GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2024

Rayann Burge
RSR Valley LLC
33255 26 Mile Road
Lenox, MI 48048

RE: License #: AM500408396
Investigation #: 2024A0617014
Sandalwood Valley II

Dear Ms. Burge:

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM500408396
Investigation #:	2024A0617014
Complaint Receipt Date:	02/01/2024
Investigation Initiation Date:	02/05/2024
Report Due Date:	03/02/2024
Licensee Name:	RSR Valley LLC
Licensee Address:	33255 26 Mile Road Lenox, MI 48048
Licensee Telephone #:	(586) 383-2802
Administrator:	Rayann Burge
Licensee Designee:	Rayann Burge
Name of Facility:	Sandalwood Valley II
Facility Address:	33255 26 Mile Rd Lenox, MI 48048
Facility Telephone #:	(586) 270-6784
Original Issuance Date:	11/15/2021
License Status:	REGULAR
Effective Date:	05/15/2022
Expiration Date:	05/14/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed and residents are not supervised properly or being cared for.	Yes
The food provided are inadequate.	Yes

III. METHODOLOGY

02/01/2024	Special Investigation Intake 2024A0617014
02/05/2024	Special Investigation Initiated - Telephone TC to Complainant
02/05/2024	Contact - Document Received Email from Complainant that included pictures of resident injuries and falls
02/05/2024	Inspection Completed On-site I completed an unannounced onsite inspection of the facility. During my onsite inspection I interviewed Licensee Designee Ms. Rayann McCoy, facility manager Cindy Shelly, staff Stephanie Jemison, Latrese Pearson and cook Martin Brabant. I also interviewed Residents A, B, C, O, I, J, M, A and G.
02/16/2024	Contact - Document Sent Email sent to Ms. McCoy
02/19/2024	Contact - Telephone call received I interviewed Resident H's son
02/19/2024	Contact - Document Received Email from Ms. McCoy. Email included Resident Registry, staff schedules, Incident reports, employee list, assessment plans, and resident ID forms
02/19/2024	Contact - Telephone call made TC to staff Paul Mattarella
02/20/2024	Contact - Document Received Email from Resident H's son

02/22/2024	Contact - Document Received Email from Resident H's son
02/22/2024	Contact - Document Received Email from Complainant including pictures of resident injuries
02/22/2024	Contact - Document Sent Email sent to Ms. McCoy
02/22/2024	Contact - Document Received Email from Ms. McCoy
02/23/2024	Contact - Telephone call made I interviewed Beacon Home Care nurse Autumn Roberts
02/23/2024	Contact - Telephone call made TC made to Mr. Paul Mattarella
02/23/2024	Contact - Telephone call made I interviewed staff Danielle Nasser
02/23/2024	Contact - Telephone call made I interviewed staff Ashly Shreffler
02/23/2024	APS Referral made Referral made to Adult Protective Services (APS)
02/24/2024	Contact - Document Received Email from Resident N's granddaughter with a written statement regarding Resident N's care
02/26/2024	Contact - Document Received Email from Resident N's granddaughter with videos and pictures from Resident N's bedroom
02/28/2024	Exit Conference I conducted an exit conference with Licensee Designee Rayann McCoy to discuss the findings of this report

ALLEGATION:

The facility is understaffed and residents are not supervised properly or being cared for.

INVESTIGATION:

On 02/01/23, a complaint was received regarding Sandalwood Valley 2. The complaint indicated the facility's lack of care and reckless disregard for the health, safety, and well-being of all the residents who reside at these two facilities are beyond appalling. There are no proper policies or procedures set in place that hold staff members accountable for ensuring the safety and overall well-being of each resident. The lack of sufficient staff-to-client ratio continues to go unaddressed by management. Being short-staffed each day has negatively affected the quality of care being given to each resident. The weekly menu for meals that should be prepared is not posted and cooks are serving whatever is available due to a lack of groceries being provided for both facilities. Staff are being forced to provide care and support for residents with complex and terminal illnesses, who should have specialist care and support for them to receive the correct level of care needed.

Sandalwood Valley 1 AM500408293 and Sandalwood Valley 2 AM500408396 are two separate facilities that are connected and share a kitchen.

