GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 28, 2024

Hope Lovell
LoveJoy Special Needs Center Corporation
17101 Dolores St
Livonia, MI 48152

RE: License #: AS330297845
Investigation #: 2024A1033042
Michigan Ave. Residential Care

Dear Ms. Lovell:

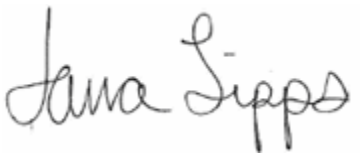
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS330297845
Investigation #:	2024A1033042
Complaint Receipt Date:	05/09/2024
Investigation Initiation Date:	05/09/2024
Report Due Date:	07/08/2024
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17101 Dolores St Livonia, MI 48152
Licensee Telephone #:	(517) 574-4693
Administrator:	Hope Lovell
Licensee Designee:	Hope Lovell
Name of Facility:	Michigan Ave. Residential Care
Facility Address:	1204 W. Michigan Ave. Lansing, MI 48915
Facility Telephone #:	(517) 367-8172
Original Issuance Date:	12/11/2009
License **Status:**	REGULAR
Effective Date:	02/23/2024
Expiration Date:	02/22/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff are not completing required documentation per Community Mental Health requirements.	No
Direct care staff, Jill Barlow, has left the residents unattended at the facility.	Yes
Direct care staff, Jill Barlow, is verbally abusive to the residents and uses profanity toward them.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/09/2024	Special Investigation Intake 2024A1033042
05/09/2024	Special Investigation Initiated - Telephone Interview with Complainant, via telephone.
05/09/2024	Contact - Telephone call made Interview with direct care staff, Paula Powell, via telephone.
05/20/2024	Inspection Completed On-site Interviews conducted with direct care staff, Camille Owens, Jamila McCoy, and Sonia McKeown. Review of Resident A, B, & C resident records initiated. Review of staff schedule for month of April 2024 initiated. Tested interconnected smoke detection system.
05/21/2024	Contact - Telephone call made Interview with direct care staff, Arica Williams, via telephone.
05/21/2024	Contact - Telephone call made Interview with Community Mental Health, Central Michigan, case manager, Rebecca Shebester, via telephone.
05/21/2024	Contact - Telephone call made Interview with Guardian C1, via telephone.
05/21/2024	Contact - Telephone call made Attempt to interview Pines Behavioral Health Services, case manager, Gail Giovannelli, via telephone. Voicemail message left, awaiting response.

05/21/2024	Contact - Telephone call made Follow-up interview conducted with Sonia McKeown, via telephone.
05/22/2024	Contact - Telephone call made Interview with Pines Behavioral Health case manager, Gail Giavanelli, via telephone.
06/13/2024	Contact - Telephone call made Interview with Guardian A1, via telephone.
06/17/2024	Contact – Telephone call made Interview with Operations Director, Heidi Morton, via telephone.
06/17/2024	Contact – Telephone call made Attempt to interview direct care staff, Jill Barlow. Message left, awaiting response.
06/25/2024	Contact – Telephone call made Attempt to interview direct care staff, Jill Barlow. Message left, awaiting response.
06/25/2024	Contact – Telephone call made Attempt to interview licensee designee, Hope Lovell. Voicemail message left, awaiting response.
06/27/2024	Exit Conference Exit conference conducted with licensee designee, Hope Lovell, and Sonia McKeown, via telephone.

ALLEGATION: Direct care staff are not completing required documentation per Community Mental Health requirements.

INVESTIGATION:

On 5/9/24 I received a telephone complaint regarding the Michigan Ave. Residential Care, Adult foster care facility (the facility). The complaint alleged that direct care staff members are not completing the required documentation per Community Mental Health requirements for the current facility residents. On 5/9/24 I interviewed Complainant regarding the allegations. Complainant reported that a Community Mental Health (CMH) case manager (name unknown) had requested the documentation for one of the residents at the facility and was told that the documentation did not exist. Complainant reported direct care staff were told to

fabricate the documentation and submit it to the case manager. Complainant reported direct care staff/home manager, Paula Powell, would have further information regarding this allegation.

