GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 7, 2025

Jodie Nowak
Tranquility AFC Home LLC
11590 Lakeshore Drive
Lakeview, MI 48850

RE: License #: AM590407641
Investigation #: 2025A1033017
Tranquility AFC Home LLC

Dear Ms. Nowak:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality-of-care violations cited and the license already being in a 1st Provisional status, 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 (517) 284-9730.

Sincerely,

Jana Lipps

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

I. IDENTIFYING INFORMATION

License #:	AM590407641
Investigation #:	2025A1033017
Complaint Receipt Date:	02/18/2025
Investigation Initiation Date:	02/18/2025
Report Due Date:	04/19/2025
Licensee Name:	Tranquility AFC Home LLC
Licensee Address:	11590 Lakeshore Drive Lakeview, MI 48850
Licensee Telephone #:	(989) 304-4041
Administrator:	Jodie Nowak
Licensee Designee:	Jodie Nowak
Name of Facility:	Tranquility AFC Home LLC
Facility Address:	1380 East Main Street Edmore, MI 48829
Facility Telephone #:	(989) 560-9733
Original Issuance Date:	04/12/2023
License Status:	1ST PROVISIONAL
Effective Date:	12/02/2024
Expiration Date:	06/01/2025
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The facility smells of urine and feces.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/18/2025	Special Investigation Intake 2025A1033017
02/18/2025	Special Investigation Initiated - Telephone Telephone interview with the Complainant.
02/19/2025	Inspection Completed On-site Interviews conducted with licensee designee, Jodie Nowak, direct care staff, Jamie Nadeau, Resident A, B, & C. Walkthrough of the facility completed.
02/19/2025	Contact - Telephone call received Interview conducted with Relative A1, via telephone.
02/20/2025	Contact - Telephone call received Voicemail message received from Relative A2.
02/20/2025	Contact - Telephone call made Interview conducted with Relative A2, via telephone.
02/20/2025	Contact - Telephone call made Telephone conversation with Licensee Designee, Jodie Nowak.
02/20/2025	Contact - Document Received Documents received via text message from licensee designee, Jodie Nowak.
02/20/2025	Contact - Telephone call made Attempt to interview The Care Team registered nurse, via telephone. Voicemail message left, awaiting response.
02/20/2025	APS Referral APS referral made per protocol.
02/20/2025	Contact - Telephone call made Interview conducted with Adult Protective Services, Adult Services Worker, Leslie Brugel, via telephone.

02/26/2025	Contact – Telephone call made Interview conducted with Cindy Villalobos of The Care Team home health care agency.
03/07/2025	Exit Conference Conducted via telephone with licensee designee, Jodie Nowak.

ALLEGATION: The facility smells of urine and feces.

INVESTIGATION:

On 2/18/25 I received an online complaint regarding the Tranquility AFC Home, adult foster care facility (the facility). The complaint alleged that there are unsanitary conditions at the facility and Complainant received a report that feces had been observed on the floor. Complainant further stated that the report came from an individual who had been to the facility on multiple occasions and noted that the facility always has an odor of urine and feces. On 2/18/25 I conducted a telephone interview with Complainant. Complainant stated Citizen 1 reported concerns about the facility smelling of urine and feces and having directly observed feces on the floor in a resident bedroom. Citizen 1 reported these concerns to Complainant on 2/14/25. Complainant reported additional questions for Citizen 1 could be emailed to Complainant's email address and Citizen 1 would answer these questions.

On 2/19/25 I received email correspondence from Complainant. Complainant reported Citizen 1 confirmed they had been onsite at the facility on at least three occasions since October 2024 and each time the facility has smelled of urine and/or feces. The building the facility is housed in shares a fire door with a separate business where private citizens rent apartments. Citizen 1 reported that the odor of feces and urine was detected on the facility side of the building.

On 2/19/25 I conducted an unannounced, on-site investigation at the facility. I conducted a walkthrough of the entire facility. The common areas of the facility including the living room, public bathroom, kitchen, hallways, back family room, were all clean and well maintained. There were five resident bedrooms occupied by residents at the time of the investigation. Most of the resident bedrooms were cluttered and had some crumbs/dirt on the flooring, but were otherwise clean and did not smell of urine and/or feces. When I entered Resident A's bedroom, I observed a strong smell of urine and feces. I observed Resident A to be lying in her bed eating her lunch. She had a lunch tray on her bedside table, that was placed directly adjacent to a female urinal. The urinal was empty at the time of this investigation. Resident A was completely covered with a blanket at the time of this investigation. I could not view the condition of her mattress. There was not visible feces or urine on the ground at the time of this investigation.

During the on-site investigation on 2/19/25 I interviewed Resident A. Resident A reported that she felt she was receiving quality care from the direct care staff, and she had no concerns about the care being provided.

During the on-site investigation on 2/19/25 I interviewed Resident B. Resident B reported that she has observed the facility to have an odor of urine/feces when she walks past Resident A's bedroom. She reported that Resident A's bedroom frequently smells of urine/feces. Resident B reported that the rest of the facility appears to be kept in a relatively clean condition.

During the on-site investigation on 2/19/25 I interviewed Resident C. Resident C reported that she spends most of her time in her resident bedroom. Resident C reported that she receives assistance with her personal care needs from direct care staff and does not have any complaints about the care she is receiving. Resident C reported that she has recently moved to the facility.

