heather Shepherd
01/10/2024	Contact - Telephone call made Left message for APS worker Jordon Walker who is assigned this investigation and Detective Meckl with Royal Oak Police Department (ROPD)
01/10/2024	Contact - Document Received Emails from ORR Heather Shepherd
01/10/2024	Contact - Document Received Discussed allegations with APS Marcie Fincher
01/10/2024	Contact - Telephone call made Left message for Detective Meckl with Royal Oak Police Dept (ROPD)
01/11/2024	Inspection Completed On-site Conducted unannounced on-site investigation

01/15/2024	Contact - Telephone call received Message left by Detective Meckl
01/16/2024	Contact - Telephone call made Left message for Detective Meckl
01/16/2024	Contact - Telephone call made Discussed allegations with DCS Yulanda Thomas, reporting person (RP), ORR Heather Shepherd, and home manager (HM) Darrin Craggette. Left messages for DCS Bridgette Walker, and Resident A's primary care physician (PCP) Dr. Mansour,
01/17/2024	Contact - Face to Face Conducted another unannounced face-to-face at the home with the HM, Resident A and Resident B
01/18/2024	Contact - Telephone call made Discussed allegations with DCS Sharon Tarver
01/22/2024	Contact - Telephone call made Discussed allegations with APS worker Jordan Walker and Detective Meckl. I contacted the group home owner, Donna Kimber's son-in-law William Belbot and Kurt with Bow Heating and Cooling.
01/23/2024	Contact - Face to Face Conducted another unannounced face-to-face in collaboration with APS Jordan Walker
01/23/2024	Contact - Face to Face Conducted a face-to-face with Resident A, RN Leslie, attending physician Rahul Pidikiti, and case manager Dawn at Trinity Health Oakland Hospital.
01/25/2024	Contact - Face to Face Conducted face-to-face with HM and Resident B
01/29/2024	Contact - Document Received Email from ORR Heather Shepherd
01/30/2024	Contact - Telephone call made Discussed allegations with DCS Eric Brooks, James Oglesby and left messages for DCS Yulanda Thomas and Sharon Tarver

01/30/2024	Contact - Telephone call made Followed up with ORR Heather Shepherd
02/05/2024	Contact - Telephone call made Interviewed DCS Bridgette Walker regarding the allegations
02/06/2024	Contact - Telephone call received Interviewed DCS Yulanda Thomas regarding the allegations
02/07/2024	Contact - Telephone call made Left message for licensee designee Monica Flagg
02/07/2024	Exit Conference Conducted exit conference with licensee designee Monica Flagg with my findings

ALLEGATION:

Resident A was observed to have bruising on 12/31/2023. Both eyes were swollen shut, with bruising on his face and head area.

INVESTIGATION:

On 01/10/2024, intake #199154 was referred by Adult Protective Services (APS) regarding Resident A was observed to have bruising on him on 12/31/2023. Both of his eyes are swollen, one side of his head is swollen, and there was bruising all over the face and head area. The home manager (HM) Darrin Craggette waited three days to take Resident A to the hospital.

On 01/10/2024, I initiated the special investigation by contacting APS worker Marcie Fincher. Ms. Fincher stated she was the on-call APS worker when she received these allegations. She reached out to Royal Oak Police Department (ROPD) requesting a welfare check of Resident A on 01/07/2024. The officers went to the home and contacted her after their visit. The officers reported to Ms. Fincher that the staff, Sharon Tarver who was on shift told officers that “Resident A fell out of bed,” which resulted in in the injuries. The officer told Ms. Fincher that the story provided by Ms. Tarver was not consistent with Resident A’s injuries. The officers took pictures of Resident A’s face and advised Ms. Fincher that the case will be assigned to a detective.

Ms. Fincher stated that the officer then spoke with the HM who advised the officers that Resident A was seen at Trinity Health Oakland Hospital on 01/01/2024. The HM also reported that Resident A’s guardian, Jim Stark with Macomb-Oakland Guardianship, Inc. (MOGI) was aware of these injuries. A safety plan was discussed with the HM who stated that DCS James Oglesby was working when Resident A fell and will be taken off the schedule. Officers reported to Ms. Fincher that after Resident A fell, the HM

removed the box spring from the bed. The officer told Ms. Fincher that the bed is not very high, so he is concerned about Resident A's injuries.

The assigned APS worker, Jordan Walker went out to the home on 01/09/2024, and followed up with Resident A's case manager Sarah Valley with Easter Seals. The safety plan is still in place with DCS James Oglesby being off the schedule and not working at this home.

On 01/10/2024, I contacted Oakland County Office of Recipient Rights (ORR) worker Heather Shepherd regarding the allegations. Ms. Shepherd went out to the group home on 01/09/2024 with APS worker Jordan Walker. The HM Darrin Craggette was present as were Resident A and Resident B. The HM stated that on 01/01/2024, DCS James Oglesby was on shift when Resident A fell out of bed. Ms. Shepherd stated she spoke with Easter Seals case manager, Sarah Valley who informed Ms. Shepherd that there was a Zoom meeting on 12/29/2023 at 12:25PM with the HM, Ms. Valley and Resident A. Ms. Valley did not observe the injuries on Resident A's face.

The HM explained to Ms. Shepherd that on 01/01/2024 he received a call from DCS James Oglesby stating that Resident A fell out of bed and had injuries. The HM supposedly "cut his vacation short with his wife," after receiving the call on 01/01/2024 from Mr. Oglesby. Ms. Shepherd called the HM's wife who stated, "we did not cut our vacation short. We checked out at 11AM because that was our checkout time. Darrin didn't receive any call from the group home." Ms. Shepherd attempted to interview Resident A, but Resident A can only answer some questions and cannot carry a conversation given his cognitive disabilities. Resident B is Resident A's brother who also lives at this group home and Resident B is non-verbal.

On 01/10/2024, I received via email progress notes from ORR worker Heather Shepherd regarding Resident A.