On 5/9/24 I interviewed Ms. Powell via telephone. Ms. Powell reported that she was previously the home manager at the facility and has since been removed from this position and reassigned to be a direct care staff at another facility owned by the same corporation, Lovejoy Special Needs Center Corporation. Ms. Powell reported that she had been hired at the facility as the home manager to assist in getting the paperwork in order as there were issues with multiple missing documents from resident records when she was hired. She reported that she did recall that a CMH case manager (name unknown) had requested Individual Plan of Service (IPOS) progress notes for the timeframe, 11/1/23 – 11/11/23, for one of the residents (she could not recall which resident). Ms. Powell reported that these documents did not exist in the current resident record, and she reported this to the CMH case manager. Ms. Powell reported that Residential Services Director, Sonia McKeown, expressed frustration with her for stating to the CMH case manager that the documents were not available and then instructed Ms. Powell to create these documents and send them to the case manager. Ms. Powell reported that she did not feel comfortable being told to fabricate documents that did not exist. Ms. Powell reported that she instituted a new daily narrative note for each resident to better comply with CMH requirements for daily documentation.

On 5/20/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. McKeown on this date. Ms. McKeown reported that CMH requires daily documentation to be completed for residents who have a data goal sheet and/or ABC Chart. She reported that narrative notes are not required by CMH, but she instituted the use of narrative notes within the past month to improve documentation for each resident file.

On 5/20/24, during the unannounced, on-site investigation, I interviewed direct care staff, Jamila McCoy. Ms. McCoy reported that a regular part of the direct care staff job duties is to complete the IPOS tracking sheets for each resident who has a tracking sheet. She reported that this tracking occurs daily and is a regular job duty. She reported not being aware of any instance when the tracking sheets were not being completed by direct care staff.

On 5/20/24, during the unannounced, on-site investigation, I interviewed direct care staff, Camille Owens. Ms. Owens reported that completing IPOS tracking sheets is a regular part of her job duties and noted these tracking sheets are completed daily per resident who has a tracking sheet assigned with their IPOS.

During the on-site investigation on 5/20/24 I reviewed the following documents:

- Pines Behavioral Health, IPOS In-Service Form, dated 3/19/24, for Resident C.
- Pines Behavioral Health, IPOS, dated 11/17/23, for Resident C.

- All Staff Procedures, months April and May 2024, for Resident C. This is a document which notates services provided to Resident C and completed by direct care staff members. It is a spreadsheet of different services and tasks accomplished for the month.
- Specialized Residential Personal Care & Comprehensive Community Support Services Log 1st Shift, March, April, & May 2024, for Resident A, B, & C.
- Specialized Residential Personal Care & Comprehensive Community Support Services Log 2nd Shift, March, April, & May 2024, for Resident A, B, & C.
- Specialized Residential Personal Care & Comprehensive Community Support Services log 3rd Shift, March, April, & May 2024, for Resident A, B, & C.
- LoveJoy Community Services Resident Daily Progress Log, for Resident C. I observed there were documented progress notes for the dates, 5/1/24 – 5/18/24.
- Community Mental Health for Central Michigan, PCP, dated 1/26/24, for Resident B.
- Behavior Tracking document for Resident B. This document was completed but not dated.
- Behavior Tracking document for Resident B, dated 5/5/24 – 5/11/24. This document was completed.
- Behavior Tracking document for Resident B, dated 5/12/24 – 5/18/24. This document was completed.
- Behavior Tracking document for Resident B, dates 5/19/24 – 5/25/24. This document was completed for date 5/19/24.
- All Staff Procedures, months April and May 2024, for Resident B. This document was completed for the dates 5/1/24 – 5/18/24.
- LoveJoy Community Services Resident Daily Progress Log, for Resident B. I observed there were documented progress notes for the dates, 5/1/24 – 5/18/24.
- Community Mental Health for Central Michigan Frequency Recording (Three Shift) document for Resident B, dates May 2024. This document was completed from 5/1/24 – 5/19/24 with multiple occurrences where there were blank spaces indicating a direct care staff member neglected to document on these dates.
- Community Mental Health for Central Michigan ABC Chart, dated April 2024, for Resident B. There were two documented dates, 4/28/24 & 5/5/24, where a behavior was observed for Resident B.
- Community Mental Health for Central Michigan PCP, dated 8/24/23, for Resident A.
- All Staff Procedures, month May 2024, for Resident A. This document was completed for the dates 5/1/24 – 5/19/24.
- LoveJoy Community Services Resident Daily Progress Log, for Resident A. I observed there were documented progress notes for the dates, 5/1/24 – 5/19/24.