During the on-site investigation on 2/19/25 I interviewed direct care staff, Jamie Nadeau. Ms. Nadeau reported that the facility is currently caring for five residents. She reported that the only residents who are incontinent of urine and/or feces are Resident A and Resident C. I inquired about the strong odor of urine and feces that was observed in Resident A's resident bedroom during my walkthrough of the facility on this date. Ms. Nadeau reported that Resident A was admitted to the facility on 11/1/24. She reported that when Resident A was admitted to the facility, she and Ms. Nowak were told that Resident A could pivot transfer with a one-person assist from bed to wheelchair and so forth. Ms. Nadeau reported that this was not the case and since admission to the facility direct care staff have not been able to transfer Resident A from bed to the wheelchair. She reported that the only direct care staff who can transfer Resident A is Matt Crosby. Ms. Nadeau reported that Mr. Crosby does not work every day, and they have to call him to the facility if they want Resident A transferred out of her bed. Ms. Nadeau reported that the facility is staffed with just one direct care staff member per shift. She reported that Resident A remains in bed all day, unless she has a physician's appointment, in which case Mr. Crosby will come to transfer her to her wheelchair. Ms. Nadeau reported that Resident A has only had one physician's appointment since being admitted in November 2024. Ms. Nadeau reported that Resident A has only been out of bed to be showered in the facility shower on one occasion since her admission to the facility. Ms. Nadeau reported that Resident A receives bed baths from a home care provider, The Care Team. She reported that this service began on 1/28/25. Ms. Nadeau reported that prior to home care services being initiated for Resident A the direct care staff would attempt to provide personal care to Resident A in her bed. Ms. Nadeau reported that the smell of urine and feces in Resident A's bedroom is related to the fact that Resident A has episodes of diarrhea as she is incontinent of bowel. She reported that the episodes will be so bad that the feces will run down the mattress and onto the floor. Ms. Nadeau reported that they have replaced multiple sets of sheets for Resident A's bed because they do not feel the sheets, once soiled, can be laundered and they discard the sheets in the trash receptacle. Ms. Nadeau reported that they have requested that Resident A's family begin to purchase sets of sheets. She further

reported, there are times when they do not have clean sheets to place on Resident A's bed. Ms. Nadeau reported that Resident A has not been out of bed to provide an opportunity for the direct care staff to clean and disinfect the mattress on the bed. She reported that there is not currently a protocol in place to accommodate for the fact that the mattress has a strong odor and needs to be cleaned on a regular basis due to Resident A's incontinence. Ms. Nadeau was asked about the use of an assistive device, such as a Hoyer lift, to assist the direct care staff with transferring Resident A from the bed for showering and cleaning/disinfecting of Resident A's bedroom, bedding, and mattress. Ms. Nadeau reported that Resident A has refused the use of a Hoyer lift and further reported that a physician has not ordered a Hoyer lift for Resident A. Ms. Nadeau reported that Resident A did admit to the facility with some bedsores on her backside and these wounds are currently being monitored and cared for by The Care Team nursing staff. Ms. Nadeau reported direct care staff are supposed to rotate Resident A in bed every two hours per the wound care protocol, but there are times Resident A will refuse to be turned from her current position. Ms. Nadeau reported that she has communicated with Relative A1 regarding the amount of care that Resident A requires and the fact that Resident A refuses certain aspects of care, such as assistive devices for safe transfers, hygiene issues, and so forth. Ms. Nadeau reported that she has requested for Relative A2 to provide Resident A's incontinence supplies, and extra linens for Resident A's bed. I inquired of Ms. Nadeau how Resident A participates in fire drills at the facility if the facility is only staffed with one direct care staff member and Resident A cannot be transferred with just one person. Ms. Nadeau reported that Resident A does not participate in fire drills. She reported that they allow Resident A to opt out of fire drills as they are not able to get her out of the facility in her current condition with one direct care staff member per shift. I inquired whether Ms. Nowak had issued Resident A a discharge notice due to the fact that Resident A's care has been communicated as being too extensive for the current staffing levels at the facility. Ms. Nadeau reported that a discharge notice has not been discussed with Resident A or her family members.

During the on-site investigation on 2/19/25 I interviewed Ms. Nowak regarding the allegations. Ms. Nowak reported that there are two residents at the facility who are incontinent, Resident A and Resident C. Ms. Nowak was asked about the condition of Resident A's bedroom and the notable odor of urine and feces observed today. Ms. Nowak reported that Resident A was admitted to the facility in November 2024. She reported that she was told Resident A was a one-person pivot transfer from bed to wheelchair and so forth. Ms. Nowak reported that once Resident A arrived at the facility, they realized that Resident A could not pivot transfer and required full assistance with transferring from at least two direct care staff or one very strong direct care staff. Ms. Nowak reported that the facility is only staffed with one direct care staff member per shift. Therefore, direct care staff have been providing for Resident A's personal hygiene needs by completing hygiene tasks at the bedside. Ms. Nowak reported that she did not feel that she and Ms. Nadeau, working together, could even transfer Resident A from her bed to the wheelchair. Ms. Nowak reported that Resident A is incontinent of bowel and uses a female urinal, in her bed, for urination purposes. Ms. Nowak reported direct care staff have only been able to get Resident A out of bed and into the shower at the

