GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2024

Charles Baroi
3979 140th Ave.
Holland, MI 49424

RE: License #: AS700417921
Investigation #: 2024A0579027
Mayabe Care

Dear Mr. Baroi:

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 (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700417921
Investigation #:	2024A0579027
Complaint Receipt Date:	06/11/2024
Investigation Initiation Date:	06/12/2024
Report Due Date:	08/10/2024
Licensee Name:	Charles Baroi
Licensee Address:	3979 140th Ave. Holland, MI 49424
Licensee Telephone #:	(616) 377-8187
Administrator:	Charles Baroi
Licensee Designee:	Charles Baroi
Name of Facility:	Mayabe Care
Facility Address:	3993 140th Ave Holland, MI 49424
Facility Telephone #:	(616) 377-9414
Original Issuance Date:	12/12/2023
License Status:	REGULAR
Effective Date:	06/12/2024
Expiration Date:	06/11/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents are given expired or moldy food.	Yes
There are no thermometers in the refrigerator or freezer.	No
The smoke detectors in the home do not work.	No
The fire extinguishers in the home are expired.	No
Fire drills are not done correctly.	No
Resident medication is not kept in appropriate packaging.	Yes
Residents are not given opportunities for independence.	No
Staff are not suitable to care for residents.	Yes
The licensee is not suitable to meet the needs of residents.	No
Residents are not given privacy.	No
Residents urinate in bottles.	No
Charles Baroi harasses Resident C for extra payment each month.	Yes
Resident D is sleeping in the dining room of the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/11/2024	Special Investigation Intake 2024A0579027
06/12/2024	Special Investigation Initiated - Letter Complainant 1
06/13/2024	Contact- Face to Face Resident A, Resident B, Resident C, James Baroi (Direct Care Worker), Maya Baroi (Direct Care Worker), Charles Baroi (Licensee), and Ian Tschirhart (Licensing Consultant)
06/14/2024	Contact- Document Received Charles Baroi, Licensee
07/01/2024	Contact- Document Received Complainant 1
07/02/2024	Contact- Telephone call Received Complainant 2
07/02/2024	Contact- Document Sent Complainant 3
07/03/2024	Contact- Face to Face

	Resident B, Resident C, Resident D, and James Baroi (Direct Care Worker)
07/03/2024	Contact- Telephone Call Received Juliet Troast, Administrator
07/16/2024	Contact- Telephone Call Made Charles Baroi, Licensee Designee Jame Baroi, Direct Care Worker
07/16/2024	Contact- Telephone Call Made Juliet Troast, Administrator
07/19/2024	APS Referral
07/19/2024	Contact- Telephone Call Made Charles Baroi, Licensee Designee
07/23/2024	Exit Conference Charles Baroi, Licensee Designee Juliet Troast, Adminstrator

ALLEGATION: Residents are given expired or moldy food.

INVESTIGATION: On 6/11/24, I received this referral which alleged residents are given food that is expired and moldy and isn't cooked all the way through. It was reported several bags of expired food were thrown away on 6/10/24.

On 6/13/24, I completed an unannounced on-site investigation with the assistance of Licensing Consultant, Ian Tschirhart due to Mr. Tschirhart being the former consultant for the home and this being my first time going to this home. Mr. Tschirhart interviewed Mr. James Baroi and Mr. Charles Baroi. I interviewed Resident A, Resident B, and Resident C.

Resident A stated he is extremely fearful of James and Charles Baroi. He stated they have threatened him, and the other residents, that they will evict them if they make complaints to licensing or anyone else. He stated Resident B was given a 30-day discharge notice because Resident B's relative said she would be reporting the home, so he knows they are serious with these threats. He stated he cannot move from this home because he has a private room that has room for his recliner and his girlfriend lives near this home. He stated he does not want to answer my questions, but he has significant concerns about this home that he cannot report to me. I inquired if he felt comfortable hearing the allegations that were already reported to me and letting me know if he agreed or disagreed with them. He agreed. I inquired about the food being expired or moldy. Resident A nodded yes and said, "I don't want

to talk about this" because he gave Charles and James Baroi his word that he would not report any concerns in the home, but he also could not lie to me.

Resident B and Resident C requested to speak to me together. Resident B stated he was given a 30-day discharge notice on 6/10/24 after his relative stated she would be reporting the home so although Charles and James Baroi threatened him and the other residents with discharge if they discuss what occurs in the home, he does not care and will tell me the truth. Resident C initially requested Resident B speak for him due to fear of 30-day discharge notice should he speak to me, but as I spoke to Resident B, Resident C he appeared to become more comfortable speaking to me and began answering questions for himself.

Resident B said the food in the home is "a mess." He stated Charles Baroi gets food from a food bank called Community Action and at times the bread is moldy, or the canned goods are expired. He reported two weeks ago he was given potato chips with an expiration date of 2009. He stated he recently had "food poisoning" from a meal that James Baroi prepared for them. He denied that he needed medical treatment and reported he felt better within a day. He stated after a relative stated she would be reporting the home, James and Charles Baroi made everyone go through all the food in the home and throw away expired items so he is confident no expired food will be found in the home today.

Resident C stated residents are served moldy and outdated food. He confirmed that on one occasion Resident B became very ill after eating food prepared by Mr. James Baroi. He denied Resident B needed medical treatment and reported Resident B "got better at home." He stated after Resident B's relative said she would be reporting the home, James and Charles Baroi had them throw away 12 bags of expired food so he does not think any expired food will be found in the home today.

Mr. Tschirhart interviewed Charles Baroi who initially denied serving expired or moldy food to residents. After I privately discussed the use of Community Action services with Mr. Tschirhart, he returned to speaking to Charles Baroi who then acknowledged he does get food from Community Action, some of which has been expired, and he has served the food to residents even though it is expired.

Mr. Tschirhart observed the food in the refrigerator, such as eggs, bread, and applesauce, and none was past its expiration date.

On 7/3/24, I completed a follow-up unannounced on-site investigation. While at the home I Interviewed Resident B, Resident C, Resident D, and James Baroi.