- Community Mental Health for Central Michigan ABC Chart, dated May 2024. This document did not have a resident name on it but was found in Resident A's resident record. There were no noted behavioral issues on this document.
- Community Mental Health for Central Michigan Frequency Recording, dated April 2024. This document did not have a resident name on it but was found in Resident A's resident record. There were zero noted frequencies of behaviors on this document.

On 5/21/24, I interviewed Rebecca Shebester, Central Michigan Community Mental Health, case manager. Ms. Shebester reported that she is the current case manager for Resident A and Resident B. Ms. Shebester reported that there have been instances where it was difficult to obtain required documentation for Resident A and Resident B from direct care staff. She reported that there have been instances where she has asked for the documentation and has been told that the paperwork was locked in the office and only the home manager had the key to access the paperwork. She reported that when this has occurred, she usually receives the documents within two to three days after she requests them. Ms. Shebester reported that Resident B requires a Behavior Tracking Log to be completed monthly. She reported that there is not a required tracking log for Resident A at this time. Ms. Shebester reported that there has been a high turnover of home managers at the facility which makes it difficult to communicate with direct care staff and receive requested documentation as she is frequently interacting with new direct care staff/home managers who are not familiar with the documentation required. She further reported that "for the most part" they provide the required documents monthly.

On 5/21/24 I interviewed direct care staff, Arica Williams. Ms. Williams reported that the direct care staff are required to complete daily documentation on each resident. She reported that they complete daily progress notes, and that each resident has a care log to be completed per day. Ms. Williams reported that these documents are completed daily, but there have been some instances where the log was not completed as required, but she indicated that this is a rare occurrence.

On 5/21/24 I interviewed Guardian C1, via telephone. Guardian C1 reported that the CMH case manager for Resident C is Gail Giavanelli. She reported that in December 2023 Ms. Giavanelli set up a meeting with licensee designee, Hope Lovell, and Operations Director, Heidi Morton, to discuss daily documentation required for Resident C. Guardian C1 reported no further knowledge of the required documentation for Resident C.

On 5/22/24 I interviewed Ms. Giavanelli via telephone. Ms. Giavanelli reported that she is the CMH case manager for Resident C and visits him at the facility monthly. She reported that in the past she had difficulty obtaining written documentation from the direct care staff members for required documentation. She reported that she would receive excuses such as the documentation is on the computer and the direct care staff do not have access to the documentation, or she would receive little

handwritten notes, but it was not documentation on the CMH required forms. Ms. Giavanelli reported that the direct care staff/home manager position has been in constant turnover at the facility. She reported that frequently she would have direct care staff tell her they could not access the documentation because the office door was locked, and they did not have access to the documents. Ms. Giaveanelli reported that she did have a meeting with Ms. Morton, Ms. Lovell, and one other unidentified direct care staff member in February 2024. She reported that she provided the tracking sheets required for Resident C during this meeting. She reported that since she provided the tracking sheets the direct care staff have been consistent with completing these and being able to produce the documentation when requested.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based upon interviews with the Complainant, Ms. Powell, Ms. McKeown, Ms. McCoy, Ms. Owens, Ms. Shebaster, Ms. Williams, Guardian C1, & Ms. Giavanelli, as well as review of the resident records for Resident A, B, & C, it can be determined that it appears there were some inconsistencies with the direct care staff completing required documentation for the current residents prior to February 2024. However, it does appear, based on interviews conducted and resident records examined that this issue has been resolved after the meeting with Ms. Giavanelli occurred in February 2024. There were required documents available for my review at the time of the on-site investigation for the months March, April, & May 2024. Furthermore, both Ms. Shebaster & Ms. Giavanelli, reported that this has improved, and they are now receiving the required documentation when requested. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff, Jill Barlow, has left the residents unattended at the facility.