- Progress note dated 12/29/2023: "Telemed Video with Resident A on 12/29/2023 with Resident A's support's coordinator (SC) Sarah Evans-Vallee with Easterseals Macomb-Oakland Regional Center (MORC) and the HM. The HM reported to Ms. Evans-Vallee that Resident A fell on Monday and this morning. HM is going to call today to schedule a doctor's appointment to check on this. SC sent email to CEO to follow up on services CEO reports they are short on staff and cannot meet the 1:1 staffing requirement at this time."
- Progress note dated 08/14/2023: "SC was notified on 08/15/2023. When staff was helping Resident A getting dressed and they noticed he had a bruise about the size of a dime on the right side of his face, just below his eye. Staff asked what happened and he said that he fell on his bedroom getting into bed. Staff cleaned his bruise with warm soapy water per SMO and he was monitored the rest of the day. Staff to be available when Resident A get in out of bed."
- Progress note dated 06/24/2023: "SC was informed on 07/11/2023 that on 06/24/2023 that Resident A was in his room. He moved his bed and bumped his

head on the bed. He sustained a cut above his eyebrow. Staff cleaned with soap and water. Tiple antibiotic ointment was applied."

On 01/11/2024, I conducted an unannounced on-site investigation. Present were the HM, Resident A and Resident B. I attempted to interview Resident A but was unsuccessful as he was unable to respond to my questions. I observed Resident A's face, his entire face was covered with bruises including both eyes, nose, and the neck area. There was a large bump on the right side of his forehead.

I observed Resident B, who is non-verbal. He was observed to have no injuries. Resident B is ambulatory. During this onsite, Resident B kept grabbing my arm forcefully and then he would strip his clothes off. I had to ask the HM several times to redirect Resident B.

I interviewed the HM Darrin Craggette regarding the allegations. The HM has been working for this corporation over 25 years. He usually works the morning/day shift from 7AM-3PM. The HM stated he was on vacation with his wife from 12/29/2023-01/01/2024. On 12/29/2023 around 10:30PM, the HM received a telephone call from DCS Yulanda Thomas stating that Resident A rolled out of bed and there was a dime size bruise on the side of his face and that she was concerned about it. Ms. Thomas asked Resident A what happened and Resident A stated, "I rolled out of bed." The HM advised Ms. Thomas to complete an incident report (IR) and to monitor Resident A throughout the night. On 12/30/2023, DCS James Oglesby worked the morning shift from 7AM-3PM and there were no concerns that day. Mr. Oglesby did not work on 12/31/2023 but did work on 01/01/2024 from 7AM-3PM. Around 10:30AM on 01/01/2024, when the HM and his wife were "on vacation," the HM received a call from Mr. Oglesby stating that "Resident A rolled out of bed and hit his face." The HM stated, "we cut our vacation short.," I went right to the group home. (**Note: ORR Heather Shepherd contacted the HM's wife who stated that they did not cut their vacation short on 01/01/2024 and that the HM never received a phone call from work.**) He observed a bruise on the right side of Resident A's face and a bump on the right side of his forehead. The HM advised Mr. Oglesby to take Resident A to the hospital, which Mr. Oglesby did at Trinity Health Oakland Hospital.

I reviewed the hospital's discharge papers, which noted that Resident A sustained a facial fracture - broke nose and contusion to the right forehead. I also reviewed two separate IR's: one written on 12/29/2023 at 10:30PM by Yulanda Thomas and another IR written on 01/01/2024 at 7AM by James Oglesby. The HM stated that the time written on 01/01/2024 should have been 10:30AM, not 7AM as written by Mr. Oglesby. The HM saw Mr. Oglesby on 01/01/2024 and described him as "being scared." The HM suspended Mr. Oglesby the next day.

I reviewed the time punch cards and according to the timecards, the HM Darrin Craggette worked on 12/31/2023 from 7:45AM-3:02PM when the HM stated he was on vacation with his wife. The HM then stated, "it must have been after work that we went on vacation. I call it vacation after work." He then said, "I did see his face on 12/31/2023, but it wasn't like it was now. There was only a scratch on the side of his

right face." The HM removed the mattress from Resident A's bed because "it was too high." There was only a box spring on the bed. The HM was questioned why he removed the mattress and not the box spring, but he was unable to provide an answer. He stated that Resident A has been sleeping on the couch so, "I can keep an eye on him." Resident A has "fallen from the bed before," but the HM said that his injuries have never been as severe as they are now. I requested to review all Resident A's IR's. There were three IRs for Resident A but only one dated 06/24/2023 was for falling out of the bed. No medical treatment was provided. The HM never lowered the bed after the previous falls, nor did he follow up with Resident A's primary care physician regarding bedrails or any other safety measures to ensure Resident A's safety when he was in bed. The HM did not take Resident A to the hospital immediately because he stated, "I'm trying to think how this happened." He then stated that, "I'm not saying that James caused the injuries, I'm saying it happened when James was here." Mr. Oglesby has been working at this home for about four years. There have been no complaints of any abuse and/or neglect by Mr. Oglesby towards any resident including Resident A. HM reported in the past, Resident B would push his brother Resident A, but that was over 10 years ago. The HM does not believe these injuries were caused by Resident B or any other person at this group home.

Note: During this visit, the HM Darrin Craggette stepped outside several times to his car to grab documents leaving me alone in the home with Resident A and Resident B.

On 01/11/2024, I received via email an update from ORR worker Heather Shepherd regarding her interviews with staff. Here is her contact: "DCS James Oglesby told me Resident A fell 12/29/2023. I have statements from Bridget Walker and Yulanda Thomas that Resident A fell on the 29th. DCS Sharon Tarver reported that Resident A had a bruise and swelling over his right eye on the 31st. The only person who is saying he fell on the 1st was Darrin, the HM. Ms. Tarver stated Mr. Oglesby was there when she came in for the midnight shift and told her Resident A fell. Mr. Oglesby stayed over an hour. The HM arrived around midnight. Ms. Tarver felt Resident A should have gone to emergency, but the HM did not instruct them to. The HM told them to ice it and watch him. Ms. Tarver stated when she came back on 01/02/2024 Resident A's eye was swollen shut. The HM waited three days to get medical care for Resident A."