facility on one occasion since admission in November 2024. She reported that Mr. Crosby is the only direct care staff member who can transfer Resident A. She reported that he uses his “full weight” and lifts Resident A with a pivot transfer to the wheelchair. Ms. Nowak reported that Mr. Crosby has only had Resident A out of bed for the one shower noted and to attend a physician’s appointment. Ms. Nowak reported that they enlisted the services of The Care Team home care on 1/28/25 to assist with Resident A’s care needs due to wounds on her backside. Ms. Nowak reported that The Care Team sends a home health aid two times per week to complete bed baths for Resident A. Ms. Nowak reported that the home health aid from The Care Team will change Resident A’s bedding when she is on-site, if they have bedding available to put on the bed. She reported that Resident A soils her bedding so frequently that they have requested that Resident A’s family begin to provide bedding, including sheets for Resident A’s bed. Ms. Nowak confirmed that Resident A does not participate in fire drills due to her immobility and direct care staff inability to complete transfers from her bed to the wheelchair. Ms. Nowak reported understanding that if there were an emergency at the facility, Resident A would not be able to be moved to safety with the current staffing levels in place of one direct care staff on each shift.

During the on-site investigation on 2/19/25 I observed the home health aid from The Care Team agency making a visit to Resident A. I was not able to interview this individual today as she was at the facility for a brief period and left during the time I was interviewing Ms. Nowak. It appeared that this individual was on-site for less than 20 minutes on this date. Ms. Nadeau reported that this individual was scheduled to provide a bed bath to Resident A on this date. I inquired about the length of time the home health aid was at the facility and Ms. Nadeau reported, “She probably didn’t wash [Resident A’s] hair today.”

During the on-site investigation on 2/19/25, I reviewed the following documents:

- *Monthly Shower Assistance Log*, for Resident A, for the month of December 2024. This document identifies on 12/3/24, 12/9/24, 12/16/24, 12/23/24, 12/31/24, Resident A “refused” a shower. On 12/7/24, Ms. Nowak signed the shower log and marked the box for “shower”. Next to this entry is a place to document whether Resident A’s hair was washed with a “yes” or a “no”. Ms. Nowak checked the box for “no”.
- *Monthly Shower Assistance Log*, for Resident A, for the month of January 2025. This document identifies on 1/7/25, 1/16/25, 1/21/25, & 1/28/25, Resident A “refused” a shower. On 1/31/25, Ms. Nowak signed the shower log and marked the box for “sponge bath”. Next to this entry is a place to document whether Resident A’s hair was washed with a “yes” or a “no”. Ms. Nowak checked the box for “yes”.
- *Monthly Shower Assistance Log*, for Resident A, for the month of February 2025. This document identifies on 2/3/25, 2/11/25, & 2/18/25 Resident A refused a shower. There is a notation on 2/12/25 that documents Resident A had a “sponge bath”. Next to this entry is a place to document whether Resident A’s hair was washed with a “yes” or a “no”. The “no” was marked on 2/12/25.

- *Durable Power of Attorney,* document for Resident A, identifies Relative A1 as the appointed Durable Power of Attorney for Resident A.
- *Health Care Appraisal,* for Resident A, dated 1/16/25. Under section, *16. Other Health-Related Information or Concerns*, it reads, “non-ambulatory, increase weakness, Decubitus ulcer.”
- *Assessment Plan for AFC Residents*, for Resident A, dated 10/31/24. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, it reads, “help getting up & pivoting.” On page two, under section, *II. Self Care Skill Assessment*, subsection, *B. Toileting*, it reads, “wears attends”. Subsection, *C. Bathing*, reads, “assist in shower”. Subsection, *G. Walking/Mobility*, notes Resident A needs assistance, but no narrative was written in this area. Subsection, *J. Use of Assistive Devices*, it reads, “walker w/c”. This document is signed by Relative A1 and direct care staff member Ms. Nadeau.
- *Michigan Workforce Background Check* eligibility letter for Matthew Crosby. This document identified that Mr. Crosby was deemed “eligible” to provide care at the facility.
- I requested to review Mr. Crosby’s employee file with training records. Ms. Nowak could not locate Mr. Crosby’s trainings at the time of this on-site investigation.

On 2/19/25 I interviewed Relative A1, via telephone, regarding the allegations. Relative A1 reported that she receives telephone calls or text messages from Ms. Nadeau about every other day. She reported that these messages report to her that Resident A refuses care and has issues with incontinence of her bowels. Relative A1 reported that prior to Resident A moving to the facility she was residing at another facility and was able to walk and get out of her bedroom and socialize. She reported that Resident A moved from the previous facility to this facility due to financial reasons. When asked about Resident A’s current physical condition, Relative A1 reported that she was told by The Care Team nursing staff that it does take two people to get Resident A up and to the edge of the bed. Relative A1 reported that she does not live locally and relies on Relative A2 to make regular visits to Resident A at the facility. She reported that Relative A2 has made statements to her that when she visits Resident A at the facility that Resident A’s bedroom smells of urine and feces. Relative A1 reported that Relative A2 made a statement to her that when she visits Resident A, her urinal is frequently full and sitting on her bedside table, where Resident A’s food trays are placed. She reported that Relative A2 had stated to her that she will then go empty the urinal in the bathroom and while conducting this task has found the bathrooms to be left in unsanitary conditions. Relative A1 reported that Relative A2 stated to her that she cleaned the bathroom at the facility, herself, because there was feces in and around the toilet and she could not tolerate the condition she found the bathroom to be in. Relative A1 reported that she has been told that she needs to order bedding for Resident A’s bed by Ms. Nadeau. Relative A1 reported that Ms. Nadeau had communicated with her that she would need to purchase two sets of sheets and four large incontinence pads for Resident A’s bed. Relative A1 reported that one large incontinence pad costs the family $59. Relative A1 reported that she received a telephone call from Ms. Nadeau, after this