INVESTIGATION:

On 5/9/24 I received a telephone complaint regarding the facility. Complainant alleged that on 4/20/24 direct care staff, Jill Barlow, left Resident A and Resident B

unattended in the facility. Complainant reported that Ms. Powell had more relevant information pertaining to this allegation as she was contacted on this date by Resident A.

On 5/9/24 I interviewed Ms. Powell via telephone regarding the allegation. Ms. Powell reported that on 4/20/24 she received a telephone call from Resident A who stated he and Resident B were home alone at the facility. Ms. Powell reported that Resident A had stated to her that he and Resident B were home by themselves, and they were afraid. Ms. Powell reported that while she was on the telephone with Resident A, Ms. Barlow called Ms. Powell. Ms. Powell reported that Ms. Barlow stated direct care staff, Arica Williams, had called her and told her to return to the facility. According to Ms. Powell, Ms. Barlow reported that Resident B had been having a behavior and Ms. Barlow had locked herself in the medication room to have a break from Resident B's behavior. Ms. Powell further reported that Ms. Barlow stated she then came out of the medication room and tried to prepare a meal for Resident A and Resident B but Resident B's behaviors persisted and this is when Ms. Barlow made the decision to leave the facility. Ms. Powell reported that Ms. Barlow verbalized to her that she then got into her vehicle and drove around the block, leaving Resident A and Resident B at the facility unsupervised. Ms. Powell reported that she then drove to the facility and found Ms. Williams & Ms. Barlow at the facility with the residents. Ms. Powell reported that Ms. Williams was there early for her shift and had reported to Ms. Powell that Resident A had called her and expressed that Ms. Barlow had left Resident A and Resident B unattended. Ms. Powell reported that Ms. Williams stated she drove to the facility early and when she arrived Ms. Barlow was not present in the home and arrived shortly after in her vehicle. Ms. Powell reported that she reported Ms. Barlow leaving the residents unattended and unsupervised to Ms. McKeown. Ms. Powell further reported that she was then involved in a consultation with Ms. McKeown and Ms. Barlow about Ms. Barlow abandoning the residents on 4/20/24. Ms. Powell reported that Ms. McKeown then spoke to the facility's Operations Director, Heidi Morton, who advised Ms. McKeown to give Ms. Barlow a three-day suspension with a write up for leaving the residents unattended.

On 5/20/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. McKeown on this date. She provided information from the direct care staff employee file of Ms. Barlow. She reported that there was not any written disciplinary action in Ms. Barlow's employee file.

On 5/20/24 during on-site investigation I interviewed Ms. McCoy. Ms. McCoy reported that she had been made aware of a situation when Ms. Barlow had left Resident A and Resident B unattended at the facility. Ms. McCoy reported that Resident A made a verbal report to her that Ms. Barlow had left the facility and gone to her vehicle and did not return for a lengthy period. Ms. McCoy reported that Resident A was not able to provide the date of this incident or a proper time frame for how long Ms. Barlow was absent from the facility. Ms. McCoy reported that she reported this information to Ms. Powell, who was the home manager at the time of

the initial allegation. She reported that the incident occurred over a weekend as Resident A reported it to her on a Monday morning, but she could not recall the exact date he had reported the incident to her. Ms. McCoy reported that she has observed Ms. Barlow become frustrated with the residents on previous occasions and leave the facility, but she reported that on these dates there was another direct care staff working and residents were not left alone.

During the on-site investigation on 5/20/24 I interviewed Ms. Owens regarding the allegation. Ms. Owens reported that she was made aware, by Ms. Williams, that Ms. Barlow had left Resident A and Resident B unattended on a Saturday in April 2024 three separate times on that day. Ms. Owens reported that Ms. Williams reported this information to her on the Monday morning after the weekend on which the incident occurred. Ms. Owens reported that Ms. Williams had stated that Resident A called her on the telephone to report that he and Resident B were alone in the facility on this date. Ms. Owens reported that Ms. Williams stated that Ms. Barlow was at the facility when she arrived on-site on the date in question. She reported that Ms. Williams confronted Ms. Barlow about leaving the residents unattended and Ms. Barlow admitted to Ms. Williams that she had driven around the block to get away from Resident B and her behaviors. Ms. Owens reported that Ms. Williams reported this information to Ms. Powell, who reported this information to Ms. Morton.