On 01/16/2024, I interviewed DCS Yulanda Thomas regarding the allegations via telephone. Ms. Thomas has been working for this corporation since September 2022. She works the midnight shift from 11PM-7AM. There is only one DCS per shift with Resident A and Resident B. Ms. Thomas worked from 12/29/2023-12/31/2023 during the midnight shift and then did not return until 01/05/2024. On 12/29/2023, during the midnight shift change, Mr. Oglesby called her around 11:05PM when she had pulled into the driveway of the group home. He told her, "Resident A fell out of bed and hit his face extremely hard on the floor." She came into the home around 11:07PM and observed Resident A's face. She saw the bruising to the right side of his face and the swelling on his forehead. Mr. Oglesby told Ms. Thomas that the HM was contacted and would be arriving at the group home soon. The HM called a couple of times checking on Resident A. Ms. Thomas felt that Resident A should go to the hospital, but it was the

HM's call. The HM arrived around 12AM and only told her to monitor Resident A. Mr. Oglesby remained at the home for an additional one and a half hours past his shift because he was concerned about Resident A. The HM told her to put ice on Resident A's face which she did. Ms. Thomas denied calling the HM on 12/29/2023 and denied completing an IR on 12/29/2023. She does not know about any other fall after 12/29/2023. She was never informed of Resident A falling out of the bed again on 01/01/2024. Ms. Thomas heard that Mr. Oglesby took Resident A to the hospital on 01/01/2024 regarding the bruising on his face. She believes these injuries are consistent with Resident A "falling out of his bed." She stated that Resident A has a history of falls, banging his head on the floor, and continues to get up from his wheelchair and/or bed without asking for assistance. He is a fall risk. Ms. Thomas stated, "I think Resident A requires a one-to-one because he is a high fall risk. In the past, we used to have two to three staff here because Resident A required that close supervision." She then stated, "A lot of this, Resident A brought on himself." Ms. Thomas would not elaborate on this statement. She felt that Resident A should have been seen by a doctor on 12/29/2023 after falling out of bed but that was not her call and she deferred to the HM. There are no protocols in place regarding what to do for an unwitnessed fall or when to call 911. Ms. Thomas saw a decline in Resident A for about two to three months with his behavior but never reported this to anyone. She attributed this to possibly his medication changed but was not sure if his medication were changed or not. She does not believe that any staff including Mr. Oglesby caused Resident A's injuries.

On 01/16/2024, I contacted the reporting person (RP) regarding the allegations. The RP was contacted by someone who was concerned that the injuries sustained by Resident A were not consistent with that of "falling out of bed." The RP was told that the "HM was acting suspiciously." The RP observed the pictures of Resident A's injuries and because they are mandated to report, they filed the complaint with Adult Protective Services (APS).

On 01/16/2023, I contacted the HM via Facetime to observe Resident A's shoulders, arms, and back to see if there are any injuries to the right side of the body to indicate he fell out of bed. I observed scabs on Resident A's right arm between the elbow and shoulder, redness near his spine and light red marks on the side of his right ribs. The HM agreed to take pictures of these marks and text/email them to my attention. The HM stated that the IR on 12/29/2023 was completed by DCS Yulanda Thomas even though Ms. Thomas denied completing one. He stated, "I helped her write it." The HM never texted and/or emailed the pictures.

On 01/17/2024, I conducted an unannounced on-site visit. The HM, Resident A and Resident B were present. I had the HM take Resident A's shirt off and took pictures of the marks I observed on his body. There was a faint bruise/scab on the top of his right shoulder, scabbing on the right side of his ribs and his middle spine. There was also a scab on the left side of his stomach and left arm near his elbow.

On 01/18/2024, I interviewed DCS Sharon Tarver via telephone regarding the allegations. Ms. Tarver has been working for this corporation since 2000. She works the afternoon shift from 3PM-11PM. On 12/31/2023, she worked that day and when she arrived at her shift, she observed the swelling above Resident A's right eye on his forehead. Ms. Tarver did not ask what happened to Resident A nor did she write an IR on what she observed. She did not take him to seek medical treatment. She stated that Resident A has a history of falls with "similar injuries," so she did not feel that this time was different. She worked again on 01/02/2024 and was informed that Resident A was taken to the hospital for his injuries. She observed Resident A's face and saw the bruises all over his face and forehead. She asked DCS James Oglesby what happened, and Mr. Oglesby stated, "Resident A fell out of bed." Ms. Tarver believes the injuries are consistent with Resident A falling out of bed because she does not believe that Mr. Oglesby would do anything to hurt Resident A. She does not believe any other staff including the HM caused these injuries. Ms. Tarver stated that in the past, Resident A has fallen out of bed and sustained similar injuries. Whenever Resident A sustained injuries, he was never taken to seek medical treatment. All the staff would do is "check him," and "write an IR." Ms. Tarver stated that because there was swelling on his forehead, that does not mean Resident A requires medical attention. She stated that "Resident A would require medical attention the way I saw his face on 01/02/2024, bruising all over." There is no protocol in place for when medical treatment must be sought for any resident at this home.

On 01/29/2024, I received an email from ORR worker Heather Shepherd with pictures of Resident A that were taken by DCS James Oglesby on 12/29/2023 at 10:59PM and 11:00PM. The pictures show a contusion on the right side of the forehead, cut inside his right ear with blood and bruising purple/green around the right eye and some discoloration on the right cheek.

On 01/30/2024, I interviewed DCS James Oglesby regarding the allegations. Mr. Oglesby has been working for this corporation for nine years. On 12/29/2023, he worked the afternoon shift from 3PM-11PM caring for both Resident A and Resident B. Around 10PM, Mr. Oglesby put Resident A in his bed, turned off the lights and left the room. Before Mr. Oglesby's shift was about to end at 11:00PM, he heard a noise from Resident A's bedroom. He went into the bedroom turned on the light and found Resident A on the floor. Resident A was on his right side and as Mr. Oglesby picked Resident A up, he noticed the right side of his head was swollen. Mr. Oglesby stated, "this was the first time that this has happened during my shift, so I immediately called the HM asking what I should do." He called the HM around 10:50PM saying, "Resident A fell off the bed and the swelling looks pretty serious." The HM asked Mr. Oglesby to send him a picture of the injury, which Mr. Oglesby did. The HM looked at the picture and said, "I'm on my way." The HM did not show up until around 12AM. At this time, DCS Yulanda Thomas had arrived at her shift at 11PM. He told her what happened, and Mr. Oglesby advised Ms. Thomas that he will stay in the home with Resident A since Resident A fell during his shift. Once the HM arrived, Mr. Oglesby left his shift. This was a little after 12AM. Mr. Oglesby stated, "I left because I believed that the HM would know what to do in situations like this." Mr. Oglesby stated before he left, he completed

an IR, took a picture of the IR, and left it at the group home. He sent the IR to ORR worker Heather Shepherd. He worked again on 12/30/2023 and Resident A's head was still swollen but Resident A was "acting normal and coherent." He did not feel it was "that serious." However, he returned on 01/01/2024 and saw that Resident A's face looked worse than it was on 12/30/2023. Mr. Oglesby called the HM and advised him that Resident A needed to go to the hospital. The HM arrived and then Mr. Oglesby transported Resident A to the hospital. Mr. Oglesby stated that Resident A never fell again on 01/01/2024 like the HM stated he did. Mr. Oglesby stated he was suspended on 01/02/2024 and does not know why.