James Baroi reported Charles Baroi has ensured that there is no expired food in the home. He stated if there is expired food in the home, it is the food Resident A brings into the home and keeps in his own room. He stated Charles Baroi purchases all the food from Walmart, and it is not expired or moldy. He stated he prepares the meals

and ensures they are cooked correctly, and residents eat the food because it is food they like.

Resident B and Resident C reported Resident B has gotten sick from the food in the home since I last spoke to them but felt better within hours. They stated they continue to be served expired lunch meat and food that is not properly cooked.

I observed the refrigerator and freezer upstairs and in the basement, as well as canned and dried goods. I did not observe any outdated canned or dried goods, however, I found a carton of eggs in the refrigerator with an expiration date of 6/8/24.

On 7/19/24, I forwarded the allegations to Adult Protective Services.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	Resident B and Resident C reported being served moldy or expired food and reported Resident B has gotten sick after eating food prepared in the home. Resident A reported he did not want to discuss allegations but nodded yes when asked about there being moldy or expired food served to residents. Charles Baroi initially denied the allegations but subsequently acknowledged he has received and served expired food to residents. Eggs, nearly a month past their expiration date, were found in the home on 7/3/24. No additional expired food was found in the home. Although it was reported by Resident B and Resident C that when threatened to be reported, Charles Baroi and James Baroi threw all the expired food away which was why no expired food was found in the home on 6/13/24. Based on the interviews completed and observations made, there is sufficient evidence that the food in the home is not safe for human consumption or free from spoilage.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There are no thermometers in the refrigerator or freezer.

INVESTIGATION: On 6/11/24, I received this referral which alleged there are no thermometers in the refrigerator and freezer.

On 6/13/24, Mr. Tschirhart observed the refrigerators and freezers in the home and found thermometers in each necessary compartment. The refrigerator and freezer were found to be appropriate temperatures.

Resident A, Resident B, and Resident C denied concerns regarding the temperature of the refrigerators or freezers in the home.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(3) All perishable food shall be stored at temperatures that will protect against spoilage. All potentially hazardous food shall be kept at safe temperatures. This means that all cold foods are to be kept cold, 40 degrees Fahrenheit or below, and that all hot foods are to be kept hot, 140 degrees Fahrenheit or above, except during periods that are necessary for preparation and service. Refrigerators and freezers shall be equipped with approved thermometers.
ANALYSIS:	Mr. Tschirhart observed thermometers in the refrigerators and freezers in the home and found them to be an appropriate temperature. Resident A, Resident B, and Resident C denied concerns regarding the temperature of the refrigerators or freezers. Based on the interviews completed and observations made, there is insufficient evidence that cold foods are not kept cold and that refrigerators and freezers are not equipped with approved thermometers.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The smoke detectors in the home do not work.

INVESTIGATION: On 6/11/24, I received this referral which alleged Relative B1 checked each smoke detector and found that none of them worked.

On 6/13/24, Charles Baroi reported he tests the smoke detectors in the home, and they are working. Mr. Tschirhart tested the smoke detectors in the home and found them functional.

Resident A said he has heard the smoke detectors before, and they work. Resident B said he and Relative B1 tested the smoke detectors in the home and only one of them works.

APPLICABLE RULE	
R 400.14505	**Smoke detection equipment; location; battery replacement; testing, examination, and maintenance; spacing of detectors mounted on ceilings and walls; installation requirements for new construction, conversions, and changes of category.**
	(4) Detectors shall be tested, examined, and maintained as recommended by the manufacturer.
ANALYSIS:	Mr. Tschirhart observed the smoke detectors in the home and found them to be functional. Resident A said he has heard the smoke detector. Resident B reported one smoke detector in the home works. Mr. Baroi reported he tests the smoke detectors, and they work. Based on the interviews completed and observations made there is insufficient evidence that the smoke detectors in the home are not tested or maintained as recommended.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The fire extinguishers in the home are expired.

INVESTIGATION: On 6/11/24, I received this referral which alleged Relative B1 found one fire extinguisher that has not been checked since 2001 and two more fire extinguishers were found in a box and did not have proof of ever being checked. A photo was provided of a fire extinguisher tag that was punched as being serviced in August 2001.

On 6/13/24, Charles Baroi reported there are two fire extinguishers in the home, and they are charged appropriately.

Mr. Tschirhart observed both fire extinguishers and found them appropriately charged.

Resident A denied concern or knowledge regarding the fire extinguishers in the

home. Resident B said he and Relative B1 found that the fire extinguishers in the home had not been serviced since 2002 and took pictures of them as proof.

APPLICABLE RULE	
R 400.14506	**Fire extinguishers; location examination, and maintenance.**
	(2) Fire extinguishers shall be examined and maintained as recommended by the manufacturer.
ANALYSIS:	Mr. Tschirhart observed the fire extinguishers in the home and found them appropriately charged. Mr. Baroi reported there are two fire extinguishers, and they are appropriately charged. Based on the interviews completed and observations made there is insufficient evidence that the fire extinguishers were not maintained appropriately charged as recommended by the manufacturer.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Fire drills are not done correctly.

INVESTIGATION: On 6/11/24, I received this referral which alleged fire drills have never been done.

On 6/13/24, Mr. Tschirhart observed the fire drill records in the home. He found one drill per month was documented as being completed since the home became licensed.

Resident A stated he has participated in fire drills in this home.

Resident B and Resident C stated they have never participated in a fire drill in this home.

On 7/19/24, I completed a telephone interview with Charles Baroi who reported he and James Baroi both do fire drills, and they are done each month. He reported the last fire drill was done last week. He reported James Baroi was not available as he was meeting with Life Circles.

APPLICABLE RULE	
R 330.1803	**Facility environment; fire safety.**
	(3) A facility that has a capacity of 4 or more clients shall conduct and document fire drills at least once during

	daytime, evening, and sleeping hours during every 3-month period.
ANALYSIS:	Mr. Tschirhart observed the fire drill record indicating one fire drill has been completed monthly since the home was licensed. Resident A stated he has completed fire drills in the home. Resident B and C stated they have never completed fire drills in the home. Charles Baroi reported he and James Baroi both do fire drills, they are done monthly, and the most recent fire drill was done the week prior to 7/19/24. Based on the observation made there is insufficient evidence that fire drills were not completed or documented correctly.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident medication is not kept in appropriate packaging.