licensing consultant had left the facility on 2/19/25, stating that a new placement would need to be found for Resident A as the facility could no longer provide for her care needs. Relative A1 reported that when Resident A moved to the facility, she was able to stand and pivot from her wheelchair to the bed and from the bed to the wheelchair.

On 2/20/25 I interviewed Relative A2, via telephone, regarding the allegations. Relative A2 reported that Resident A was stronger than she is now in November 2024, when she moved to the facility. She reported that at this time Resident A cannot get out of bed on her own and she does not feel that one direct care staff member could transfer Resident A. Relative A2 reported that she makes unannounced visits to Resident A, at the facility, at least once per week. She reported that when she goes she always finds Resident A's bedroom to smell of urine and/or feces. She reported that frequently she will find Resident A's female urinal sitting on the over the bed table, full of urine, with feces on the container. She reported that she will empty the urinal in the bathroom and clean the urinal for Resident A. Relative A2 reported that she has observed the bathroom to be in an unsanitary condition on at least one occasion as she found the toilet to be covered with feces and the sink to be clogged. She reported that she cleaned the bathroom herself on this date, because she could not tolerate how unsanitary it appeared. Relative A2 reported that when she visits Resident A, she will often have to mop the floor in Resident A's bedroom as it will be covered with urine. She reported that she finds the room in this condition on almost every trip to the facility. Relative A2 reported that she frequently finds Resident A in her bed with the sheets pulled up around her neck because they are not able to reposition the bedding when Resident A moves around in the bed. Relative A2 reported that Ms. Nadeau has given the directive that the family needs to purchase bedding, including sheets, pillowcases, incontinence pads, and incontinence wipes. Relative A2 reported that she has not seen Resident A out of bed since she admitted to the facility in November 2024. Relative A2 reported that she does not feel a shower or a bed bath were provided by direct care staff until The Care Team agency began providing care to Resident A. Relative A2 reported that she does not think Resident A's mattress has been cleaned or disinfected since admission and noted that Resident A is incontinent of bowel and spills her urine in her bed when she uses her female urinal. Relative A2 reported that after this licensing consultant's on-site investigation on 2/19/25, the family has received a directive from Ms. Nadeau that Resident A will need to be moved to another location for her care.

On 2/20/25 I had a telephone conversation with Ms. Nowak regarding the investigation. I requested Ms. Nowak provide documentation of direct care staff schedule and fire drill records. Ms. Nowak reported that she had issued a 30-Day Discharge Notice to Resident A on 2/19/25. I stated to Ms. Nowak that she would be required to staff the facility with adequate staffing to meet the needs of Resident A until a new placement can be found for Resident A's care. This includes staffing at least two direct care staff members per shift. Ms. Nowak reported understanding of this directive.

On 2/20/25 I interviewed Adult Protective Services, Adult Services Worker, Leslie Brugel, regarding the allegations. Ms. Brugel reported that she does make regular visits to the facility as she is working with a couple of the current residents. Ms. Brugel

reported that she does not have a current working relationship with Resident A and has never entered Resident A's bedroom. Ms. Brugel reported that she does not recall smelling urine or feces in the common areas of the facility, where she typically meets with her clients.