Note: I reviewed the IR written by DCS James Oglesby on 12/29/2023 at 10:50PM. The IR stated that "around 10:50PM, before going home. I heard a noise from Resident A's bedroom. I went into his bedroom, noticed Resident A on the floor. I help him up onto the bed and asked Resident A was he ok. He replied, I'm ok. I noticed that Resident A had a very large lump on the right side of his forehead. Blood on the inside of his right ear. I called the HM Darrin at 10:51PM. After speaking with Darrin, I put ice pack on Resident A's right forehead. Monitor for health and safety until management arrived at 12AM. I left and went home."

On 01/30/2024, I interviewed DCS Bridgette Walker regarding the allegations. She worked the midnight shift on 12/31/2023 and observed Resident A's eye bruised after he got up at 4AM to go to the bathroom. She did not seek medical treatment for him at that time. She was off until 01/01/2024 and when she got to work, she was told that Resident A went to the hospital for his injuries. She was informed he fell out of bed. She denied that he had fallen out of bed during any of her shifts. She has no concerns with any staff causing these injuries to Resident A and believes they are consistent with that of falling out of bed. She had no further information.

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:	Based on my investigation and information gathered, Resident A's personal needs, including protection and safety were not attended to at all times by the DCS at Warick Group Home. On 12/29/2023, Resident A fell out of his bed and sustained serious injuries to his face; contusion to his right forehead, fractured nose, and bruising on his entire face and neck. Resident A had a history of falling out of his bed and sustaining injuries as reported by the HM Darrin Craggette; however, there were no

	protective measures put in place to ensure Resident A's safety or further incidents and/or injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my investigation, the HM Darrin Craggette did not seek immediate medical care for Resident A after he fell out of bed on 12/29/2023. Around 11PM, DCS James Oglesby contacted the HM Darrin Craggette informing him that Resident A fell out of bed and had a serious bump on the right side of his head. The HM arrived at the home and advised staff to put an ice pack on the forehead and to only monitor Resident A. On 12/31/2023, Resident A's injuries on his face worsened as there was now bruising on his entire face and neck, but Resident A did not go to the hospital until 01/01/2024. It was discovered that Resident A had a fractured nose and contusion to the right forehead.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	Based on my investigation and information gathered, the living room that is not ordinarily used for sleeping was used for Resident A. The HM Darrin Craggette stated that Resident A was sleeping on the couch instead of his bed after the fall on 12/29/2023 so the HM could keep an eye on him.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a waterbed is not prohibited by this rule.
ANALYSIS:	During the on-site investigation on 01/11/2024, I observed Resident A's bed to only have a box spring. The HM Darrin Craggette stated that he removed the mattress from the bed to lower it instead of removing the box spring.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Resident A was admitted into the hospital for failure to thrive, dehydration, and hypothermia.

INVESTIGATION:

On 01/22/2024, I received another complaint from APS regarding Resident A was admitted into Trinity Health Oakland Hospital on 01/20/2024, for failure to thrive, dehydration, hypothermia and two broken right ribs.

On 01/22/2024, I followed up with APS worker Jordan Walker. Mr. Walker will go to see Resident A at Trinity Health Oakland Hospital today and speak with the doctors. He will follow up with me afterwards.

On 01/22/2024, I contacted Detective Meckl with Royal Oak Police Department (ROPD). Detective Meckl sent officers to the home yesterday and followed up with APS regarding the new complaint pertaining to Resident A admitted into the hospital on 01/20/2024. He stated he will leave the interviews to APS and licensing and follow up with us later.

On 01/22/2024, I received an email from APS worker Jordan Walker stating that he will be conducting an on-site visit at this group home tomorrow. I advised Mr. Walker that I would be meeting with him at the home.

On 01/23/2024, I along with APS worker Jordan Walker conducted an unannounced on-site investigation regarding the new allegations pertaining to Resident A. Present were

the HM and Resident B. The HM seemed surprised to see us. When explained to him that we were there regarding Resident A's most recent hospitalization he stated, "Resident A died Saturday." Mr. Walker advised the HM that was impossible because Mr. Walker saw Resident A at the hospital yesterday 01/22/2024 and he was still alive. The HM then said, "wait a minute, he's brain dead and on a ventilator."

The allegations regarding Resident A's weight loss were discussed. The HM stated he received a call from DCS Eric Brooks on 01/20/2024 stating that Resident A was "still not eating," and "didn't seem himself." The HM arrived at the group home and immediately took Resident A to the hospital. The HM did not have any prior concerns about Resident A's weight but then said, "I took Resident A to see Dr. Mansour on 01/08/2024, and I told him about his weight and Dr. Mansour just said to keep an eye on him." The HM then said that he was "about to call Dr. Mansour to have Ensure prescribed to Resident A," but then he didn't. The HM weighs Resident A monthly on the scale. I reviewed Resident A's weight records from 01/15/2022-12/15/2023.

According to the weight records, Resident A weighed 153 pounds on 01/15/2022 and as of 12/15/2023 he weighed 145 pounds. I asked the HM to see the scale he was using to weigh both Resident A and Resident B. The HM was unsuccessful in locating the scale. He stated, "it was in this linen closet, but I can't find it." Resident A was eating cereal in the morning and peanut butter and jelly sandwiches for lunch as he was a picky eater. There was plenty of food in the home, but according to the HM, they were not following the menu. He nor the staff were documenting the changes or substitutions on the menus. He would just feed both Resident A and Resident B cereal in the morning with milk. When asked about Resident A's dehydration, the HM stated, "he gets sips of water with his medication." The HM did not feel that Resident A was underweight because he was "getting old." The HM was asked about Resident A's hypothermia. He stated that Resident A has not been outside at all to get hypothermia. He does not know how that happened and was unable to provide any explanation. The HM stated that he feels he and the staff at this home can meet the medical needs of Resident A should he be discharged home. He stated, "I'll consult his doctor on what to do better and how to better take care of him. This will never happen anymore." The HM believes that the failure to thrive, dehydration, and hypothermia all occurred on 01/20/2024 and that it was not an ongoing issue. The HM denied that Resident A fell again after the initial fall on 12/29/2023 that resulted in his face injury. He stated if there was another fall, an IR would have been written and there would be documentation in the staff log. I reviewed the staff log and there was a note on 01/11/2024 written by DCS Yulanda Thomas stating that Resident A fell at the hotel room out of his wheelchair when she was in the bathroom. The HM stated, "Oh yeah, he did fall. I forgot about that." He was unable to provide any further information.