INVESTIGATION: On 6/11/24, I received this referral which alleged residents are given their medication in plastic wrap and there is no appropriate system to ensure residents receive their medication when they are on leave of absence.

On 6/13/24, I observed Resident A's medication in a weekly pill dispenser. I observed two tied unlabeled sandwich bags with pills on a rolling side table in Resident A and Resident B's room.

Resident A stated Mr. Tschirhart investigated allegations that he keeps his medication in his room. He stated following that investigation, he got permission from his physician to manage his own medications. He stated he prefers to keep them in the weekly pill container, and he does not have a roommate so no one else has access to his medication.

Mr. Tschirhart confirmed he received proof that Resident A's physician authorized him managing his own medication.

Resident B and Resident C stated Charles Baroi is responsible for managing their medication. They both stated at the beginning of the day, Mr. Baroi gives them tied, unlabeled sandwich bags of pills and they know to take them at the correct times throughout the day. They stated all their daily pills, including morning, noon, and evening, are in bags given to them in the morning by Mr. Baroi.

James Baroi told Mr. Tschirhart that he puts Resident B's medication in an empty

prescription bottle when he goes on leave of absence. He stated Resident C's medication is put in an unlabeled sandwich bag, without the written instructions of what the medication is and when and how it should be taken, for Resident C to take should he choose to go on leave of absence.

On 7/3/24, I observed resident pill packs from the pharmacy under the television in the upstairs dining room of the home. They were out in the open and not locked. Resident D was present in the dining room at this time. I again observed tied, unlabeled sandwich bags of pills in the room of Resident B and Resident C.

On 7/16/24, I completed a telephone interview with Charles Baroi who reported he is responsible for managing Resident B and C's medication. He stated he gives them their daily medication in an unlabeled sandwich bag for them to take throughout the day. I inquired why he did this. He explained he gives them their medications all at once because they take it multiple times throughout the day and then they can take them independently throughout the day. He acknowledged Resident A is the only resident who has a physician's order to manage his own medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	I observed unlabeled, tied sandwich bags of medication in the room of Resident B and C on two occasions. I observed pharmacy supplied pill packs out in the open, under the television in the home. Resident B and Resident C reported Mr. Baroi gives them all their daily medication in the morning in unlabeled sandwich bags. James Baroi acknowledged that he puts Resident C's medication in unlabeled sandwich bags.

	Charles Baroi acknowledged putting residents' daily medications in unlabeled sandwich bags for them to take throughout the day. Based on the interviews and observations made, there is sufficient evidence that medications are not kept in original pharmacy supplied containers and in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not given opportunities for independence.

INVESTIGATION: On 6/11/24, I received this referral which alleged residents aren't allowed to help with chores such as doing their own laundry or cooking their own meals. They feel like their independence is being taken away.

On 6/13/24, Resident A, Resident B, and Resident C denied concerns about the chores they complete in the home. Resident B and Resident C said they make their own beds and maintain the cleanliness of their room with the help of James Baroi, although they would prefer if Mr. Baroi did not assist them.

Charles Baroi reported to Mr. Tschirhart that James Baroi and Ms. Maya Baroi do the laundry, dishes, and other house cleaning, and that if James Baroi sees any of the residents doing chores, he tells them not to. James Baroi confirmed what Charles Baroi reported to Mr. Tschirhart.

On 06/13/2024, Mr. Tschirhart sent an email to Charles Baroi requesting the assessment plan for each resident.

On 6/14/24, Mr. Tschirhart received the Assessment Plan for AFC Residents form for each resident. For Resident A, it noted he does not complete household chores. For Resident B and Resident C, it noted they complete household chores, but their assessments did not include any additional details.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(5) A licensee shall provide both of the following when specified in the resident's written assessment plan: **(a) Direction and opportunity for the growth and development of a resident as achieved through activities that foster independent and age-appropriate functioning, such as dressing, grooming, manners, shopping, cooking, money management, and the use of public transportation.**

ANALYSIS:	Resident A, Resident B and Resident C denied concern regarding the chores they complete in the home. Resident B and Resident C reported they wished James Baroi did not assist with cleaning their room. Charles Baroi and James Baroi reported James Baroi tells residents not to do chores in the home. Resident A's assessment plan noted he does not do chores. Resident B and Resident C's assessment plans noted they do chores but did not specify which chores as required on the form. Based on the interviews completed and documentation reviewed, there is insufficient evidence that residents are not given opportunities that foster independence as specified in their written assessment plans.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff are not suitable to care for residents.

INVESTIGATION: On 6/11/24, I received this referral which alleged on 6/10/24 James Baroi hit his wife, Maya Baroi, and was yelling at her in front of residents. Resident B called Relative B1 who immediately came to the home. It was alleged that James Baroi also goes through resident rooms and "stuff comes up missing." James Baroi reportedly told Relative B1 to "sit down woman and shut up."

On 6/13/24, James Baroi told Mr. Tschirhart he did not get into an argument with Ms. Baroi or hit her. Charles Baroi also told Mr. Tschirhart James Baroi did not get into an argument with Ms. Baroi and hit her. He stated James Baroi was confronting Resident B about smoking marijuana in his room when Ms. Baroi attempted to get involved in the conversation. James Baroi told Ms. Baroi to leave because he was busy talking to Resident B. He stated at that time James Baroi grabbed Ms. Baroi by her arm, pulled her away, and told her to leave. James Baroi denied threatening residents with discharge should they report any concerns in the home.

Resident A stated that my asking him about these allegations "put (him) in a tough spot." He nodded yes; they were true. I asked if he could provide any further information. He said Resident B witnessed the incident directly, but he heard it in his room. He stated James Baroi and Ms. Baroi got into what sounded like a violent argument. He stated he did not witness anyone hit each other but Resident B said they did and from what he heard, he believes Resident B. He stated James Baroi has threatened that if he reports his concerns regarding this home to anyone, he will be discharged from the home, so he cannot say more. Resident A denied that James Baroi takes things from his room or that he has concern for his personal belongings

“coming up missing.” He denied that James Baroi is rude or speaks inappropriately to his visitors.