On 2/26/25 I interviewed Cindy Villalobos a registered nurse with The Care Team home health care agency. Ms. Villalobos reported that she started providing services to Resident A on 1/28/25. She reported that upon her initial assessment on 1/28/25, she met Resident A at the facility. She reported that she found Resident A to be in an unhygienic condition on this date. She found Resident A soiled in her bed with feces and urine. Ms. Villalobos reported that she took this incident as an opportunity to teach the direct care staff about proper hygiene and how to care for a bedbound resident. Ms. Villalobos reported that she makes weekly visits to the facility to manage the wounds on Resident A's sacrum and frequently finds Resident A to be soiled upon her arrival. Ms. Villalobos reported that she also finds Resident A's female urinal to be sitting next to her and to have urine in the container. Ms. Villalobos reported that Resident A can use her urinal independently, but she often spills the urine in her bed. Ms. Villalobos reported that Resident A's bedroom always has an odor of urine and/or feces when she arrives for her visits. She reported that a home health aid was ordered, one time per week to assist with bed baths for Resident A. She reported that this service had just started within the past two weeks. Ms. Villalobos reported that Resident A's wounds are improving, and she can document this improvement as she takes photographs of the wounds during each visit. She reported that the direct care staff do assist in cleaning Resident A up when she makes visits to Resident A, but she reported she must ask them for this assistance. I inquired of Ms. Villalobos whether Resident A could be transferred from the bed with less than two direct care staff assisting her. She reported that it would take two strong individuals to assist Resident A in transferring to a wheelchair. She reported that she can get Resident A to sit at the side of the bed, but this takes two people. She reported that a physical therapist has been ordered to work with Resident A on strengthening her muscles with the goal of transferring to a bedside commode so that Resident A is no longer defecating in her bed. Ms. Villalobos reported that she stated to Resident A that if she were to tell the direct care staff, she needed to have a bowel movement that a bedpan could be placed under her so that she was not incontinent on her sheets and her mattress. Ms. Villalobos reported that Ms. Nadeau stated that there was not a bedpan available at the facility so they could not accommodate this request. Ms. Villalobos reported that Resident A does tend to refuse the care that is offered to her, and she is uncertain why. She reported that she has never found urine or feces on the floor in Resident A's bedroom but finds it on her bed linens every time she visits Resident A. Ms. Villalobos reported that she has not been able to obtain a weight on Resident A, as she is non weight bearing and the facility does not have the necessary equipment to weight a non-weight bearing resident.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon interviews conducted and observations made during the on-site investigation, it can be established that the direct care staff are not providing adequate housekeeping standards to present a comfortable and clean living space for Resident A. Although, Resident A did not make a complaint about her living conditions, it was directly observed by this licensing consultant, and verbally reported by the Complainant, Ms. Nadeau, Ms. Nowak, Resident B, Relative A1, Relative A2, and Ms. Villalobos, that Resident A's bedroom had an odor of urine/feces, has been found soiled with urine and feces on the floor and the bedding. Due to these findings a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/11/24, *Special Investigation Report 2024A0622047*, identified a rule violation regarding Rule 301(2)(a)(b), regarding resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal. The *Analysis* section of this rule violation reported that the licensee designee, Ms. Nowak, admitted a resident to the facility before determining whether the direct care staff to resident ratio was adequate to safely care for the resident cited in the report. The *Corrective Action Plan*, dated 9/19/24, and signed by Ms. Nowak, states the *Corrective Action* as follows: "Will call family members re: admission criteria". Under the section, *How maintained*, it reads, "Will make certain all paperwork is filled out."

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

	(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.
ANALYSIS:	Based upon interviews conducted with the Complainant, Ms. Nadeau, Ms. Nowak, Residents A, B, C, Relative A1, Relative A2, Ms. Brugel, & Ms. Villalobos, as well as review of resident records, it can be determined that the accommodations required to accommodate Resident A's care needs have not been available at the facility since Resident A's admission to the facility in November 2024. Multiple individuals expressed concern that Resident A is bedbound, and the facility does not staff adequate direct care staff members to be able to provide for her personal care/hygiene needs. It was noted by observing Resident A's shower log, through interviews, and direct observations, that Resident A is not receiving adequate personal care at the facility due to a lack of equipment and capable direct care staff to transfer Resident A from her bed. It was identified that Resident A is incontinent of bowel, and frequently spills her female urinal on the bed, which causes the mattress to smell of urine and feces. Furthermore, Resident A is not being removed from the bed for direct care staff to appropriately clean and sanitize the mattress. This has led to a lingering odor of urine and feces in her bedroom. Ms. Nadeau and Ms. Nowak both reported that they do not include Resident A in facility fire drills as they are not capable of moving Resident A from her bed out of the facility in the event of an emergency. They reported that they have allowed Resident A to refuse fire drills due to the inability to move her from her bed. Ms. Nadeau & Ms. Nowak have reported that they are only capable of staffing one direct care staff member per shift and cannot satisfactorily provide Resident A's personal care needs with the current available staffing.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2024A0622047 AND CAP DATED 9/19/24].**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 2/19/25 I interviewed Ms. Nadeau. Ms. Nadeau reported that she has requested Relative A1 to provide sheets, incontinence pads, and

incontinence wipes for Resident A's use at the facility. Ms. Nadeau reported that there are times when they do not have clean sheets to put on Resident A's bed as Resident A has multiple episodes of bowel and urine incontinence. She reported that the urine and feces will be so extensive that it will roll down the mattress onto the floor of Resident A's bedroom. She reported that on numerous occasions Resident A's sheets have been soiled to the point that they have chosen to throw the sheets away, versus laundering them. Ms. Nadeau reported that due to this issue, she has requested Resident A's family to begin providing sheets for Resident A's use at the facility.

During the on-site investigation on 2/19/25 I interviewed Ms. Nowak. Ms. Nowak confirmed that Resident A's family has been requested to provide sheets, incontinence pads, and incontinence wipes, for Resident A's use at the facility.

During the on-site investigation on 2/19/25 I reviewed the following document:

- *AFC Resident Care Agreement*, for Resident A, dated 10/31/24. On page one, under the section, "*The basic fee includes the following basic services*:" it reads, "3 meals a day, 8p snack, laundry, medication management, rent, basic care." On page two, under the section, "*I agree to additional services according to the fee schedule contained in attachment ___. Such additional services may include but are not limited to:"*, this section is blank. There is no narrative written on this section of the document. There was no attachment cited on this document.