On 5/21/24 I interviewed Ms. Shebester via telephone, regarding the allegation. Ms. Shebester reported that she is the CMH case manager for Resident A and Resident B. She reported that Resident A can speak for himself and is a good historian. She reported that he can express concerns about direct care staff in a verbal way. She reported that Resident B has a limited ability to verbalize concerns. Ms. Shebester reported that she has never interacted with Ms. Barlow and has not been made aware of concerns that Ms. Barlow may have left Resident A and Resident B unattended at the facility.

On 5/21/24 I interviewed Ms. Williams via telephone, regarding the allegation. Ms. Williams reported that on 4/20/24 around 11am, she received a telephone call from Resident A who stated that Ms. Barlow had left he and Resident B alone at the facility. Ms. Williams reported that Resident A expressed that he was worried as this was the second time on this date that Ms. Barlow had left the facility and left the residents unsupervised. Ms. Williams reported that she had been scheduled to work second shift (arriving at 3pm) on 4/20/24 and decided to come in early to care for the residents based on Resident A's telephone call. Ms. Williams reported that when she arrived, Ms. Barlow was entering the facility through the backdoor. Ms. Williams reported that Ms. Barlow admitted to Ms. Williams and Ms. Morton that she had left the facility on this date and left the residents unattended. Ms. Williams reported that Ms. Barlow also admitted leaving the residents unattended on this date to Ms. McKeown and Ms. Powell. Ms. Williams reported that Ms. Powell wanted to take immediate disciplinary action against Ms. Barlow, but Ms. Morton would not allow this. Ms. Williams reported that she stayed at the facility and continued working her shift. She reported that she and Ms. Barlow had a disagreement about her leaving

the residents alone and she asked her to leave the facility, but Ms. Barlow remained at the facility until her shift ended that date.

On 5/21/24 I conducted a follow up interview, via telephone, with Ms. McKeown. Ms. McKeown reported that no direct care staff member or resident ever reported to her that there was a concern Ms. Barlow left Resident A and Resident B unattended on 4/20/24.

On 6/13/24 I interviewed Guardian A1, via telephone. Guardian A1 gave verbal consent for this licensing consultant to interview Resident A. Guardian A1 reported that Resident A has not expressed to her that he and Resident B were left unattended at the facility. Guardian A1 reported that Resident A is a truthful person and does not have a history of fabricating details.

On 6/14/24 I conducted a follow-up on-site investigation at the facility and interviewed Resident A in person. Resident A reported that he could not recall the exact date, but he and Resident B were left unattended by Ms. Barlow. Resident A stated, “I don’t feel safe when she works here”, referring to Ms. Barlow. He then proceeded to report that Ms. Barlow had left he and Resident B unattended at the facility on two instances in one day. He reported that he was concerned that she had left, and he was writing down the times on a piece of paper, which he provided to direct care staff and he no longer was in possession of this paper. Resident A reported that he remembered the first time she left the facility was around 10am and then she came back and left again around 11am. Resident A reported that he did not have access to the telephone during this period of time as Ms. Barlow had locked the telephone in the medication room. He reported that he does not have a cell phone for personal use. Resident A reported that Ms. Williams arrived early for her shift on this date and when she arrived Ms. Barlow was also returning to the facility at the same time. Resident A reported that he gave the piece of paper with the times written on it to Ms. Williams. He reported that Ms. Barlow was upset by this.

During the on-site investigation on 5/20/24 I reviewed the following documents:

- Direct Care Staff Schedule for the month of April 2024. I observed that on this date Ms. Barlow was scheduled as the only direct care staff at the facility between the hours of 7am to 3pm on 4/20/24.
- I reviewed Ms. Barlow’s employee file. I observed the proper required trainings as well as a completed *Michigan Workforce Background Check* eligibility letter. I did not observe any disciplinary action in this employee file.