Resident B said he witnessed James Baroi slap Ms. Baroi in her face and Ms. Baroi then slapped James Baroi back. He became upset telling me this stating, “I should have called the police. I can’t stand men who hit women. I wish I would have called the police.” He reported James Baroi also goes through his and Resident C’s belongings and “countless things have gone missing.” He could not provide specific examples. He stated James Baroi often comes into his room screaming and has nearly gotten physically aggressive with all the residents on multiple occasions. He stated on one occasion James Baroi forcefully grabbed and pulled on his toe to wake him up. He stated James Baroi is a “pathological liar” and “out of control” at times with all residents in the home. He stated James Baroi has told him, “Don’t talk to anybody” about what occurs in the home, or he will be discharged from the home. He denied knowledge of James Baroi being rude or speaking inappropriately to visitors.

Resident C stated James Baroi often comes into his room screaming and agitated. He stated James Baroi aggressively goes through Resident C’s belongings when he is upset. He stated he has witnessed James Baroi scream at Resident A and Resident B. He stated he has been told by James Baroi, “don’t tell anyone nothing” or he will receive a 30-day discharge notice. Resident C was initially hesitant to speak to me and requested Resident B speak for him as Resident B had already received a 30-day discharge notice. He stated James Baroi takes things from his room when he goes through his room. He could not give specific examples of what James Baroi takes but reported recently Ms. Baroi took Resident A’s ice cream, approximately $75 worth, out of the downstairs freezer for her, James Baroi, and Charles Baroi to eat. He reported James Baroi is rude to his visitors.

Resident A was asked about his ice cream being taken by Ms. Baroi. He stated she did take his ice cream, but he was not upset by this. He stated it was only maybe $15 worth of ice cream and he thinks she did not know it was his and must have assumed it was theirs, so she took it. He denied addressing this with anyone or that he wanted me to address it with anyone.

On 6/13/24, I was informed by Mr. Tschirhart that Ms. Baroi was next-door working at another licensed AFC home. I agreed to interview her.

I briefly spoke with Ms. Baroi about the home she was at before inquiring about the alleged incident of violence between her and Mr. Baroi. Ms. Baroi was able to answer those questions confidently and calmly. Ms. Baroi’s body language and voice immediately changed when asked about this incident. She paused for some time, looked away, and stammered before saying, “No.” I reverted to discussing other things before inquiring again about the alleged incident. Ms. Baroi’s body language and speech again changed, with her pausing and stammering before saying, “No.” I inquired why residents would make these allegations if an incident did not occur. Ms. Baroi reported the residents are making the allegations because Resident B and C

use marijuana in the home. She stated Charles and James Baroi do not want marijuana in the home and told residents this, but they made false allegations because they use marijuana.

After interviewing Ms. Baroi, I went to leave the home and James Baroi followed me to my vehicle. He denied any allegations against him. He presented me a marijuana cigarette and reported that is why residents say things that are untrue about him and Ms. Baroi, and that the marijuana cigarette was taken from Resident B. He discussed that Resident B was using marijuana in the home which is what led to these allegations.

On 7/1/24, Complainant 1 reported James Baroi gave Resident C's fishing poles to Resident C's friend without telling Resident C. Resident C became upset thinking his fishing poles were stolen. James Baroi and Ms. Baroi reportedly "blew up" and "got in his face screaming and pointing their fingers" at Resident C. James Baroi and Ms. Baroi began screaming at Resident B and Resident C that they are "evil", "bad", and "trouble." James Baroi would not leave Resident C's room and told Resident C he needs to leave the home within 24 hours. Complainant 1 expressed concern that James Baroi was attempting to agitate Resident C and escalate his behaviors to violence, but Resident C did not engage to that extent.

On 7/3/24, Resident C said there was an incident "the other day" when he thought James Baroi took his fishing poles. He stated James Baroi had agreed that it was okay for Resident C's friend to take the fishing poles but did not tell Resident C. He stated he became upset when he could not find his fishing poles and began yelling at James Baroi. Ms. Baroi got involved and Ms. Baroi and Mr. Baroi began screaming at both Resident C and Resident B and calling them names. He reported James Baroi told him he needed to leave the home within 24 hours. He stated James Baroi would not leave his room and was trying to make Resident C get aggressive but Resident C did not. He stated it has been more than 24-hours, he has not left the home, and his discharge has not been discussed again. He stated he has since had his fishing poles returned to him.

Resident B confirmed there was an incident regarding Resident C's fishing poles when James Baroi and Ms. Baroi screamed at them both and were calling them names and telling them they needed to leave the home immediately. He stated James Baroi has since apologized to him.

James Baroi spoke to me and had his daughter, Juliet Troast, on the phone. James Baroi said Resident C became upset because he thought James Baroi took Resident C's fishing poles. James Baroi said Resident C became upset, but he and Ms. Baroi did not yell at Resident C. He stated after the argument, he called Resident C's friend because he had seen this friend at the home and had this friend's contact information. He stated this friend reported he had taken the fishing poles and agreed to return them. Mr. Baroi denied giving Resident C's friend permission to take the fishing poles and reported he was only able to get them returned because he

guessed who had them and happened to have his phone number. Ms. Troast confirmed that what James Baroi reported was her understanding of the incident.