On 01/23/2024, I made a face-to-face visit with Resident A at Trinity Health Oakland Hospital. I was not allowed inside the room as Resident A was positive for COVID. He was observed from the window to have a breathing ventilator. I spoke with his RN Leslie regarding his condition. Resident A is not brain dead as the HM reported. The RN reviewed Resident A's chart and stated that Resident A arrived on 01/20/2024 weighing

only 103 pounds. He appeared malnourished and failing to thrive. The RN stated for Resident A to be dehydrated, it means that Resident A was not eating and drinking for a few days prior to hospitalization. Resident A's body temperature at arrival was extremely low. He was at 76° Fahrenheit. The RN does not want to speculate on the hypothermia and called the attending physician.

I spoke with attending physician/resident Rahul Pidikiti regarding Resident A's condition. Resident A's failure to thrive and dehydration showed his sodium was higher than 170 and the normal range is between 135-145. This is attributed to not eating and/or drinking for prolonged periods of time. Resident A's hypothermia is due to prolonged exposure to cold or severe sepsis infection that can be due to Resident A not receiving his thyroid medication. Resident A has hypothyroidism and if he is not given his medication daily that may lead to sepsis which may lead to hypothermia. I was also informed that on 01/20/2024, it was discovered that Resident A had two broken ribs on his right side. These broken ribs were acute as he reviewed the x-ray taken on 01/01/2024, there was no abnormalities found at that time to the ribs; therefore, there was a recent injury. I also reviewed Resident A's pictures taken by the hospital on 01/01/2024 regarding Resident A's face and body. There were pictures of scabs on the right shoulder, four scabs on the right side of his ribs and the contusion to his forehead along with the bruises on his face, neck, and wrists. The attending physician stated he cannot say definitively that the injuries on 01/01/2024 were a result of falling out of the bed as they do not appear to be consistent with a fall.

I interviewed the hospital case manager Dawn. Dawn stated she is following Resident A's case while he is admitted to the hospital. She reported that there are notes regarding wounds on his left heel and pressure sores on his buttocks. This is due to prolonged sitting. She will investigate possibly having Resident A discharged once medically cleared to a sub-acute rehabilitation facility and not back to this group home.

On 01/23/2024, I contacted licensee designee Monica Flagg regarding the allegations. Ms. Flagg stated she is aware of the injuries on Resident A's face and believes they are consistent with "falling out of bed." She is unsure why Resident A is failing to thrive and had significant weight loss, dehydration, and hypothermia. She believes the HM and the staff are caring properly for Resident A and Resident B as the HM has been working at this home for over 20 years. Ms. Flagg does not believe that the HM or any other staff would abuse and/or neglect Resident A.

On 01/23/2024, I contacted Resident A's primary care physician (PCP) Dr. Imad Mansour via telephone. Dr. Mansour saw Resident A on 01/08/2024 along with the HM. He stated this visit was regarding the follow-up on Resident A's injuries and hospitalization on 01/01/2024. Dr. Mansour stated that Resident A is confined to a wheelchair; therefore, he questioned the HM about how Resident A fell out of bed. Dr. Mansour stated, "give the height of the bed and Resident A being small in stature, these injuries do not seem consistent with the fall because there was no force." He stated if Resident A was large in stature, then maybe the force would be stronger when hitting the floor and causing these injuries, but he cannot believe that these injuries were

sustained by “falling out of bed.” Dr. Mansour asked if Resident B was still in the group home because Dr. Mansour recalls about 10 years ago that Resident B was extremely aggressive, punched holes in the doctor’s office walls and was very strong. Dr. Mansour stated there is a possibility that the injuries on Resident A’s face may have been caused by someone else other than falling out of the bed.

Dr. Mansour stated that the HM never brought up any concerns regarding Resident A’s weight loss. His doctor’s office does not have a weight scale for wheelchairs; therefore, they only record the “reported weight,” by the HM. At this visit, the reported weight was 150 pounds. Dr. Mansour stated that Resident A is on thyroid medication but that the dosage was very mild that if not administered it would not cause hypothermia. He does not know how Resident A was hypothermic if he was not outside for long periods of time in the cold.

On 01/25/2024, I conducted another unannounced on-site visit at the group home to review Resident A’s and Resident B’s medications. Present were the HM and Resident B. Resident A is still at the hospital. Resident B was lying in bed in his bedroom. I reviewed Resident A’s and Resident B’s medications and medication logs and found the following errors:

- Resident A’s **Tamsulosin 0.4MG CAP**: take one capsule by mouth once daily ½ hour following the same meal each day was not given at 8PM on 01/19/2024 as the pill was still in the blister pack.
- Resident A’s **Tamsulosin 0.4MG CAP**: take one capsule by mouth once daily ½ hour following the same meal each day was given at 8PM 01/12/2024-01/15/2024 and from 01/17/2024-01/18/2024 but staff did not initial the medication log.
- Resident A’s **Olanzapine 5MG**: take one tablet by mouth at bedtime for 31 days was not given as prescribed. The prescription was filled on 12/05/2023. I counted the pills and there were 18 pills in the bottle. There should not be any pills left for this month.
- Resident A’s **Mirtazapine 30MG Tab**: take one tablet by mouth at bedtime was not given as prescribed. This medication was filled on 12/05/2023 with 31 pills. I counted the pills and there were 20 pills left in the bottle. There should not be any pills left in the bottle for this month.
- Resident A’s **Quetiapine 25MG Tab**: take two tablets by mouth at bedtime was not given as prescribed. The prescription was filled on 01/02/2024 with 62 pills. I counted the pills and there were 32 pills left in the bottle. There should only be 28 pills in the bottle if Resident A was given his medication as prescribed.
- Resident A’s **Fluticasone 50MCG Spray**: spray two sprays in each nostril daily were not given as prescribed. The spray bottles were completely full.
- Resident A’s **Levothyroxine 25MG Tab**: take one tablet by mouth once daily was given at 7AM from 01/12/2024-01/14/2024 and from 01/17/2024-01/19/2024 but staff did not initial the medication log. In addition, Resident A was in the

hospital on 01/20/2024 and 01/21/2024, but the log is blank under those dates to indicate that Resident A was at the hospital.