On 6/17/24 I interviewed Ms. Morton, via telephone, regarding the allegations. Ms. Morton reported that she is not aware of any incident where Ms. Barlow allegedly left Resident A and Resident B unattended at the facility. Ms. Morton reported that there was a report that she went out to her vehicle, on an unknown date, but not that she drove the vehicle away from the facility, leaving the residents unattended. Ms. Morton reported that Ms. Barlow denies this claim and stated that she just went to get something out of her vehicle and came back inside. Ms. Morton reported that to

her knowledge there have not been any reports of residents feeling unsafe in the facility.

On 6/17/24 and 6/25/24, attempts were made to interview Ms. Barlow, via telephone. Voicemail messages were left, and she had not yet returned these calls.

On 6/27/24 I conducted an exit conference with licensee designee, Hope Lovell, and Ms. McKeown. Ms. Lovell reported that she did not have knowledge of Ms. Barlow leaving the residents unattended at the facility. She and Ms. McKeown reported that they had no comments or statements to make regarding the allegation.

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:	Based upon interviews with the Complainant, Ms. Powell, Ms. McCoy, Ms. Williams, Ms. Owens, Ms. McKeown, Ms. Morton, Guardian A1, Ms. Shebester, & Resident A, it can be determined that there is a preponderance of evidence to suggest that there has been at least one occasion in which Ms. Barlow left Resident A and Resident B unattended at the facility. Even though Resident A's recollection of the details of the incident does not fully match the details provided by Ms. Williams and Ms. Powell regarding whether he made a telephone call to these two direct care staff members the date of the incident, his recollection of Ms. Williams arriving to her shift early, and the details surrounding the time of day Ms. Barlow left in her vehicle, align with the details provided by Ms. Williams and Ms. Powell. Additionally, Ms. McCoy confirmed that Resident A reported the events to her upon her arrival for her next scheduled shift, stating that Ms. Barlow had left Resident A and Resident B unattended in the facility. I interviewed Guardian A1 who confirmed that Resident A was a good historian and did not have a history of fabricating details when recalling events. Based on this information, it can be determined that Ms. Barlow did not provide for the required supervision, protection, and personal care needs of Resident A and Resident B by leaving them, alone, unattended in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff, Jill Barlow, is verbally abusive to the residents and uses profanity toward them.

INVESTIGATION:

On 5/9/24 I received a telephone complaint regarding the facility. Complainant reported that Ms. Barlow has been verbally abusive to the residents and uses profanity directed at the residents. On 5/9/24 I interviewed Ms. Powell via telephone. Ms. Powell reported that on an unknown date she received a telephone call from Guardian C1 who reported that she had been on the telephone with Resident C while Resident C was at the facility and she could clearly hear in the background a female yelling, “Shut the fuck up!” Ms. Powell reported that on this date Ms. Barlow and direct care staff, Keyonna Stewart, were scheduled to work at the time of this occurrence. Ms. Powell reported that she then made a telephone call to Ms. Stewart, who reported she had not been in the facility at the time of the incident and that Ms. Barlow had been in the facility. Ms. Powell reported that she then made a telephone call to the facility and Ms. Barlow answered the telephone. She reported that Ms. Barlow confirmed that Ms. Stewart was not present at the facility when Ms. Powell called.

On 5/20/24, during the on-site investigation I interviewed Ms. McCoy. Ms. McCoy reported that she has no direct information or knowledge of Ms. Barlow using profanity toward the residents of the facility.

On 5/20/24, during the on-site investigation I interviewed Ms. Owens. Ms. Owens reported that Resident A has made reports to Ms. Williams that Ms. Barlow directs profanity toward the residents. Ms. Owens reported that she works weekdays and Ms. Barlow works weekends, so she does not have direct knowledge regarding these allegations.

On 5/21/24 I interviewed Ms. Shebester, regarding the allegation. Ms. Shebester reported that Resident A has not expressed any concerns to her that the direct care staff are directing profanity at the residents.