James Baroi and Ms. Troast reported Resident B will be discharged from the home on 7/10/24 and Resident C has not been given a discharge notice. James Baroi denied telling them they needed to leave immediately. I discussed the process for an appropriate discharge with James Baroi and Ms. Troast. She stated Charles Baroi and James Baroi understand they cannot threaten or put a resident on the street, in the hospital, or in a homeless shelter, and they need to follow the appropriate discharge process, and agreed they would not threaten or act on inappropriately discharging a resident.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Resident A reported he heard what sounded like a violent altercation between Ms. Baroi and James Baroi. Resident B reported he witnessed James Baroi slap Ms. Baroi and Ms. Baroi then slap James Baroi. Charles Baroi reported James Baroi grabbed and pulled Ms. Baroi away while he was speaking to Resident B. Ms. Baroi presented with changed body language and speech when asked about a physical altercation with James Baroi as opposed to when discussing other matters. Resident A, Resident B, and Resident C all reported they were told not to discuss what occurs in the home or they would be given 30-day discharge notices. Resident C initially stated he wanted Resident B to speak for him so he would not be discharged from the home. Resident B and Resident C reported James Baroi screams at residents, calls them names, aggressively goes through their belongings, and is often agitated. Resident B reported James Baroi has aggressively grabbed and pulled on his toe to wake him up. Relative B1 reported James Baroi has told her to “sit

	down woman and shut up." Mr. Baroi became slightly verbally aggressive with me when he believed I was not listening to him. Based on the interviews completed and observations made, there is sufficient evidence that James Baroi is not suitable to assure the welfare of residents based on his demeanor and behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The licensee is not suitable to meet the needs of residents.

INVESTIGATION: On 6/11/24, I reviewed the referral which alleged "something happened" with Resident B's bank when James Baroi and Charles Baroi took him to do some banking the first week he lived at the home. It disturbed the bankers enough for them to call law enforcement and Adult Protective Services (APS).

On 6/11/24, I reviewed the case file and did not find any prior investigations regarding Resident B's funds. I did not see any referrals from law enforcement or APS.

On 6/13/24, Resident B denied any concerns regarding his funds, or any incident involving his bank. He denied APS or law enforcement had interviewed him regarding his bank, bank account, or funds.

On 7/2/24, I received a second referral for investigation. The referral alleged Charles Baroi recently presented Resident C with a blank sheet of paper and requested that he sign it. Resident C was confused and contacted his guardian and his caseworker who both told him to never sign a blank sheet of paper. Complainant 2 was made aware that this also occurred one other time. Complainant 2 expressed concern that something fraudulent was occurring and that Resident C was being "threatened and verbally harassed" to sign this document.

On 7/2/24, Complainant 3 reported she was made aware that on multiple occasions Resident C has been asked to sign his name on a blank piece of paper. She stated, thankfully, Resident C requested to ask his guardian and caseworker and did not sign any blank sheets of paper. She stated she was not able to address this with Charles Baroi yet, but she has concern that he may be attempting something fraudulent with Resident C's signature. She stated Resident C has a guardian and cannot sign for himself so Charles Baroi will not be successful if attempting something fraudulent, but she has concerns there might be other residents in the home who do not have guardians especially since she has heard that Charles Baroi has moved an elderly resident into the home.

On 7/3/24, Resident C said on two occasions Charles Baroi has brought him a blank piece of paper and requested he sign his name. He stated he has a guardian so he has called her and his caseworker to ask what to do since he cannot sign for himself. He stated he feels like Charles Baroi is attempting to do something wrong using his signature.

On 7/3/24, Charles Baroi was not present. James Baroi and Ms. Troast denied the allegation that Charles Baroi requested Resident C or any resident sign a blank sheet of paper.

On 7/16/24, Charles Baroi said he and James Baroi did bring Resident B to the bank the first week Resident B was at the home to assist him with getting his monthly AFC payment. He said the bank was concerned because Resident B did not have any identification and would not allow him to withdraw any money. He said since then, Resident B has identification and makes his monthly AFC payments via checks. He does not have to go to the bank, and Charles and Mr. James Baroi are not involved in his banking.

Charles Baroi said he has only attempted to have Resident C sign his Resident Care Agreement. He denied ever giving a blank document to Resident C to sign and said it was his Resident Care Agreement that still needed Resident C's signature, so he asked Resident C to sign it.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	Resident B denied concern regarding Charles Baroi doing anything inappropriate at the bank with him regarding his funds. No referrals were received from APS or law enforcement regarding Resident B or his funds. Charles Baroi reported Resident B's bank became concerned when he and James Baroi brought Resident B to the bank and Resident B attempted to withdraw his AFC payment but did not have identification.

	Charles Baroi reported he has attempted to get Resident B's signature on his Resident Care Agreement but denied attempting to have him sign blank documents. Ms. Troast and James Baroi denied these allegations as well. Based on the interviews completed, there is insufficient evidence that Charles Baroi is not suitable to meet the needs of residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are not given privacy.

INVESTIGATION: On 6/11/24, I reviewed the referral which alleged James Baroi needed a prescription from Resident B's physician and he requested it worded a certain way. James Baroi handed Relative B1 one of Resident A's prescriptions that had all his information on it and said, "It must look like this."

On 6/13/24, Resident A, Resident B, and Resident C denied concern regarding their privacy in the home or any of their documentation being shared inappropriately. Resident A denied concern regarding his prescription ever being shared with anyone else in the home or their relatives.

On 7/1/24, Complainant 1 stated Ms. Troast discussed Resident C's behaviors and discharge from the home with Relative B2.

On 7/16/24, I completed a telephone interview with James Baroi who denied showing Relative B1 Resident A's prescription. He stated Resident A manages his own medication and goes to physician's appointments independently so Resident A may have shown Relative B1 his prescription, but James Baroi did not.

On 7/16/24, I completed a telephone interview with Ms. Troast. She stated she has discussed with Relative B1 and Relative B2 that she has concerns that Resident B's behaviors for drinking alcohol and using marijuana began when Resident C moved into the home. She stated she expressed concern to Relative B1, who reported Resident B and Resident C would be leaving this home to go to an independent apartment together, that she did not feel it was a good idea because Resident B started having behaviors when Resident C moved into the home. She reported she did not say Resident C's name or any behaviors specific to Resident C when communicating with Relative B1 and Relative B2.

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:	Resident A, Resident B, and Resident C denied concerns regarding their privacy in this home. James Baroi denied showing Relative B1 Resident A's prescription. Ms. Troast denied discussing Resident C's private information with Relative B1 or Relative B2. She stated she only expressed concern that Resident B's behaviors started when Resident C moved into the home and that it was not a good idea for them to live together when it was reported they'd be moving out of this home to an independent apartment. Based on the interviews completed, there is insufficient evidence that residents are not treated with consideration and respect regarding their need for privacy.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents urinate in bottles.