On 02/05/24, I conducted an interview with the complainant. According to the complainant, even though the facility has two separate licenses, they treat the facility as one facility and schedules are posted with two staff members to care for the entire facility. The layout of the facility leaves caregivers without the ability to maintain visual and auditory monitoring of each resident at all times. The complainant stated that the lack of care and reckless disregard for the health, safety and well-being of all the residents that reside at these two facilities are beyond appalling. There are no proper policies or procedures set in place that hold staff members accountable for ensuring the safety and overall well-being of each resident. The lack of sufficient staff to client ratio continues to go unaddressed by management which is causing burnout amongst numerous caregivers. For this reason, some caregivers have taken mental health days off, in order to recover from the stressful environment that they are forced to work in. This issue also causes daily call offs on each shift which leaves caregivers often left alone to operate daily functions of both facilities without help. Being short staffed each day has negatively affected the quality of care being given to each resident. According to the complainant, Sandalwood Valley 1 has 12 rooms of which six of those rooms are occupied. Three of the residents, Residents A, E, and G are two-person assist, with Resident E also needing staff assistance being fed. Sandalwood Valley 2 has 12 rooms in which seven of those rooms are occupied. Two of the residents, Residents H, and L are both two-person assist and require assistance being fed. Resident N is bed bound and needs monitoring while eating meals.

According to the complainant, Sandalwood Valley 2 used to have a monitor that displayed live camera footage of both sides of the facility, which was helpful to ensure the safety of residents. Approximately two weeks ago, the monitor stopped working and the issue has yet to be fixed, which makes it even harder to ensure the safety of each resident. The med techs are scheduled to act as caregiver, med tech, shift leader and

sometimes cook for both licensed facilities. This leaves the med tech responsible for get-ups, showers, med passing, and over-seeing both facilities while also answering phones, handling resident family concerns and being present during hospice visits and doctor appointments. Because of this, often resident showers are being missed without follow-up to ensure they received their showers for the week. Caregivers are also showering two person assists with only one caregiver as well as caring for them alone, which is dangerous not only for the resident, but the caregiver as well. Unexpected injuries and sores have been found on residents specifically Resident L and Resident H.

Resident H began to have skin break down on her buttocks which was reported to Cindy Shelly the manager. This went unaddressed until a caregiver took it upon herself to schedule a doctor appointment for her, which occurred on 1/25/24. Doctor Pou scheduled an appointment for the resident the following day on 1/26/24. The doctor determined the resident had Stage 3 and 2 pressure sores on her buttocks which he stated could have been prevented had management taken action by contacting him sooner.

According to the complainant, on numerous occasions residents have fallen on the floor without staff notifying the residents guardians or proper documentation being filled out regarding each incident. On 12/29/23 and on 1/5/24 Resident N who resides in Sandalwood Valley 2 which is a fall risk was found on the floor due to lack of staff. On 12-28-23 Resident M who resides in Sandalwood Valley 2, which is also a fall risk, was found by Lance, the maintenance man on the floor in her bedroom doorway. (I received and reviewed pictures of this incident). On 1/27/24 one med tech and one caregiver were scheduled on dayshift to cover both buildings. Resident H who resides in Sandalwood Valley 2 had to be sent to the hospital on this day. This left one caregiver to assist with both facilities while the med tech handled the situation during lunch hours. On 1/19/24, Resident N who resides in Sandalwood Valley 2 was found by dayshift laying in urine which was soaked through her mattress which happens often with numerous residents. (I received and reviewed pictures of this incident). On 1/30/24, Resident N, is bed bound, was found soaked in urine and covered in food and spilled fluids. Staff were unable to clean her up until 2pm (almost end of day shift), because they were short staffed and one of the caregivers on shift was unable to care for this particular resident per residents Guardian request.

According to the complainant, on 6/8/23 this same resident's family filed a complaint with the State of Michigan regarding mistreatment of this resident and violations were established but things have not changed and continue to go unaddressed.

According to the complainant, staff have also supplied the facility with needed items such as toilet paper, plastic spoons for crushed med orders, and other supplies needed for residents without compensation from management. Staff are being forced to provide care and support for residents with complex and terminal illnesses, who should have specialist care and support for them to receive the correct level of care they need. Resident A has an order from his hospice nurse to have his catheter flushed daily to prevent build-up of mucus within his bladder. Staff have told manager Cindy that they

were uncomfortable with performing this task due to lack of experience in providing such care and they were told that they must do it because his hospice nurse said she refuses to come to the facility daily to do so. All the complaints continue to go unaddressed even after management has been notified. Management continues to admit new residents into the facilities without the proper staff and supplies needed in order to give residents, the proper care they deserve. Staff are being told “it’s called job security” when they tell manager Cindy their concerns with moving new residents in without hiring proper staff. Management is not doing anything to enrich the lives of the residents that reside in both facilities. They definitely have not done anything at all to reduce the probability of future injury to residents.