On 5/21/24 I interviewed Ms. Williams, via telephone. Ms. Williams reported that on at least two separate occasions she has observed Ms. Barlow yell, “shut the fuck up!” and direct this statement toward Resident C. She reported that she does not have memory of the exact date of these occurrences. Ms. Williams reported that she addressed this with Ms. Barlow when the incidents occurred and noted to Ms. Barlow that this is not appropriate behavior.

On 5/21/24 I interviewed Guardian C1, via telephone. Guardian C1 reported that within the last two weeks (date unknown) there was an incident when she was talking on the facility telephone to Resident C and she overheard a female in the background shouting, “You don’t fucking talk to me that way!” Guardian C1 reported that she took her concerns about what she overheard to Ms. Lovell. Guardian C1

reported that Ms. Lovell stated that she had discussed the alleged incident with the direct care staff (name not identified) and the direct care staff had indicated Resident B made these statements. Guardian C1 reported that she makes frequent visits to the facility to visit Resident C and she is aware of Resident B's personality and behaviors. Guardian C1 reported that she does not believe Resident B has this language in her vocabulary and has never observed Resident B speak in this manner. Guardian C1 reported that she made this statement to Ms. Lovell, who agreed that she did not think Resident B would make this statement. Guardian C1 reported that she also reported this concern to Ms. Powell and Ms. McKeown, but she was not made aware whether any disciplinary action resulted from her complaint.

On 5/21/24 I interviewed Ms. McKeown via telephone. Ms. McKeown denied having any knowledge of the allegation. She reported that Guardian C1 did not express concerns to her that a direct care staff member had directed profanity toward the residents.

On 5/22/24 I interviewed Ms. Giavanelli, via telephone, regarding the allegation. Ms. Giaveanelli reported that Guardian C1 had expressed to her that on an unknown date she was on the telephone with Resident C and overheard a female in the facility swearing at the residents. Ms. Giavanelli reported that she has no further knowledge of this incident. She reported that she has not observed any direct care staff directing profanity toward the residents. Ms. Giavenelli reported that if a direct care staff member were directing profanity toward Resident C that he would not be able to report this as he is not capable of this level of verbal communication.

On 6/14/24 I conducted a follow-up on-site investigation at the facility. I interviewed Resident A during this investigation. Resident A reported, "I don't feel safe when she works here", referring to Ms. Barlow. Resident A reported that Ms. Barlow "cusses" at the residents and threatens the residents. Resident A reported that Ms. Barlow has told him that she will "have her people come and beat him up." Resident A reported that Ms. Barlow does not physically harm him, but he has observed Ms. Barlow grab Resident B tightly by the arm when she wants to redirect her. When asked if Resident A could provide examples of the profanity Ms. Barlow uses toward the residents, Resident A declined to do so and stated he does not feel comfortable speaking in that manner.

On 6/17/24 I interviewed Ms. Morton, via telephone. Ms. Morton reported that she is not aware of Ms. Barlow directing profanity toward any of the residents. She reported that she has not received any complaints regarding these allegations.

On 6/17/24 and 6/25/24, attempts were made to interview Ms. Barlow, via telephone. Voicemail messages were left, and she has not yet returned these calls.

On 6/27/24 I conducted an exit conference with Ms. Lovell and Ms. McKeown. Ms. Lovell reported that Guardian C1 did share with her that she did overhear someone