INVESTIGATION: On 6/11/24, I reviewed the referral which alleged a resident in the home has "stomach problems" and can take an hour in the bathroom at one time. There are two bathrooms in the home, but residents are not allowed to use the second. As a result, residents urinate in bottles every morning.

On 6/13/24, Resident A stated residents can use both bathrooms in the home. He denied concern regarding not having access to the bathroom or anyone taking an unreasonably long time in the bathroom.

Resident B and Resident C stated they are told they cannot use the upstairs bathroom. They stated Resident A takes an unreasonably long time to use the bathroom in the morning and they are not allowed to use the second bathroom so they urinate in bottles and pour them out when the bathroom is free. They stated on occasion, Charles Baroi will “sneak” them upstairs to use the bathroom but typically, in the morning they urinate in bottles.
While at the home on 6/13/2024 I did not see bottles of urine or smell an odor of urine in their room.

On 7/3/24, Resident B and Resident C stated they are no longer allowed to use the upstairs bathroom at all, even if they ask to. As a result, they are regularly urinating in bottles in the morning because Resident A takes so long in the bathroom.

While at the home on 7/3/2024 I did not see bottles of urine or smell an odor of urine in their room.

James Baroi stated he does not like the male residents using the upstairs bathroom now that there is a female resident living upstairs. However, if they need to use the bathroom because the downstairs bathroom is occupied, they could ask, and he would allow them to.

On 7/16/24, Charles Baroi reported he does not encourage the male residents to use the upstairs bathroom now that a female resident resides upstairs. He has told them if it is an emergency, and their bathroom is occupied, they may use the bathroom upstairs. He denied knowledge of residents urinating in bottles.

On 7/16/24, Ms. Troast reported the male residents are allowed to use the upstairs bathroom if theirs is occupied, but they would prefer they use the downstairs restroom since there is a female resident using the upstairs restroom now. She denied any knowledge of residents urinating in bottles.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Resident A denied having any concerns related to bathroom access in the home. Resident B and Resident C reported Resident A takes excessive time in the bathroom in the morning, so they urinate in bottles since they are not allowed to use the second restroom. James Baroi reported the upstairs bathroom is used by the female resident in the home but if residents ask, they can use

	the upstairs bathroom. Charles Baroi and Ms. Troast reported if the downstairs bathroom is occupied, they may use the upstairs bathroom. I did not observe bottles of urine or an odor of urine in Resident B and Resident C's room on 6/13/24 or 7/3/24. Based on the interviews completed and observations made, there is insufficient evidence to support the allegation that the home is not maintained to provide for the health and safety of residents due to residents urinating in bottles in their room.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Charles Baroi harasses Resident C for extra payment each month.

INVESTIGATION: On 7/2/24, I reviewed the second referral for investigation. The complaint alleged Charles Baroi has attempted to get more money, outside of $1056.60 which is listed in his Resident Care Agreement as his monthly payment, multiple times. Charles Baroi stated Resident C owes $1080.00 a month because "rent went up." Charles Baroi has never updated Resident C's Resident Care Agreement and requested signatures to authorize this increase. Charles Baroi keeps verbally harassing Resident C, his relatives, and his caseworker regarding Resident C paying $1080.00 and threatening to "kick him out." Resident C's caseworker has confirmed with Charles Baroi that Resident C is not eligible for $1080.00.

On 7/2/24, I contacted Complainant 2 via email confirming receipt of the allegations.

On 7/2/24, I received a telephone call from Complainant 3. She stated Charles Baroi is verbally harassing Resident C, his relatives, and "cornered" his caseworker, threateningly, demanding he receive payment he feels is owed to him by Resident C. She stated it was determined by Resident C's case management team that he is only eligible to receive $1056.60 for his care each month. She stated Charles Baroi insists since another resident in the home receives $1080.00 that Resident C should too. She stated for months Charles Baroi has been demanding the money from Resident C and his relatives and threatening to evict him if he does not pay. She stated she has rapport with Charles Baroi, James Baroi, and Juliet Troast, and she called to confront Charles Baroi about this behavior. She stated Charles Baroi initially argued with her that because another resident receives $1080.00, Resident C should be paying that amount too. She confronted Charles Baroi regarding his badgering Resident C, his relatives, and his caseworker about this amount and Mr. Baroi eventually acknowledged that his behavior was not appropriate.
On 7/3/24, Resident C stated for months Charles Baroi has told him that he owed him $180.00 more a month and he would threaten to "kick (him) out" if he did not pay. He stated Charles Baroi told the same thing to his relatives too. He stated his

caseworkers have told him that he does not owe that amount but “over the last few months” Charles Baroi has begun to request that $180.00 again. I inquired if he meant that Charles Baroi requested his payment be $1080.00 a month and not $180.00 extra a month and he said he thinks that is what he meant.

Charles Baroi was not present for my onsite investigation but Ms. Troast, via telephone, confirmed she discussed this with Charles Baroi as it was a misunderstanding. She stated Charles Baroi assumed since another resident pays $1080.00, Resident C should be paying that much as well, and he began requesting it from Resident C and his guardian. She stated she has since advised him that Resident C only receives $1056.60 and cannot pay anymore, and just because one resident pays one amount, does not mean all residents have to pay the same amount. She stated it was a misunderstanding that has since been clarified with Charles Baroi.

On 7/16/24, Charles Baroi stated he had been asking Resident C, Resident C’s relatives, and caseworker for a payment of $1080.00 each month and had asked multiple times because another resident was paying $1080.00 a month and he thought Resident C should as well. He denied changing Resident C’s Resident Care Agreement to reflect that change. He stated he was advised that Resident C only gets $1056.60 a month and not $1080.00 so he knows not to ask anymore.