On 02/05/24, I completed an unannounced onsite inspection of the facility. During my onsite inspection I interviewed Licensee Designee Ms. Rayann McCoy, facility manager Cindy Shelly, staff Stephanie Jemison, Latrese Pearson and cook Martin Brabant. I also interviewed Residents I, J, M and O.

When I arrived at the facility on 02/5/24, I observed the cook Martin Brabant cooking and staff Stephenie Jemison assisting residents for both facilities. Facility manager Cindy Shelly was upstairs in the staff office for approximately 15 to 20 minutes, leaving Ms. Jemison to care for all of the residents for both facilities. Staff were unable to provide me incident reports, assessment plans or staff schedules before 1/28/24. Ms. Shelly stated that since the departure of former licensee designee Ms. Strickland, the paperwork and files are not in order, and she would have to spend time sorting through the staff office to find requested documents.

During the onsite investigation, staff stated that there are two two-person assist residents in Sandalwood Valley 2, Residents H and L.

I reviewed the posted staff schedules from 1/28/24 to 2/10/24. According to the staff schedules, the facilities was short staffed on the following dates and times:

- 1/28/2024:
    - 1 staff scheduled for each facility from 7am to 3pm
    - 1 staff scheduled to cover both facilities from 8pm to 11pm
    - 1 staff scheduled for each facility from 11pm to 7am
- 1/29/2024:
    - 1 staff scheduled to cover both facilities from 8pm to 11pm
    - 1 staff scheduled for each facility from 11pm to 7am
- 1/30/2024:
    - 1 staff scheduled to cover both facilities from 8pm to 11pm
    - 1 staff scheduled for each facility from 11pm to 7am
- 1/31/2024:
    - 1 staff scheduled for each facility from 7am to 3pm and 3pm to 8pm
    - 1 staff scheduled to cover both facilities from 8pm to 11pm
    - 1 staff scheduled for each facility from 11pm to 7am

- 2/1/2024:
    - 1 staff scheduled each facility from 8pm to 7am
- 2/2/2024:
    - 1 staff scheduled to cover both facilities from 8pm to 11pm
    - 1 staff scheduled for each facility from 11pm to 7am
- 2/3/2024:
    - 1 staff scheduled for each facility from 8pm to 7am
- 2/4/2024:
    - 1 staff scheduled for each facility from 7am to 3pm
    - 1 staff scheduled to cover both facilities from 8pm to 11pm
    - 1 staff scheduled for each facility from 11pm to 7am
- 2/5/2024:
    - 1 staff scheduled for each facility from 2pm to 3pm, and 8pm to 7am
- 2/6/2024:
    - 1 staff scheduled for each facility from 8pm to 7am
- 2/7/2024:
    - 1 staff scheduled for each facility from 8pm to 7am
- 2/8/2024:
    - 1 staff scheduled for each facility from 8pm to 7am
- 2/9/2024:
    - 1 staff scheduled for each facility from 7am to 3pm and 8pm to 7am
- 2/10/2024:
    - 1 staff scheduled for each facility from 7am to 7am

During the onsite investigation, I interviewed the facility manager Ms. Cindy Shelly. Ms. Shelly stated that there are no issues at the facility regarding care for the residents. According to Ms. Shelly, the facilities are not short staff although there are call offs often. Ms. Shelly stated that one staff member per facility is sufficient to provide adequate care for the residents, although there are five residents between the two facilities who require two staff to provide sufficient care. Originally, Ms. Shelly stated that there have not been any resident falls but later recanted and stated that there have been multiple resident falls. Ms. Shelly could not provide any documentation of any resident falls. According to Ms. Shelly, she has not seen any staff at work intoxicated or drinking on the job. Ms. Shelly stated that on 1/28/24, a staff member found alcohol bottles in a pile of supplies. The bottles were empty and thrown away. Ms. Shelly is not sure how long the bottles were there. While onsite staff showed me a text message that was sent to Ms. Shelly displaying five empty bottles of fireball alcohol in the trash. The text message dated 1/28/24 stated, “someone on afternoon shift drank five bottles of fireball and left it in the employee bathroom trash.”