- Resident A's **Vitamin D3 25MCG Tab**: take one tablet by mouth once daily was given at 7AM from 01/12/2024-01/14/2024 and from 01/17/2024-01/19/2024, but staff did not initial the medication log.
- Resident A's **Vitamin D2 50,000U Cap**: take one capsule by mouth once a week was given at 7AM but staff were not initialing the medication log correctly. Staff initialed on 12/01/2023, 12/06/2023, 12/13/2023, 12/25/2023 and 12/26/2023. In July 2023, this medication was on the log, but there was no time noted and there were no initials.
- Resident A's **Loratadine 10MG Tab**: take one tablet by mouth daily was given at 7AM from 12/13/2023-12/17/2023 and from 12/20/2023-12/22/2023 and on 12/24/2023 and from 12/27/2023-12/31/2023 but staff did not initial the medication log.
- Resident A's **Famotidine 20MG Tab**: take one tablet by mouth daily was given at 7AM from 12/13/2023-12/17/2023 and from 12/20/2023-12/24/2023 and from 12/27/2023-12/31/2023 but staff did not initial the medication log.
- Resident A's **Ketoconazole Cream**: topically once daily to affected area was applied at 7AM from 12/13/2023-12/16/2023, from 12/20/2023-12/22/2023, 12/24/2023, and from 12/27/2023-12/31/2023 but staff did not initial the medication log.
- Resident A's **Amlodipine 5MG Tab**: take one tablet by mouth daily was given at 7AM from 12/13/2023-12/15/2023, from 12/20/2023-12/22/2023, 12/24/2023, and from 12/27/2023-12/31/2023 but staff did not initial the medication logs.
- Resident B's **Amlodipine 5MG Tab**: take one tablet my mouth daily was given on 01/25/2024 at 7AM but the HM did not initial the medication log.
- Resident B's **Famotidine 20MG Tab**: take one tablet by mouth daily was given at 7AM on 01/25/2024, but the HM did not initial the medication log.
- Resident B's **Fluticasone 50MCG Spray**: spray two sprays in each nostril daily were not given as prescribed. Both spray bottles were completely full.
- Resident B's **Ketoconazole Cream**: topically once daily to affected area was not given as prescribed as both the cream bottles still had the seals on, but staff initialed the medication logs from 01/01/2024-01/24/2024 indicating it was applied.
- Resident B's **Loratadine 10MG Tab**: take one tablet by mouth daily was given at 7AM on 01/25/2024, but the HM did not initial the medication log.

The HM stated that he is not sure why there are pills left in Resident A's prescription bottles because all staff including himself give Resident A his medications. He was unable to state why staff were not initialing the medication logs at the time they pass medication. He commented saying, "I looked at them not too long ago the other day and I didn't find any issues."

On 01/30/2024, I interviewed DCS Eric Brooks via telephone regarding the allegations. Mr. Brooks has been with this corporation for three years, but it was his first day at this group home on 01/20/2024. He began his shift that day at 7AM and DCS Yulanda Thomas was present. Ms. Thomas was assisting Resident B in the bathroom while Resident A was in his bedroom. Mr. Brooks proceeded into Resident A's bedroom and found Resident A on the floor with his wheelchair behind him. Mr. Brooks went to Ms. Thomas and asked, "Why is Resident A on the floor?" Ms. Thomas replied, "he wasn't on the floor. I left him on his chair, but he was slumped over." Mr. Brooks immediately picked Resident A off the floor and saw that he was completely soiled. Resident A was lethargic, had low energy and breathing was shallow. Mr. Brooks is a Certified Nursing Assistant (CNA) so because of his experience and CNA training, he took Resident A's vitals. Resident A's heart rate was extremely low, and his eyes were rolling back. He knew something was wrong. He again asked Ms. Thomas what was wrong with Resident A and Ms. Thomas stated, "nothing. He was sitting in his wheelchair." Mr. Brooks called the HM informing him of Resident A's vitals and the HM told him he was coming to the group home. The HM arrived around 40 minutes later and transported Resident A to the hospital. Mr. Brooks stated this was the first time he had met both Resident A and Resident B therefore, he was unable to provide any further information as to Resident A's failure to thrive, dehydration, fractured ribs, or hyperthermia.

On 01/30/2024, I interviewed DCS James Oglesby regarding the allegations via telephone. Resident A is a "picky eater." He only likes cereal in the morning and peanut butter and jelly sandwiches for lunch. At dinner, Mr. Oglesby would follow the menu but sometimes if there was chicken, he would bake that, and Resident A would eat. He did not think there was anything wrong with his weight and just felt that was with age. Mr. Oglesby made sure that Resident A ate and drank whenever he worked his shifts. He stated that Resident A would tell you when he is thirsty and whenever he was, Mr. Oglesby would give him water or something to drink. The HM is responsible for weighing both Resident A and Resident B, but he is not sure if the HM was because Resident A is wheelchair bound and the scale they have is not for wheelchairs. He is not sure how he weighed him. Mr. Oglesby does not know anything about Resident A's hypothermia as he has not been working at the home since 01/02/2024. He stated that Resident A never liked going outside so when he was working at this group home, they would always be inside the house. He had no further information to offer.