APPLICABLE RULE	
R 400.14315	**R 400.14315 Handling of resident funds and valuables.**
	(12) Charges against the resident's account shall not exceed the agreed price for the services rendered and goods furnished or made available by the home to the resident.
ANALYSIS:	Complainant 2, Complainant 3, and Resident C reported Charles Baroi has “harassed” Resident C, his relatives, and caseworker because he felt Resident C should be paying $1080.00 a month, as opposed to $1056.60 which he is authorized to pay. Mr. Baroi admitted asking Resident C, his relatives, and caseworker on multiple occasions to pay $1080.00 and that the price increase he was requesting was not written in Resident C’s Resident Care Agreement. Complainant 3 and Ms. Troast confirmed they have discussed this with Charles Baroi, and he acknowledged this was wrong. Based on the interviews completed, there is sufficient evidence that Charles Baroi attempted to request charges from Resident C, his relatives, and his caseworker, that exceeded the agreed price for services rendered in the home.

CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident D is sleeping in the dining room of the home.
INVESTIGATION: On 7/1/24, I received an email from Complainant 1 who reported there are two female residents sleeping on couches in the upstairs living room who are waiting to be placed in Resident B and Resident C's room.

On 7/2/24, Complainant 3 reported she was informed that there is a female resident sleeping on a bed in the dining room upstairs. She stated Resident C's caseworker went to the home and observed a female resident upstairs in the home and a bed in the dining room of the home.

On 7/2/24, I reviewed the Original Licensing Study for this home which confirmed the home is licensed to accept both male and female residents. There is also a semi-private bedroom that is licensed for two residents, in addition to a private bedroom that is licensed as a staff room on the upper level of the home.

On 7/3/24, I met Resident D who showed me her bedroom. She showed me which bed is hers and reported she does not have a roommate. The room she showed me was the semi-private, resident bedroom. I observed a twin sized mattress on a frame in the dining room of the home and Resident D denied sleeping on that mattress.

James Baroi reported he was previously sleeping in the room that Resident D resides in but when she moved in, he had to put a mattress in the dining room of the home for him to use since Charles Baroi sleeps in the staff room. He stated Resident D has the semi-private, resident bedroom to herself currently and does not use the twin sized mattress in the dining room, as that is his.

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:	I observed a twin sized mattress on a frame in the upstairs dining room of the home. James Baroi reported he uses the mattress in the dining room to sleep since he previously used to sleep in the room Resident D now resides in.

	Based on the interviews completed and observation made, there is sufficient evidence that the dining room is being used for sleeping purposes by Mr. James Baroi.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 6/13/24, while discussing the allegations listed in the referral, Resident A, Resident B, and Resident C reported they were threatened with discharge if they made complaints to anyone about what occurs in the home. Resident A stated he was unwilling to verbally report any complaints out of fear of being discharged from the home. Resident B reported after a relative threatened to make a complaint, he was given a 30-day discharge notice.

James Baroi and Maya Baroi reported Resident B was given a discharge notice due to using marijuana in or around the home.

On 7/1/24, Complainant 1 reported Resident B was given a discharge notice on 6/10/24, after Relative B1 threatened to report the home and his discharge date is 7/10/24.

On 7/16/24, Charles Baroi stated Resident B was given a discharge notice for using marijuana in the home. He stated he only gives discharge notices for valid reasons. When asked multiple times if he or James Baroi threaten residents or tell them not to talk to licensing or any other agency about their concerns, he did not answer the question.

APPLICABLE RULE	
R 400.14308	**R 400.14308 Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(iv) Threats.**
ANALYSIS:	Resident A, Resident B, and Resident C reported they were threatened with discharge if they discussed concerns regarding the home. Resident A was unwilling to verbally report concerns to me. Resident B reported he was given a discharge notice after his relative threatened to report the home.

	Complainant 1 reported Resident B was given a discharge notice on 6/10/24 after Relative B1 threatened to report the home. Charles Baroi did not answer when asked multiple times if he or James Baroi has threatened residents with discharge if they make complaints to licensing or another agency regarding the home. Based on the interviews completed, there is sufficient evidence that the licensee designee and direct care staff have subjected residents to threats.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 7/2/24, Complainant 2 discussed Resident C having a caseworker and a guardian.

On 7/2/24, Complainant 3 discussed Resident C having a caseworker and a guardian.

On 7/3/24, Resident C discussed that he cannot sign documents for himself because he has a guardian. He also discussed that he has a caseworker.

On 7/16/24, Charles Baroi reported Resident C has a guardian and a caseworker.

On 7/16/24, while reviewing Resident C's Assessment Plan for AFC Residents, I observed it was completed/signed only by Resident C and Charles Baroi, it did not have the signature of Resident C's guardian or his placing agency.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident C's assessment plan was missing the signatures of his designated representative and his responsible agency.

	Complainant 2, Complainant 3, Resident C, and Charles Baroi confirmed Resident C has a guardian and a caseworker. Based on the interviews completed and document reviewed, there is sufficient evidence that Resident C's assessment plan was not completed with the resident's designated representative and responsible agency.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 6/13/24, while investigating the allegation that resident medications are kept in plastic bags, I observed that Resident B and C's daily medications were tied in unlabeled sandwich bags and left for Resident B and Resident C to take independently throughout the day.

Resident B and Resident C stated Charles Baroi is responsible for managing their medication.

Mr. Tschirhart confirmed he previously investigated an allegation of Resident A's medications being kept in a weekly pill container and Mr. Baroi was made aware at that time that physician authorization needed to be obtained if he did not directly supervise resident medication taking.

James Baroi acknowledged Resident C's medication is put in a plastic, unlabeled sandwich bag, without instructions, for him to take independently.

On 7/3/24, I observed multiple unlabeled sandwich bags of pills in the room of Resident B and Resident C again.

On 7/16/24, Charles Baroi reported he is responsible for managing Resident B and Resident C's medication. He stated he gives them their daily medication in a sandwich bag for them to take throughout the day. He confirmed Resident A is the only resident with a physician's order to manage his own medication.