During the onsite investigation, I interviewed staff Stephanie Jemison. According to Ms. Jemison, there has not been sufficient staff for several months. Staff will often call off, leaving the facilities short staff to pass meds, provide care and sometimes cook for the residents. There have been a multitude of times where one staff would have to provide care for both buildings. Ms. Jemison does not believe one person can adequately provide care to the residents, as many of the residents are high needs. Due to lack of

staffing, residents are not properly and timely changed, which leaves residents in soiled briefs long period of times. According to Ms. Jemison, almost every day that she has come in at 7am, the residents are soaked in urine and feces. During the afternoon and night shift, there are often one staff to cover both buildings and as a result, there has been an increase in resident falls. Ms. Jemison showed me a text message from 2/3/24 at 1:36am that a coworker sent her, asking if she could come in on her off day due to that staff being alone and residents on the floor that she could not get up alone. Ms. Jemison stated that one staff can't get residents up, dressed, fed, toileted, showered, etc. When there is only one person working there are often situations where staff gets caught up helping a resident and has to ignore and neglect the others. Ms. Jemison stated that less than a week ago, there was a situation where EMS had to be called for a resident. One staff member had to assist with the emergency and it left one other staff member to care for both facilities. During this time, there was a resident who is a two-person assist and he had to wait at least three hours before he could be changed. That resident was soaked with urine and feces.

During the onsite investigation, I interviewed staff Latrese Pearson. According to Ms. Pearson, there is a lack of staff, which causes residents not to receive proper and timely care. Ms. Pearson stated that there always call offs from staff that causes them to be short staffed. There have been multiple times that she had to cover both buildings by herself.

During the onsite investigation, I interviewed staff licensee designee Ms. Rayann McCoy. According to Ms. McCoy, she just took over as licensee designee and has not had a chance to get the facilities in order.

During the onsite investigation, I interviewed Resident I. Resident I had no issues or concerns to report with regards to her care or the care of any of her housemates.

During the onsite investigation, I interviewed Resident J. Resident J had no issues or concerns to report with regards to her care or the care of any of her housemates.

During the onsite investigation, I interviewed Resident M. Resident M had no issues or concerns to report with regards to her care or the care of any of her housemates.

During the onsite investigation, I interviewed Resident O. Resident O had no issues or concerns to report with regards to her care or the care of any of her housemates.

On 02/19/24, I interviewed Resident H's son. According to Resident H's son, Resident H has been a resident at the facility since 2014, however over the last several weeks, the care Resident H receives has not been adequate. Resident H's son stated that Resident H has been in and out of the hospital over the last few weeks and he was never notified by the facility. Resident H currently has horrible bed sores from the lack of care she is receiving at the facility. Resident H's son found out his mother was in the hospital when the non-facility nurse contacted him. The nurse notified Resident H's son that Resident H went to the hospital with bed sores and viruses on 1/27/24 to 1/30/24, 2/1/24 to

2/7/24, and again on 2/14 (still hospitalized). According to Resident H's son, his mother had surgery on 2/15/24 because of the severity of a bed sore on her backside. This has been growing for weeks and getting worse. Resident H's son stated the hospital doctor told him that when his mother arrived at the hospital on 2/14/24, she was severely dehydrated to the point where nurses could not get a vein for an IV. According to Resident H's son, prior to her latest hospitalization, a wound care nurse from Beacon Home Care came to the facility to check her wound. The nurse was appalled at the size of her wound and said the doctor needs to look at it immediately. Resident H's son still did not receive a call from the facility about this. Resident H's son stated that he found out through the nursing company. Resident H's son stated that according to the nurse, the only possible way for Resident H to have a wound this big is neglect. Resident H hasn't been being rotated per the nurses' instructions and this has led to her current condition.

According to Resident H's son, Resident H has lived in this facility for 10 years, and they have paid over $500,000 for her to live there in that time. She has never had a bedsore before. When Ms. Strickland was in charge, she would always make sure there was good communication and would meet with him at any time, at his convenience, since they are the customer. It's also been brought to his attention that there are staffing issues/shortages currently, which is 100% unacceptable. Resident H's son stated that he contacted Licensee designee Ms. McCoy to schedule a meeting to go over his mother's care, however she did not want to meet. Resident H's son demanded that they meet, and Ms. McCoy agreed they could meet on 2/15. According to Resident H's son, Ms. McCoy would not show him any documentation regarding his mother's care. Ms. McCoy had a stack of papers that she would quickly flash to Resident H's son, but she refused to let him review them. Resident H's son stated that prior to the meeting, multiple staff members told him that they were forced to fill out incident reports that morning and backdate them because they were not originally completed. Resident H's son stated that his mother is a two-person assist and he requested to see staff schedules but was denied.

On 2/19/24, I received and reviewed Resident Assessment plans and incident reports sent by Ms. McCoy. Almost all the assessments were outdated or completed on 2/7/24 with no signatures from the guardians. None of the incident reports indicate that the resident's guardians were contacted. There were no Incident Reports for Resident H.