On 02/05/2024, I interviewed DCS Bridgette Walker regarding the allegations via telephone. Ms. Walker works the midnight shift at this home. On 01/20/2024 sometime between 12PM-3PM, she received a call from DCS Yulanda Thomas saying, "Resident A is out of it." Ms. Thomas told Ms. Walker that the HM was contacted and DCS Eric Brooks assisted Ms. Thomas in getting Resident A dressed to go to the hospital. The HM arrived and transported Resident A to the hospital. Resident A is still at the hospital and according to Ms. Walker, "he's doing better." When Ms. Walker arrives at the home at 11PM, Resident A is sleeping. She stated, "to the best of my knowledge he's being fed." She had no concerns about his weight loss. She stated that the afternoon shift is responsible for weighing the residents but that she has not seen the bath scale for

“years.” The bath scale was in the linen closet in the hallway of the home. Ms. Walker stated that if Resident A is awake during her shift and asks for a drink, she gives it to him. She does not know anything about his dehydration. She stated she does not know anything about his hypothermia either. When asked about Resident A’s medications she stated, “I checked his medications and did see that many of them were not given because the prescription bottles were full. I didn’t tell anyone about the medications not being passed.”

On 02/06/2024, I received a return call from DCS Yulanda Thomas regarding the allegations. Ms. Thomas worked the midnight shift on 01/29/2024 beginning at 11PM-7AM. When she arrived, Resident A and Resident B were sleeping in their beds. She conducted about four-five wellbeing checks to ensure their safety. She stated that Resident A likes sleeping with the blanket over his head, but that she would pull the blanket down to ensure he was breathing, which he was. The morning of 01/20/2024, Resident A woke up around 6AM and “appeared weak, not himself and had wet the bed.” Ms. Thomas said to herself, “he’s going to need medical care,” and called the HM. At this time, DCS Eric Brooks arrived at the home early for his shift on 01/20/2024. She advised him what was happening to Resident A, so Mr. Brooks got Resident A dressed after the HM stated he was on his way to the home. According to Ms. Thomas, the HM was contacted before 7AM and was at the home within 15 minutes, but according to Mr. Brooks’ interview, the HM did not arrive until about 40 minutes later. The HM took Resident A to the hospital, and he has been there ever since. Ms. Thomas stated prior to 01/20/2024 she had not noticed Resident A’s weight loss because she said, “I never had to assist with showers or get him dressed or undressed so I never saw how thin he was.” She stated, “I was shocked to see the condition this mas was in. He’s always asleep when I arrive at my shift.” Ms. Thomas believes that staff were feeding Resident A, but she is not sure if they were since he was observed in the condition, he was in. Ms. Thomas was unable to state why he was dehydrated and reported that sometimes Resident A wakes up during the night and asks for water which she gives him, but other times Resident A refuses to drink water. Ms. Thomas does not understand why Resident A was hypothermic but stated that the home gets cold at night, but that Resident A always has his pajamas on and a blanket. She has no other information to offer.

On 02/07/2024, I received a return call from Easterseals MORC Sarah Evans-Vallee. Ms. Evans-Vallee advised the HM on 12/29/2023 to call the doctor after the appointment but the HM never called the doctor until after the hospitalization on 01/01/2024. Ms. Evans-Vallee is extremely concerned about both Resident A and Resident B. She is actively looking for alternative placement for both Resident A and Resident B given all these concerns pertaining to Resident A’s injuries and staff’s inability to provide care to either resident.

On 02/07/2024, I conducted the exit conference with licensee designee Monica Flagg with my findings. Ms. Flagg has been speaking with Resident A’s guardian Jim Stark and Easterseals MORC regarding Resident A’s discharge from the hospital. Mr. Stark wants Resident A to return to Warick Group Home with his brother Resident B. Ms.

Flagg acknowledges the concerns with regards to staff and their ability to provide care to Resident A who appears to require a high level of care. Ms. Flagg wants both Resident A and Resident B to remain in the home but indicated that the hospital was also discussing nursing home options for Resident A. Ms. Flagg acknowledged that my recommendation will be revocation of the license due to the severity of the findings pertaining to Resident A's injuries and most recent hospitalization of failure to thrive, dehydration, and hypothermia.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation and information gathered, the HM Darrin Craggette and the staff at Warick Group Home are not suitable to meet the physical, emotional, intellectual, and social needs of Resident A. Resident A was hospitalized on 01/20/2024 for failure to thrive, dehydration, and hypothermia, but the HM stated that these concerns occurred on 01/20/2024 as that is when DCS Eric Brooks contacted him and reported these issues. The HM informed Resident A's PCP of the weight loss during the follow-up visit on 01/08/2024. However, according to the PCP, there were no concerns noted by the HM regarding Resident A's weight loss. The HM was falsifying Resident A's and Resident B's weight records as there was no weight scale found at the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	Based on my investigation and information gathered, there was insufficient amount of personal care, supervision, and protection that was required for Resident A by staff at Warick Group Home. Resident A required a higher level of care than what the staff could provide. Resident A was not eating or drinking for long periods of time which resulted in significant weight loss and dehydration, but staff never reported these concerns to Resident A's PCP. Resident A was lethargic, and he appeared extremely frail, skin and bones. Resident A was hospitalized on 01/20/2024 for failure to thrive, dehydration, and hypothermia. The HM nor any of the staff could provide an explanation on how Resident A lost significant amount of weight, was dehydrated, or got hypothermia.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Based on my investigation and information gathered, the HM and staff at Warick Group Home did not have the services, skills, and physical accommodations that are required of the home to meet Resident A’s needs. Resident A required a higher level of care than what the HM and staff at Warick Group Home could provide. Resident A was not eating or drinking but no staff contacted the medical professionals regarding this issue. The HM and staff believed these concerns were due to Resident A's aging and not possibly medical decline. The HM and staff neglected to follow through with Resident A’s medical needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based on my investigation and information gathered, Resident A was in a wheelchair that was “donated,” and not specified in his assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on my investigation and information gathered, there was no authorization in writing for the wheelchair that was being used by Resident A. According to the HM, the wheelchair was “donated,” so Resident A could use it for long distances.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.