yelling obscenities while she was on the telephone with Resident C. Ms. Lovell reported that it could not be determined at the time that the obscenities were being yelled by a direct care staff or a resident. Ms. Lovell reported that she was unaware of this type of behavior from any of her direct care staff members.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon interviews with the Complainant, Ms. Powell, Ms. McCoy, Ms. Owens, Ms. Williams, Ms. Giavanelli, Ms. Shebester, Ms. McKeown, Ms. Morton, Guardian C1, and Resident A it can be determined that Ms. Barlow has not been treating residents with dignity and respect, by directing profanity at the residents, which was reported and observed by Ms. Williams and Resident A. Even though, others interviewed reported no direct knowledge of Ms. Barlow using profanity toward the residents, Resident A reported that he did not feel safe around Ms. Barlow regarding how she spoke to the residents at the facility. Ms. Williams reported observing Ms. Barlow treating residents in a disrespectful manner on at least two occasions by using profanity toward the residents, Guardian C1 reported overhearing profanity being used toward the residents while she was on the telephone with Resident C, and Ms. Owens reported that Resident A has made claims of Ms. Barlow using profanity toward the residents to direct care staff members. Even though it cannot be determined who yelled the obscenities in the background while Guardian C1 was on the telephone with Resident C there is a preponderance of evidence to determine that Ms. Barlow has been directing profanity toward residents and therefore not treating the residents with dignity and respect. Based upon this information a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the on-site investigation on 5/20/24 I conducted a test of the interconnected smoke detection system as this system was cited on the 1/29/24 renewal inspection report as not being functional. I tested the effectiveness and functionality of the interconnected smoke detection system from the main level smoke detector located between the dining room and the living room and the second-floor smoke detector located directly outside the first bedroom at the top of the stairs. I observed that when the smoke detector was placed in testing mode using the main level smoke detector that the interconnected system was still not operating as designed. Only the main level smoke detector alarmed at this time. The second-floor smoke detectors did not alarm in unison when the main floor smoke detector was placed in testing mode. When I tested the system from the second floor the second-floor smoke detector did connect with the main floor smoke detector and worked in unison as an interconnected unit. Having noted this, if a fire were to start on the main floor of the home the system would not function correctly to alarm on the second floor and alert those residents to the danger of a fire.

On 1/29/24, renewal inspection, AS330297845_RNWL_20240129, cited a rule violation of Rule R330.1803(1), requiring that a facility with capacity of 4 to 6 clients shall be equipped with an interconnected multi-station smoke detection system which is powered by the household electrical service and which, when activated, initiates an alarm that is audible in all areas of the home. The corrective action plan (CAP), dated 2/14/24, and signed by Ms. Lovell, identified that a new fire system was installed on 2/12/24 and that this system will be monitored by the Program Manager, Jessica Cortez, through quarterly fire drills as well as annual fire system inspections. To ensure compliance with this CAP I completed follow up on-site inspections on the dates, 3/19/24, 4/10/24, 5/20/24, & 6/14/24. On each of these occurrences the interconnected smoke detection system was not functional. The direct care staff present did not have any updates to provide about the functionality of the system or when it would be remedied. I held email correspondence with Ms. Lovell on the following dates, regarding the interconnected smoke detection system not working properly, 1/29/24, 3/20/24, 4/4/24 (Ms. McKeown also received this email), 5/21/24. There has been no change to the functional status of the interconnected smoke detection system from 1/29/24 to 6/14/24.

APPLICABLE RULE	
R 330.1803	**Facility environment; fire safety.**
	(1) A facility that has a capacity of 4 to 6 clients shall be equipped with an interconnected multistation smoke detection system which is powered by the household

	electrical service and which, when activated, initiates an alarm that is audible in all areas of the home. The smoke detection system shall be installed on all levels, including basements, common activity areas, and outside each sleeping area, but excluding crawl spaces and unfinished attics, so as to provide full coverage of the home. The system shall include a battery backup to assure that the system is operable if there is an electrical power failure and accommodate the sensory impairments of clients living in the facility, if needed. A fire safety system shall be installed in accordance with the manufacturer's instructions by a licensed electrical contractor and inspected annually. A record of the inspections shall be maintained at the facility.
ANALYSIS:	Based upon information collected from on-site inspections at the facility on 1/29/24, 3/19/24, 4/10/24, 5/20/24, & 6/14/24, it can be determined that the licensee designee, Hope Lovell, has not taken the necessary measures to ensure that the interconnected smoke detection system functions as an interconnected unit. Therefore, a repeat violation has been established at this time.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE AS330297845_RNWL_20240129 AND CAP DATED 2/12/24]**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

6/27/24

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Jana Lipps Date
Licensing Consultant

Approved By:

06/28/2024

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Dawn N. Timm Date
Area Manager