On 02/21/24, I received an email from the complainant. According to the complainant, things have not changed since my onsite investigation on 2/5/24. Since that time, the facility has brought in two new residents, with one being a two-person assist. The complainant stated that the managers created a fake schedule to reflect that the facility have coverage but that is not true. The complainant sent me copies of the real schedule and a copy of the fake schedule. The complainant also sent a photo of the new resident showing how staff wrapped gauze around his neck and left his tumor to bleed out all night. According to the complainant, the picture reflects how she found him when she arrived on the day shift.

On 02/22/24, I received and reviewed an updated Resident Registry for both facilities from Ms. McCoy. According to the updated Resident Registry, the facility has admitted one new resident since 2/5/24.

On 2/23/24, I interviewed Beacon Home Care nurse Autumn Roberts. According to Ms. Roberts, when she went to the facility last week, she observed that Resident H had a large wound to her buttock. The wound was a Stage 3 bedsore that was black and had a foul smell. Nurse Roberts stated that she had a mask on and could vividly smell it through the mask. Staff at the facility was unable to tell her when the wound started. She became concerned and contacted Resident H's visiting doctor. The visiting doctor believed the wound had progressed to the point where more intensive treatment was needed, and he sent Resident H to the hospital. Nurse Roberts stated that staff at the facility should have been more proactive with dealing with the wound. According to Nurse Roberts, staff admitted to her that they had notice the wound and smell for some time, but they assumed the wound care nurses would handle it. Nurse Roberts stated that she is the one who contacted Resident H's son about his mother's wound. According to her nursing notes, the wound was first documented by her agency on 1/27/24.

On 2/23/24, I interviewed staff Danielle Nasser. According to Ms. Nesser, both facilities are extremely short staffed and overworked. She primarily works the night shift and there are only two people scheduled for the entire building. There have been multiple resident falls during the night shift due to staff being overwhelmed by other resident needs. Ms. Nasser stated that she recently worked by herself to cover both buildings and Resident O fell and she was unaware due to assisting other residents. She is not sure how long Resident O was on the floor before she discovered her. There was also another incident where there were two people working the night shift and Resident N fell and staff were not aware due to providing care to other residents. According to Ms. Nasser, she has witnessed other staff (approximately four different staff members) intoxicated on shift. Sometimes they come into work intoxicated or they drink on the job. Ms. Nasser stated that there have been cases of COVID in the building and staff were unaware due to improper testing. Also, the facility lacked appropriate PPE supplies. Due to being short staffed, management have recently started denying time off for staff, even for legitimate reasons, which has resulted in the loss of even more staff.

On 02/23/24, I interviewed staff Ashly Shreffler. According to Ms. Shreffler, there have been multiple residents who have sustained injuries in recent weeks. Resident H received bedsores due to improper care. Resident H injuries were so severe that she required surgery. On 2/20/24, Ms. Shreffler worked, and provided care to Resident L and Resident L was fine. The next day she returned to work and found Resident L with a large open wound on her right elbow. The wound was heavily bandaged and according to Ms. Shreffler, the injury was caused due to improper care being provided to Resident L by staff. Ms. Shreffler stated that staff do not always properly use assistive devices and sometimes are too rough with the residents. Ms. Shreffler stated that residents are not being showered consistently.

According to Ms. Shreffler, there have been multiple residents who have contracted COVID, but the facility was unaware because the tests at the facility are expired. Ms. Shreffler notified Ms. Shelly that there was an issue with Resident H's breathing, and she needed to go to emergency, but Ms. Shelly denied the request. Staff then contacted the home care nurse to come out and the nurse immediately sent the resident out to the hospital. Other residents started showing COVID symptoms, but the tests were negative because the tests were expired. Ms. McCoy brought new test kits to the facility that were still expired. Now Resident K is positive for COVID. Ms. Shreffler and her children tested positive for COVID recently due the facility's mismanagement of testing. Ms. Shreffler stated that on 02/22/24, cook Paul Mattarella tested positive for COVID. The facility does not have sufficient PPE supplies.

According to Ms. Shreffler, the facility stopped paying staff overtime and now many staff members are not working extra hours, which causes the facility to be even more short staffed. According to Ms. Shreffler, management created a fake schedule after my onsite investigation on 2/5/24, to display proper staffing. However, staff was told to continue working their normal schedule and to ignore the new posted schedule. According to Ms. Shreffler, management hired a worker named April Halatsis, and she did not pass her background check. Ms. Halatisis worked from 02/01/24 to 02/17/24.

I observed the staff schedule and April Halatsis was on the schedule from 2/4/24 to 2/10/24. I also reviewed the facility's department file, and I observed an Employment Disqualification Notice that April Halatsis is ineligible to work at an AFC licensed facility until 10/8/28. The notice was dated 2/16/24.