ANALYSIS:	Based on my investigation and information gathered, the HM was not weighing Resident A nor Resident B using a weight scale. During my on-site inspection on 01/11/2024, the HM was unable to locate the weight scale and according to DCS Sharon Tarver, she has not seen the weight scale for years. The HM was falsifying the weight records with inaccurate weights of both Resident A and Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During the on-site on 01/25/2024, I reviewed Resident A's and Resident B's medications and medication logs and found the following errors: • Resident A's **Tamsulosin 0.4MG CAP**: take one capsule by mouth once daily ½ hour following the same meal each day was not given at 8PM on 01/19/2024 as the pill was still in the blister pack. • Resident A's **Olanzapine 5MG**: take one tablet by mouth at bedtime for 31 days was not given as prescribed. The prescription was filled on 12/05/2023. I counted the pills and there were 18 pills in the bottle. There should not be any pills left for this month. • Resident A's **Mirtazapine 30MG Tab**: take one tablet by mouth at bedtime was not given as prescribed. This medication was filled on 12/05/2023 with 31 pills. I counted the pills and there were 20 pills left in the bottle. There should not be any pills left in the bottle for this month. • Resident A's **Quetiapine 25MG Tab**: take two tablets by mouth at bedtime was not given as prescribed. The prescription was filled on 01/02/2024 with 62 pills. I counted the pills and there were 32 pills left in the bottle. There should only be 28 pills in the bottle if Resident A was given his medication as prescribed. • Resident A's **Fluticasone 50MCG Spray**: spray two sprays in each nostril daily were not given as prescribed. The spray bottles were completely full.

	• Resident B's **Ketoconazole Cream**: topically once daily to affected area was not given as prescribed as both the cream bottles still had the seals on, but staff initialed the medication logs from 01/01/2024-01/24/2024 indicating it was applied. • Resident B's **Fluticasone 50MCG Spray**: spray two sprays in each nostril daily were not given as prescribed. Both spray bottles were completely full.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	During the on-site on 01/25/2024, I reviewed Resident A's and Resident B's medications and medication logs and found the following errors: • Resident A's **Tamsulosin 0.4MG CAP**: take one capsule by mouth once daily ½ hour following the same meal each day was given at 8PM 01/12/2024-01/15/2024 and from 01/17/2024-01/18/2024 but staff did not initial the medication log. • Resident A's **Levothyroxine 25MG Tab**: take one tablet by mouth once daily was given at 7AM from 01/12/2024-01/14/2024 and from 01/17/2024-01/19/2024 but staff did not initial the medication log. In addition, Resident A was in the hospital on 01/20/2024 and 01/21/2024, but the log is blank under those dates to indicate that Resident A was at the hospital. • Resident A's **Vitamin D3 25MCG Tab**: take one tablet by mouth once daily was given at 7AM from 01/12/2024-01/14/2024 and from 01/17/2024-01/19/2024, but staff did not initial the medication log.

	• Resident A's **Vitamin D2 50,000U Cap**: take one capsule by mouth once a week was given at 7AM but staff were not initialing the medication log correctly. Staff initialed on 12/01/2023, 12/06/2023, 12/13/2023, 12/25/2023 and 12/26/2023. In July 2023, this medication was on the log, but there was no time noted and there were no initials. • Resident A's **Loratadine 10MG Tab**: take one tablet by mouth daily was given at 7AM from 12/13/2023-12/17/2023 and from 12/20/2023-12/22/2023 and on 12/24/2023 and from 12/27/2023-12/31/2023 but staff did not initial the medication log. • Resident A's **Famotidine 20MG Tab**: take one tablet by mouth daily was given at 7AM from 12/13/2023-12/17/2023 and from 12/20/2023-12/24/2023 and from 12/27/2023-12/31/2023 but staff did not initial the medication log. • Resident A's **Ketoconazole Cream**: topically once daily to affected area was applied at 7AM from 12/13/2023-12/16/2023, from 12/20/2023-12/22/2023, 12/24/2023, and from 12/27/2023-12/31/2023 but staff did not initial the medication log. • Resident A's **Amlodipine 5MG Tab**: take one tablet by mouth daily was given at 7AM from 12/13/2023-12/15/2023, from 12/20/2023-12/22/2023, 12/24/2023, and from 12/27/2023-12/31/2023 but staff did not initial the medication l Resident B's **Amlodipine 5MG Tab**: take one tablet my mouth daily was given on 01/25/2024 at 7AM but the HM did not initial the medication log. • Resident B's **Famotidine 20MG Tab**: take one tablet by mouth daily was given at 7AM on 01/25/2024, but the HM did not initial the medication log. • Resident B's **Loratadine 10MG Tab**: take one tablet by mouth daily was given at 7AM on 01/25/2024, but the HM did not initial the medication log.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**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:	Based on my investigation and review of the menus, staff are not noting the changes or substitutions to the menu when it is not being followed. The HM Darrin Craggette stated that they would substitute food but did not note the change or substitution on the menus.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my on-site investigation on 01/11/2024, I observed no ramp on the front entrance of the home. There was a space heater being used inside because according to the HM, the furnace was not working and there was no heat. The screen door leading to the outside in the backyard was dry rotted and cracked on the outside. I also observed feces on Resident B's linens and no pillowcase. The pillow was dirty and there was no blanket for Resident B. The front door that is an egress was difficult to open and close.

On 01/22/2024, I contacted the owner of this home who reported that the furnace was replaced and working on 01/12/2024.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(4) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.
ANALYSIS:	During the on-site investigation on 01/11/2024, I observed the back screen door cracked and the inside of the door was dry rotted.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14411	**Linens,**
	(1) A licensee shall provide clean bedding that is in good condition. **The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.**

ANALYSIS:	During the on-site investigation on 01/11/2024, I observed feces on Resident B's bedsheets. Resident B did not have a blanket or a pillowcase on his pillow.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14411	**Linens.**
	(2) A licensee shall provide at least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident bed.
ANALYSIS:	During the on-site investigation on 01/11/2024, Resident B's pillow was stained or in good condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14509	**Means of egress; wheelchairs.**
	(1) Small group homes that accommodate residents who regularly require wheelchairs shall be equipped with ramps that are located at 2 approved means of egress from the first floor.
ANALYSIS:	During my on-site investigation on 01/11/2024, I observed Resident A using a wheelchair, but there was no ramp to accommodate Resident A's wheelchair. I also reviewed Warick Group Home records and this home is not wheelchair accessible.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14510	**Heating equipment generally.**
	(5) Portable heating units shall not be permitted.

ANALYSIS:	During the on-site investigation on 01/11/2024, I observed a portable heater being used in this home. The HM Darrin Craggette stated that the furnace had not been working properly. The furnace was replaced on 01/12/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

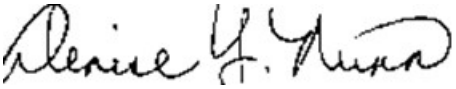
IV. RECOMMENDATION

I recommend revocation of the license.

02/07/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



02/07/2024

Denise Y. Nunn Date
Area Manager