On 2/19/25 I interviewed Relative A1, via telephone. Relative A1 confirmed that Ms. Nadeau has communicated with her, via text messaging and direct telephone communication, that the family will be responsible for purchasing new sheets for Resident A's bed, due to Resident A's episodes of incontinence. Relative A1 reported that the incontinence pads for Resident A's bed cost $59 per pad and she has purchased at least four of these pads to date.

On 2/20/25 I interviewed Relative A2, via telephone. Relative A2 reported that Ms. Nadeau sends text messages to Relative A1 and reports to the family that they are responsible for purchasing new sheets for Resident A's bed.

On 7/19/24 *Special Investigation Report 2024A1033045* identified a rule violation of Rule 301(6) regarding resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal. The *Analysis* section of this rule violation reports that Ms. Nowak did not have a completed *Resident Care Agreement* document for the resident cited in the report. The *Corrective Action Plan*, dated 8/7/24, reported that the plan of correction would be for Ms. Nowak to keep two copies of all resident records and have the records uploaded into a computer.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(c) A description of additional costs in addition to the basic fee that is charged.**
ANALYSIS:	Based upon interviews conducted with Ms. Nadeau, Ms. Nowak, Relative A1, and Relative A2, as well as review of the *Resident Care Agreement* document for Resident A, it can be determined that Resident A's family members were being instructed to purchase items that were not identified on the *Resident Care Agreement* document dated 10/31/24 and signed by Ms. Nadeau & Relative A1. There is not a cited attachment with the document highlighting an agreement for Resident A to be charged for bed linens, incontinence pad, or incontinence wipes. However, Relative A1 was instructed to purchase these items through text messages and telephone conversations with Ms. Nadeau. Therefore, a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2024A1033045 CAP DATED 8/7/24].**

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

ANALYSIS:	Based upon interviews conducted with Ms. Nadeau, Ms. Nowak, Relative A1, & Relative A2, Ms. Nadeau reports that she instructed Relative A1 to purchase bed linens for Resident A due to Resident A's frequent episodes of incontinence. Ms. Nadeau reported that Resident A's bed linens were disposed of in the trash on multiple occasions due to the direct care staff making the decision that the linens could not be laundered after these episodes of incontinence. Ms. Nowak reported that she was aware Ms. Nadeau had instructed Relative A1 to purchase bed linens for Resident A's bed. A licensee is responsible to provide clean bedding that is in good condition and laundered at least once a week or more often if soiled. Ms. Nowak failed to provide bedding for Resident A due to the choice to dispose of the available bedding in the trash. As a result, a violation has been established due to Ms. Nadeau and Ms. Nowak requesting additional beddings being purchased for Resident A by her family, instead of providing the bedding as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 2/19/25 I interviewed Ms. Nadeau. Ms. Nadeau reported that the facility conducts fire drills but noted that Resident A does not participate in the scheduled fire drills. Ms. Nadeau reported that Resident A is not able to get out of bed to participate in the fire drills due to immobility. She reported that the facility only staffs one direct care staff member per shift and that it would take two strong individuals to get Resident A out of bed and into a wheelchair for evacuation purposes. Ms. Nadeau reported that Resident A has been allowed to refuse to participate in fire drills due to her bedbound status.

During the on-site investigation on 2/19/25 I interviewed Ms. Nowak. Ms. Nowak reported that Resident A does not participate in facility fire drills. She reported that Resident A is bedbound and requires a strong individual to get her out of bed and into a wheelchair. She reported direct care staff member, Mr. Crosby, is capable of pivot transferring her to a wheelchair, but he does not work every shift. Ms. Nowak reported that she and Ms. Nadeau struggle to get Resident A out of bed using the two of them together for a transfer. Ms. Nowak reported that the facility is only staffed with one direct care staff member per shift. Ms. Nowak reported that Resident A has been allowed to refuse to participate in fire drills due to the difficulty it poses getting her out of bed and out of the facility in the event of an emergency.

During the on-site investigation on 2/19/25 I reviewed Resident A's resident record. I reviewed the following document:

- *AFC – Resident Care Agreement*, for Resident A, dated 10/31/24. On page one, under the section, *Resident or Designated Representative Check All Boxes Below that Apply:* the box was checked for the disclaimer, "I agree to participate in all required fire and emergency drills, as determined by BCHS and the licensee". This document was signed by Ms. Nadeau and Relative A1.

On 2/20/25 I made a telephone call to Ms. Nowak and requested she send the fire drill records and employee schedule for February 2025. Ms. Nowak provided the following documentation via text message:

- *Monthly Fire Drill Log*, 11/10/24, 11pm. This log notes the fire drill lasted 8 minutes. Resident A is listed as a resident present during the fire drill. Under the section, *Special problems encountered during drill*, it reads, "[Resident A] was not able to get into wheelchair – legs were stiff." This document was signed by Ms. Nowak.
- *Monthly Fire Drill Log*, 12/18/24, 4pm to 4:04pm. Resident A is listed as a resident present during the fire drill. Under section, *Special problems encountered during drill*, it reads, "They all went outside".
- *Monthly Fire Drill Log*, 1/20/25, 7:02pm to 7:07pm. Resident A is listed as a resident present during the drill. Under section, *Special problems encountered during drill*, it reads, "[Resident A] refused". This document was signed by Ms. Nowak.
- I reviewed the document Ms. Nowak provided as the direct care staff schedule for the month of February 2025. I made the following observations of this document:
    - On 2/1/25 through 2/6/25 there are no direct care staff scheduled to work at the facility. The document is blank on these dates.
    - On 2/7/25 through 2/9/25 Ms. Nowak is written, but there are no times next to her name to indicate when she is scheduled to work. Another direct care staff is scheduled on these dates from 7pm to 7am.
    - On 2/10/25, 2/11/25, 2/13/25 there is a direct care staff scheduled from 8am to 6pm, and another direct care staff scheduled from 7pm to 7am. There is not a direct care staff scheduled from 7am to 8am or 6pm to 7pm on these dates.
    - On 2/12/25 a direct care staff is scheduled from 8am to 6pm. There is writing on the bottom of this date that appears illegible.
    - On 2/14/25, 2/15/25, 2/16/25 Ms. Nowak is the only name listed on the schedule covering the entire 24-hour periods of these dates.
    - On 2/17/25 & 2/18/25 there are two direct care staff scheduled to cover the entire 24-hour period.
    - On 2/19/25 a direct care staff is scheduled from 8am to 5pm and another direct care staff is scheduled from 6pm to 8am. There is no direct care staff scheduled to cover from 5pm to 6pm on this date.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(1) A licensee shall have a written emergency procedure and evacuation plan to be followed in case of fire, medical, or severe weather emergencies. The evacuation plan shall be prominently posted in the home. Residents who require special assistance shall be identified in the written procedure. **(4) A licensee shall ensure that residents, all employees, volunteers under the direction of the licensee, and members of the household are familiar with emergency and evacuation procedures.**
ANALYSIS:	Based upon interviews conducted with Ms. Nadeau & Ms. Nowak, as well as review of Resident A's resident record, fire drill records, and the employee schedule for the month of February 2025, it can be determined direct care staff & Ms. Nowak have been allowing Resident A to refuse to participate in required fire drill practices based upon direct care staff members inability to transfer Resident A from her bed to a wheelchair. It was reported by Ms. Nadeau & Ms. Nowak that the facility is only staffed with one direct care staff member per shift and that Resident A requires at least two strong, direct care staff to assist her with a transfer from her bed to a wheelchair. It was also observed on the employee schedule that was provided by Ms. Nowak for the month of February 2025 that the facility is generally scheduled with only one direct care staff member per shift. There were also times when there were no direct care staff members scheduled to cover shifts. The fire drill documents reviewed indicated that on 11/10/24 & 1/20/25 Resident A refused or was otherwise unable to participate in the scheduled fire drill. Ms. Nadeau & Ms. Nowak did not have a plan in place at the time of the on-site investigation to provide for Resident A's evacuation from the facility in the event of an emergency. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 2/19/25 I conducted a walkthrough of the facility. When I observed Resident B's bedroom, I found her bed to have been removed from the bedframe. The bedframe was sitting out in the area where direct care staff keep

resident documentation. Resident B's box springs for her bed were broken as I observed them to be cracked down the side and bent inward. Resident B's mattress was laying on top of the damaged box springs and was sunken down in the middle where the box springs were broken. I interviewed Resident B during this on-site investigation. Resident B reported that her bed broke about two weeks ago. She reported that an exterminator had come to the facility, and it was reported to her that when the exterminator was spraying in her bedroom, the bed was broken. Resident B was unsure how this happened. Resident B reported that Ms. Nowak attempted to repair the bed, but this attempt was unsuccessful. She reported that Ms. Nowak has not made any mention to her about how to go about repairing or replacing the broken bed. Resident B reported that she has been sleeping on this broken bed for the past two weeks. She reported that she would like to have a bed that is not broken.

During the on-site investigation on 2/19/25 I interviewed Ms. Nowak regarding Resident B's broken bed. Ms. Nowak reported that she thinks the bed was damaged over the weekend of 2/15/25. Ms. Nowak reported that she attempted to repair the bed but was unsuccessful. She reported that she had the bed frame removed and left the broken box spring and mattress laying on the ground in Resident B's bedroom. She reported that Resident B has been sleeping on this damaged bed since at least the weekend of 2/15/25. I inquired what steps Ms. Nowak had taken to repair or replace the damaged bed. Ms. Nowak reported that her husband was going to go to Walmart and buy a new bed. I asked if she had ordered a bed from Walmart. Ms. Nowak reported that her husband was just going to drive to Walmart and buy one. Ms. Nowak stated she did not know if the local Walmart sold box springs and mattresses in the store even though this was the plan. Ms. Nowak stated she did not know the reason the broken box springs and bed frame had not been replaced even though Resident B had been sleeping on the broken ones for at least four days. Ms. Nowak stated she did not know why a bed from and box spring from an unoccupied resident room had not been used to replace Resident B's broken bed frame and box spring. During my walkthrough of the facility, I observed multiple vacant resident bedrooms with available and functional beds.

On 2/20/25 I made a telephone call to Ms. Nowak. Ms. Nowak reported that she had moved Resident B to another resident bedroom at the facility which had a functional bed. She reported that Resident B agreed with this transition.