According to Ms. Shreffler, she has witnessed staff intoxicated on shift. Sometimes they come into work intoxicated or they drink on the job. According to Ms. Shreffler, on 02/20/24 staff Eugina Crocheron brought a strange male into the facility and took him into Resident N's room. According to Ms. Shreffler, Ms. Crocheron and the male facetimed someone from inside Resident N's room and showed them Resident N. Resident N was visibly scared according to Ms. Shreffler. Ms. Crocheron and the male went into Resident N's bathroom and close the door. They were in there for several seconds before leaving out and leaving Resident N's room completely. Resident N has a camera in her the room and her daughter sent the video of this incident to staff.

On 02/24/24, I received a written statement from Resident N's granddaughter. According to the statement, even with a camera in her room 24/7 the staff has been verbally and emotionally abusive to Resident N. Meals have been intermittent and she has very often been told they didn't have the basics of groceries on site to make her things she could eat, as she has no teeth nor dentures (before she was a resident at this facility). Cleaning practices were intermittent, the family often came in to do cleaning that was not done. According to the statement, they have many pictures of spilled food and liquids that were barely or carelessly cleaned up, including Resident N's bedding. Many times, the family were told by the facility that they didn't have trash can liners, therefore, the family provided them. Resident N's soiled briefs would end up in an unlined can, causing an odor which made it difficult to even visit her.

The statement indicated that the family have pictures of Resident N's bed being left with feces in it. The facility continued to promise to do better, but also told the family they didn't have enough staff to take care of her properly. The family had to constantly, hound, ask, request and follow up. The facility would change her bed only when the family requested, they would not change her clothing daily or when they noticed it was soiled. The family always had to ask for Resident N's clothing to be changed.

The statement indicated Resident N has fallen in her room several times, most of the falls, the family were not informed. The family wouldn't have known if they didn't have the camera. Resident N was not offered help to wash her hands before, after a meal, or after digging around in her own urine or feces, trying to clean herself up. The family have had to request that Resident N be bathed, ultimately seeking help from a hospice facility. The family have witnessed yelling between Resident N and staff, staff antagonizing her, saying horrible things to her. The family have witnessed staff telling Resident N that she doesn't deserve the care they are offering. Resident N is not always a joy to deal with but often times her acting out was a reaction to being neglected and verbally abused. At times she would try to barricade her door for fear of harm or retribution. According to the statement, twice the family have filed complaints and nothing has happened. Now there is another new administrator. An administrator known amongst her peers to have an alcohol problem. The family have suspected other employees of drinking on the job.

On 02/26/24, I received an email from Resident N's granddaughter with several videos from Resident N's bedroom. I observed in the videos dated 2/9/24 at 6:40am regarding Resident N in her room with the door closed, sitting on the edge of her bed in distress. Later in the video, Resident N can be seen falling to the ground and screaming in pain for help. Approximately 36 seconds later, staff came into the room to assist. In another video dated 2/20/24 at 6:44pm, a staff member came into Resident N's room with a male who was wearing all black with a hood on. The male can be seen on his phone taking pictures or on a video chat. The male placed the camera on Resident N several times. The female staff and the unknown male went into Resident N's bathroom and shut the door for several seconds. When they came out of the bathroom, Resident N ask the staff for more to drink. The staff member took Resident N's cup and handed it to the unknown male prior to leaving the room.

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.** **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	During the onsite investigation, staff showed me a text message that was sent to Ms. Shelly displaying five empty bottles of fireball alcohol in the trashcan located in Sandalwood Valley 1. The text message dated 1/28/24 stated, “someone on afternoon shift drank five bottles of fireball and left it in the employee bathroom trash.” Multiple staff and residents stated that they have witnessed staff working the afternoon and night shift being intoxicated and or drinking on shift. Staff Eugina Crocheron brought a strange male into the facility and took him into Resident N’s room during the night shift. This caused the resident to be frighten and agitated. With regards to Resident H, Nurse Roberts went to the facility last week and observed that Resident H had a large wound to her buttock. The wound was a Stage 3 bedsore that was black and had a foul smell. Nurse Roberts stated that she had a mask on and could vividly smell it through the mask. Nurse Roberts stated that staff at the facility should have been more proactive with dealing with the wound. According to Nurse Roberts, staff admitted to her that they had notice the wound and smell for some time, but they assumed the wound care nurses would handle it. Resident H was sent to the hospital and received surgery due to her injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**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:	During the onsite investigation, I observed that there is a total of two two-person assist residents in this facility. I reviewed the posted staff schedules from 1/28/24 to 2/10/24. According to the staff schedules, the facility did not schedule or have enough staff to meet the needs of the residents everyday between 1/28 to 2/10/24. The facility often has one to two staff working in each building on the afternoon and night shift. Due to improper staffing, multiple residents were injured. Resident H was sent to the hospital due and required surgery due to her injuries