On 7/16/24, I reviewed SIR# 2024A0350022 dated 3/13/24. Mr. Tschirhart investigated allegations that Resident A's medications were kept in a weekly pill dispenser, and he was managing them himself. Mr. Tschirhart confirmed Resident A did not have physician approval to be managing his own medication. Charles Baroi was advised that a physician's approval was needed prior to a resident managing their own medication. The special investigation report was dated 3/18/24. Charles Baroi submitted an acceptable plan of corrective action, acknowledging physician approval was obtained for Resident A to manage his own medications, which Mr. Tschirhart confirmed on 4/2/24.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	I observed unlabeled sandwich bags of medication in the room of Resident B and Resident C on two occasions. Resident B and Resident C reported Mr. Baroi gives them all their daily medication in the morning in tied sandwich bags and does not supervise them taking the medication. James Baroi acknowledged putting Resident C's medication in plastic unlabeled sandwich bags and not supervising Resident C taking the medication. Charles Baroi acknowledged giving Resident B and Resident C all their medication for the day in a tied sandwich bag. He confirmed only Resident A has a physician's order to manage his own medication. Based on the interviews completed and observations made, there is sufficient evidence that residents do not have physician approval but are taking prescription medication without supervision.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** SIR# 2024A0350022 3/13/24, LSR 3/18/24, CAP 4/2/24

ADDITIONAL FINDING: On 6/13/24, while investigating the allegation that resident medications are kept in plastic bags, I observed Resident C's daily medications tied in an unlabeled sandwich bag and left for Resident C to take independently throughout the day. There were no labels or instructions on the plastic bag.

Resident C stated Charles Baroi is responsible for managing his medications and he gives them to him in a plastic bag for Resident C to take on his own.

James Baroi stated if Resident C goes on a leave of absence, he puts Resident C's medication in a plastic unlabeled sandwich bag that does not have instructions regarding the medications and how to correctly take them.

On 7/16/24, Charles Baroi reported he is responsible for managing Resident B and Resident C's medication. He stated he gives them their daily medication in unlabeled sandwich bags for them to take throughout the day.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	I observed Resident C's medications tied in an unlabeled sandwich bag on two occasions. The bag did not have a label or instructions for how to correctly take the medication. James Baroi acknowledged putting Resident C's medication in plastic unlabeled sandwich bags if he goes on leave of absence and that the bags do not include instructions or information regarding the medication. Charles Baroi acknowledged giving Resident B and Resident C their medications in unlabeled sandwich bags. Based on the interviews completed and observations made, there is sufficient evidence that Resident C's medications are put in plastic bags which do not contain the necessary information and instructions should he go on leave of absence.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 6/13/24, while investigating the allegation that resident medications are kept in plastic bags, I observed that Resident B and Resident C's daily medications are tied in unlabeled sandwich bags and left in Resident B and Resident C's room for them to take independently throughout the day.

Resident B and Resident C stated Charles Baroi is responsible for managing their medication, they are not, and that he gives them all their daily medications in the morning in unlabeled sandwich bags for them to take on their own.

James Baroi acknowledged putting Resident C's medications in unlabeled sandwich bags.

On 7/3/24, I observed pharmacy supplied medication packs in the open under the television in the home. Resident D was present in the room at the time the medications were observed.

I again observed unlabeled, tied sandwich bags of medication in Resident B and Resident C's room.

On 7/16/24, Charles Baroi stated he is responsible for passing Resident B and Resident C's medications and he gives them all their medications at once, in an unlabeled sandwich bag, for them to take independently throughout the day.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	I observed unattended, unsecured, and unlabeled sandwich bags full of resident medications in the home on 6/13/24 and 7/3/24 and unattended and unsecured pharmacy supplied pill packs on 7/3/24. Based on the interviews completed and observations made, there is sufficient evidence that reasonable precautions are not taken to ensure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 6/13/24, while discussing the allegations of moldy or expired food being served in the home, Mr. Tschirhart requested to see the menu in the home. Charles Baroi said he does not create or post a menu. Mr. Tschirhart advised him that there is a licensing rule requiring the creation and posting of a menu in the home. Charles Baroi agreed he would create, post, and follow a menu moving forward. Mr. Tschirhart observed the kitchen and confirmed there was no menu in the home.

Resident A said that there is no menu, so he must purchase his own food.

Resident B and C both stated that there is no menu in the home and residents eat whatever James Baroi chooses to prepare for them. He stated he wishes there was a menu.

On 7/3/24, I observed the kitchen and again found no menu in the home.

James Baroi reported they do not use a menu at this home and there is no need for one because he ensures residents eat meals they like every day.

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. **(5) Records of menus, including special diets, as served shall be provided upon request by the department.** **(6) Records of menus, including special diets, shall be kept by the licensee for 1 calendar year.**
ANALYSIS:	Charles Baroi acknowledged menus are not written, posted or maintained in the home. During the first on-site investigation, Mr. Tschirhart provided consultation on the requirements of the licensing rule and Charles Baroi agreed to correct this. During a second on-site investigation, nearly three weeks after the first, it was found that menus continued to not be written, posted, or maintained in the home. James Baroi confirmed menus are not written, posted, or maintained and expressed they are not necessary. Menus and record of previous menus were not found in the home or provided to the department during the investigation. Based on the interviews completed and observations made, there is sufficient evidence that menus are not written at least one week in advance and posted in the home, records of menus were not available or provided to the department during this investigation, and records of menus were not kept for one calendar year.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 6/13/24, while knocking on the front door prior to entering to complete my on-site investigation, I discovered a deadbolt lock on the door that was covered on the outside with clear packing tape. I observed the deadbolt locking mechanism on the inside of the front door of the home.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped

	with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	I observed a functional deadbolt lock, that had tape over the outside lock face, on the front door of the home. Based on the observation made there is sufficient evidence that a door that forms a part of a means of egress has locking against egress hardware.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/23/24, I completed an exit conference with Licensee Designee, Mr. Baroi, and Administrator, Juliet Troast. Ms. Troast expressed an understanding of my findings and recommendations. She agreed she and Mr. Baroi would review the report and await a letter from the Disciplinary Action Unit before expressing agreement or disagreement with the findings and recommendations.

IV. RECOMMENDATION

I recommend that the license be revoked as a result of the above-cited quality of care violations.

Cassandra Duursma 07/23/2024

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 07/23/2024

Jerry Hendrick Date
Area Manager