On 2/20/25 I interviewed Ms. Brugel, via telephone. Ms. Brugel reported that she works with Resident B and visits her at the facility. She reported that her last visit with Resident B occurred on 1/31/25. She reported that Resident B had a working bed that was not damaged on this date.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long.

	The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a water bed is not prohibited by this rule.
ANALYSIS:	Based upon interviews conducted with Ms. Nowak, Resident B, and Ms. Brugel, as well as observations made during the on-site investigation it can be concluded that Resident B did not have a bed available for her use that was in good condition and capable of providing adequate support at the time of the on-site investigation. Whether the bed was damaged two weeks prior to this visit, as Resident B indicates, or days prior, Ms. Nowak did not utilize critical thinking skills to resolve this issue for Resident B. There were beds available in the facility that were in good repair that could have been offered to Resident B when her bed was damaged. Ms. Nowak failed to consider this as an option or replace Resident B's bed with a new bed in a timely manner. As a result, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 2/20/25 I conducted a telephone conversation with Ms. Nowak. I requested that she send me a copy of the February 2025 employee schedule for my review. Ms. Nowak sent a text message including a photograph of the February 2025 employee schedule as requested. I reviewed the schedule and made the following observations:

- On 2/1/25 through 2/6/25 there are no direct care staff scheduled to work at the facility. The document is blank on these dates.
- On 2/7/25 through 2/9/25 Ms. Nowak is written, but there are no times next to her name to indicate when she is scheduled to work. Another direct care staff is scheduled on these dates from 7pm to 7am.
- On 2/10/25, 2/11/25, 2/13/25 there is a direct care staff scheduled from 8am to 6pm, and another direct care staff scheduled from 7pm to 7am. There is not a direct care staff scheduled from 7am to 8am or 6pm to 7pm on these dates.
- On 2/12/25 a direct care staff is scheduled from 8am to 6pm. There is writing on the bottom of this date that appears illegible.
- On 2/14/25, 2/15/25, 2/16/25 Ms. Nowak is the only name listed on the schedule covering the entire 24-hour periods of these dates.
- On 2/17/25 & 2/18/25 there are two direct care staff scheduled to cover the entire 24-hour period.

- On 2/19/25 a direct care staff is scheduled from 8am to 5pm and another direct care staff is scheduled from 6pm to 8am. There is no direct care staff scheduled to cover from 5pm to 6pm on this date.
- The employee schedule did not list direct care staff job titles.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Based upon the review conducted of the February 2025 employee schedule that Ms. Nowak provided, via text message photograph, it can be determined that Ms. Nowak was able to produce an employee schedule for review, but this document contained incomplete required details. The document did not account for any direct care staff scheduled from 2/1/25 through 2/6/25. The document did not identify the job titles of the direct care staff listed on the schedule. The schedule reflected periods of time when there were no direct care staff scheduled to be at the facility. Due to these findings a violation has been established as the employee schedule that was reviewed was incomplete in content.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 2/19/25, I interviewed Ms. Nadeau. Ms. Nadeau reported that Resident A is not able to be weighed at the facility due to her immobility and the direct care staff not being able to get her out of bed to be weighed. Ms. Nadeau reported that there is not a device at the facility that can weigh a bedbound resident.

During the on-site investigation on 2/19/25 I interviewed Ms. Nowak. Ms. Nowak reported that there are not current weight records available for Resident A because the direct care staff are not able to get her out of her bed to be weighed. She reported that the facility does not have the necessary equipment to weigh a bedbound resident.

During the on-site investigation on 2/19/25 I reviewed Resident A's *Resident Weight Record*. This document contained an entry on 1/1/25 which read, "Resident is unable to weigh". On 2/1/25 I observed an entry which read, "Unable to stand". There were no weights recorded on this document. This is the only *Resident Weight Record* document for Resident A that was provided by Ms. Nowak on 2/19/25.

On 2/26/25 I interviewed Ms. Villalobos, via telephone. Ms. Villalobos reported that she has been providing Home Care services to Resident A since 1/28/25. Ms. Villalobos reported that she is uncertain of Resident A's current weight as Resident A cannot bear weight on her legs. She reported that the facility is not equipped with the necessary equipment to weigh a non-weight bearing resident.

On 11/12/24 *Special Investigation Report 2025A0577002* identified a rule violation for Rule 310(3), A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years. The *Analysis* section of this report noted that the resident identified in the report was not weighed on a weekly basis as prescribed by their attending physician. It further identified that weights were recorded on the *Resident Weight Record* but there were no dates to identify when these weights were taken. The *Corrective Action Plan*, dated 11/27/24, stated, "We will require to have the order in writing and will follow it."

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

ANALYSIS:	Based upon interviews conducted with Ms. Nadeau, Ms. Nowak, & Ms. Villalobos, as well as a review of Resident A's *Resident Weight Record*, it can be determined direct care staff were not able to weigh Resident A monthly and record these weights. Therefore, a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A0577002 AND CAP DATED 11/27/24].**

IV. RECOMMENDATION

Based upon the quality of care violations cited in this Special Investigation Report and the current 1st Provisional License, a revocation of the license is recommended at this time.

3/5/25

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Jana Lipps Date
Licensing Consultant

Approved By:

03/05/2025

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Dawn N. Timm Date
Area Manager