	sustained at the facility. I also observed residents sitting in the dining room for over 30 minutes waiting to be fed due to lack of staff. There were not enough staff to watch and feed the residents in the dining room and feed the bedbound residents in their rooms. The two-person assist residents were left in their rooms and had to wait until the other residents finished eating so that there would be sufficient staff to safely get those residents up and out of bed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14209	**Home records generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(d) Resident Records** **(g) Accident records and incident reports.** **(h) Personnel records, as required in R 400.15208** **(t) Menus.**
ANALYSIS:	During the onsite investigation, staff were unable to provide me resident files including incident reports and assessment plans. Ms. Shelly was not able to provide me with staff schedules before 1/28/24. Ms. Shelly stated that since the departure of former licensee designee Ms. Strickland, the paperwork and files are not in order, and she would have to spend time sorting through the staff office to find requested documents. No resident falls or hospitalization were documented. On 02/19, Ms. McCoy emailed me copies of incident reports. None of the incident reports indicate that the resident's guardians were contacted. There were no Incident Reports for Resident H who has been hospitalized three times since January. The menu posted was dated 12/31/23 to 1/6/24. Ms. Shelly stated that there are more up to date menus, but she was unable to provide them to me.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	During the onsite investigation, I observed a total of two two-person assist residents in this facility. According to the posted staff schedules from 1/28/24 to 2/10/24, the facility did not schedule or have enough staff to meet the needs of the residents everyday between 1/28 to 2/10/24. The facility often has one to two people working in each building in the afternoon and night shift. Due to improper staffing, multiple residents were injured. Resident H was sent to the hospital due and required surgery due to her injuries sustained at the facility. On 2/19/24, Ms. McCoy emailed copies of resident assessment plans and Residents H and L are both two-person assist. However, the facility doesn't schedule enough staff to meet the needs of the residents as specified in the residents' care plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Due to improper staffing, multiple residents were injured. Resident H was sent to the hospital due and required surgery due to her injuries sustained at the facility. I also observed residents sitting in the dining room for over 30 minutes waiting to be fed due to lack of staff. There were not enough staff to watch and feed the residents in the dining room and feed the bedbound residents in their rooms. The two two-person assist residents were left in their rooms and had to wait until the other residents finished eating so that there would be sufficient staff to safely get those residents up and out of bed. I received and reviewed multiple pictures of various residents on the floor from falls, pictures of residents with injuries such as

	bed sores and leaking tumors. There also pictures of residents soiled bedding and clothing.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.**

	(h) Incident reports and accident records. **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**
ANALYSIS:	During the onsite investigation, staff were unable to provide me resident files including assessment plans and incident reports. Ms. Shelly stated that since the departure of former licensee designee Ms. Strickland, the paperwork and files are not in order, and she would have to spend time sorting through the staff office to find requested documents. On 2/19/24, I received and reviewed Resident Assessment plans and incident reports. Almost all of the assessments were outdated or completed on 2/7/24 with no signatures from the guardians. None of the incident reports indicate that the resident's guardians were contacted. There were no Incident Reports for Resident H.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The foods provided are inadequate.

INVESTIGATION:

According to the complainant, residents at this facility are not being fed proper nutritious meals each day. The required weekly menu for meals that should be prepared are not posted and cooks are serving whatever is available due to lack of groceries being provided for both facilities. Cooks are not preparing special dietary meals to residents that are in their care plans. Caregivers often spend their own money on meals for residents when they run out of items without being compensated for the purchases. On 1/30/24 the facility only had four eggs to feed all 13 residents. The cook on duty called the manager Cindy to inform her and she told him to serve everyone oatmeal.

I interviewed Ms. Shelly on 02/05/24. According to Ms. Shelly, groceries are ordered once a week to biweekly, depending on the needs of the home. Ms. Shelly stated that there are no issues with adequate and nutritious food being provided to the residents.

During the onsite investigation I observed an outdated menu posted in the kitchen. The menu posted was dated 12/31/23 to 1/6/24. Ms. Shelly stated that there are more up to date menus, but she was unable to provide them to me. Also, there was not a list of residents or special menus for residents who require an alternate menu.

I observed the refrigerator, cabinets, and freezers to be fully stocked with appropriate amounts of food. The facility has multiple freezers and I observed the freezers to be

fully stocked with an assortment of frozen meat, vegetables and other frozen food entries.

During the onsite investigation, I interviewed cook Martin Brabant. According to Mr. Brabant, there are no issues with food at the facility. Although there are no updated menus, Mr. Brabant stated that he has worked there long enough to be able to make up his own menu based on the foods available. He stated that he always makes sure that the residents have a protein, starch and vegetables. Mr. Brabant stated that he works five days a week Thursday to Monday from 6:30am to 1:30 and is responsible for breakfast and lunch. According to Mr. Brabant, he prepared fried eggs, ham and toast for breakfast.

I observed Mr. Brabant prepare roast beef, gravy and green beans for lunch. I also observed residents sitting in the dining room for over 30 minutes waiting to be fed due to lack of staff. There were not enough staff to watch and feed the residents in the dining room and feed the bedbound residents in their rooms. The two-person assist residents were left in their rooms and had to wait until the other residents finished eating so that there would be sufficient staff to safely get those residents up and out of bed.

During the onsite investigation, I interviewed Resident I. Resident I had no issues or concerns to report with regards to the meals and food being provided at the facility.

During the onsite investigation, I interviewed Resident J. Resident J had no issues or concerns to report with regards to the meals and food being provided at the facility.

During the onsite investigation, I interviewed Resident M. Resident M had no issues or concerns to report with regards to the meals and food being provided at the facility.

During the onsite investigation, I interviewed Resident O. Resident O had no issues or concerns to report with regards to the meals and food being provided at the facility.

Resident H’s son stated that he has concerns about the food that Resident H is receiving. He stated that there are no menus in the facility and the resident end up eating a lot of pasta. According to Resident H’s son, the hospital doctor notified him that Resident H has a protein deficiency.

According to staff Danielle Nasser, cook Paul Mattarella calls of work often, leaving caregivers to cook in addition to their other duties. When Mr. Mattarella does work, he doesn’t follow a menu and just put things together. Ms. Nasser stated that the food does not look appetizing and are often small in portions.

According to the statement received regarding Resident N’s care, the family have supplied her with food the entire time she’s been there, a nutritional drink, milks, yogurt, water, snacks and so on. One of the things she would eat for a while was a scrambled egg, many times she was told there were not groceries, that they were out of eggs or basic foods.

On 02/28/24, I conducted an exit conference with Licensee Designee Rayann McCoy to discuss the findings of this report. Ms. McCoy stated that she is actively interviewing to hire more staff.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	During my unannounced onsite investigations, I observed the residents eating lunch. The foods for both facilities are kept in one kitchen. I observed the refrigerator, freezer, and pantries with appropriate amounts of food. However, according to the complainant, residents at both facilities are not being fed proper nutritious meals each day. The required weekly menu for meals that should be prepared are not posted and cooks are serving whatever is available due to lack of groceries being provided for both facilities. Resident H's son has concerns about the food that Resident H is receiving. He stated that there are no menus in the facility and the resident end up eating a lot of pasta. According to Resident H's son, the hospital doctor notified him that Resident H has a protein deficiency. According to Ms. Nasser, When Mr. Mattarella does work, he doesn't follow a menu and just put things together. Ms. Nasser stated that the food does not look appetizing and are often small in portions. I received and reviewed a picture of a meal that was provided for the residents. The meal was a small portion and did not look appealing.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.

ANALYSIS:	During the onsite investigation I observed an outdated menu posted in the kitchen. The menu posted was dated 12/31/23 to 1/6/24. Ms. Shelly stated that there are more up to date menus but she was unable to provide them to me. Also, there was not a list of residents or special menus for residents who require an alternate menu. According to Resident Files, Residents N, J and I all require special diets.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(5) Records of menus, including special diets, as served shall be provided upon request by the department.
ANALYSIS:	During the onsite investigation I observed an outdated Menu posted in the kitchen. Menu posted was dated 12/31/23 to 1/6/24. Ms. Shelly stated that there are more up to date menus but she was unable to provide them to me. Also, there was not a list of residents or special menus for residents who require an alternate menu. According to resident files, Residents N, J and I all require special diets.
CONCLUSION:	**VIOLATION ESTABLISHED**

II. RECOMMENDATION

I recommend revocation of the license.

03/06/24

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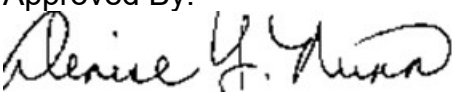
Eric Johnson Date
Licensing Consultant

Approved By:



03/11/2024

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Denise Y. Nunn Date
Area Manager