GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 21, 2025

Connie Clauson
Leisure Living Mgt of Portage
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390016015
Investigation #: 2025A0581017
Fountain View Ret Vil 0f Port #2

Dear Connie Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations and continued quality of care 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 (517) 284-9730.

Sincerely,

Cathy Cushman

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390016015
Investigation #:	2025A0581017
Complaint Receipt Date:	02/25/2025
Investigation Initiation Date:	02/25/2025
Report Due Date:	04/26/2025
Licensee Name:	Leisure Living Mgt of Portage
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Sara Johnson
Licensee Designee:	Connie Clauson
Name of Facility:	Fountain View Ret Vil 0f Port #2
Facility Address:	7818 Kenmure Drive Portage, MI 49024
Facility Telephone #:	(269) 327-9595
Original Issuance Date:	08/01/1995
License Status:	1ST PROVISIONAL
Effective Date:	10/08/2024
Expiration Date:	04/07/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS

	Violation Established?
Resident A suffered a leg injury sometime between 02/15/2025 and 02/17/2025; however, direct care staff are unable to report what occurred despite Resident A being non ambulatory.	Yes
The licensee did not notify Resident A's responsible person after Resident A suffered an injury.	No
Additional Findings	Yes

III. METHODOLOGY

02/25/2025	Special Investigation Intake - 2025A0581017
02/25/2025	Special Investigation Initiated – Letter - Email correspondence with Complainant
02/25/2025	Contact – Document Sent – Email correspondence with Relative A1.
02/26/2025	APS Referral - Referral made via email
02/27/2025	Contact - Telephone call received - Interview with Kalamazoo Adult Protective Services specialist, Amber Price-Johnson.
03/03/2025	Contact - Telephone call made - Interview with Elizabeth Dravet, Careline Hospice nurse
03/03/2025	Contact - Document Sent - Requested Careline Hospice records for resident
03/03/2025	Contact - Telephone call made - Left voicemail with Angela Copeland, physician.
03/03/2025	Inspection Completed On-site - Interviewed staff, administrator, and requested documentation.
03/03/2025	Contact - Telephone call received - Interview with Angela Copeland, physician.
03/04/2025	Contact - Telephone call made - Interview with direct care staff, Cat Ware.
03/04/2025	Contact - Telephone call made - Left message with Brooklyn Rybarczyk

03/04/2025	Contact - Telephone call made - Left message with direct care staff Julia and Faith Flemming.
03/04/2025	Contact - Telephone call made - Interview with direct care staff, Tandra McKinney.
03/05/2025	Contact - Document Received - Received Careline hospice records for resident
03/06/2025	Contact - Telephone call made - Interview with Careline Hospice aide.
03/07/2025	Contact - Telephone call made - Interview with direct care staff, Tatiana Reed.
03/10/2025	Contact - Document Sent - Requested resident's death certificate.
03/10/2025	Contact - Document Received - Received death certificate from vital records
03/10/2025	Contact - Document Sent - Requested WMed pathology and/or investigative report.
03/10/2025	Contact - Document Received - Received email from WMed the report was not completed.
03/12/2025	Contact - Document Received - Email from Relative A1.
03/13/2025	Contact - Document Sent - Email sent to Relative A1.
03/25/2025	Contact - Document Received - Email from Relative A1.
03/28/2025	Contact - Document Sent - Email sent to Relative A1.
04/02/2025	Contact - Telephone call made - Interview with direct care staff, Brooklyn Rybarczyk
04/02/2025	Contact – Document Sent – Email to WMed requesting update on investigative report.
04/04/2025	Contact - Telephone call made - Follow up interview with Tandra McKinney
04/04/2025	Contact - Face to Face - Re-interview with direct Jessica Kellogg
04/04/2025	Inspection Completed-BCAL Sub. Non-Compliance

04/04/2025	Contact - Document Received - Email from Relative A1.
04/07/2025	Contact - Document Sent - Requested any police report from Portage Police Dept. involving resident.
04/07/2025	Contact - Document Sent - Email sent to Relative A1.
04/07/2025	Contact – Document Received – Portage Police Department case report # 2025-00005882
04/08/2025	Contact – Document Received – Email from Relative A1.
04/08/2025	Contact – Document Sent – Email to Sara Johnson.
04/08/2025	Contact – Document Received – Email from Sara Johnson.
04/08/2025	Contact – Telephone call made – Interview with Sara Johnson.
04/17/2025	Contact – Telephone call made – Left voicemail with the licensee designee, Connie Clauson.
04/17/2025	Contact – Document Sent – Email to Connie Clauson.
04/21/2025	Contact – Telephone call made – Left another voicemail with Connie Clauson.
04/21/2025	Exit conference with Administrator, Sara Johnson, via telephone.

ALLEGATION: Resident A suffered a leg injury sometime between 02/15/2025 and 02/17/2025; however, direct care staff are unable to report what occurred despite Resident A being non ambulatory.

INVESTIGATION: On 02/25/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged sometime between 02/15/2025 and 02/17/2025 Resident A broke her ankle; however, the complaint documented none of the facility's direct care staff could report how Resident A broke her ankle despite Resident A being totally dependent on direct care staff with transferring, mobility assistance, personal care, and all activities of daily living. The complaint alleged Resident A is either in her bed or in a wheelchair.

The complaint further alleged on 02/17/2025, Resident A's hospice nurse notified Relative A1 that Resident A had a swollen right ankle and leg and required x-rays. The complaint alleged Resident A was diagnosed with a displaced distal fracture of

the right fibula and needed surgery to fix the injury; however, the complaint alleged surgery was not an option. The complaint alleged there was no documentation of how Resident A broke her ankle and direct care staff who worked that weekend did not report seeing anything unusual or out of the ordinary.

On 02/25/2025, I received email correspondence from Complainant identifying Resident A's guardian and Power of Attorney as Relative A1. Complainant also documented Resident A's involvement with Careline Hospice agency. Complainant documented Resident A's injury should have been surgically repaired but Resident A was not physically or mentally strong enough to withstand the surgery.

On 02/27/2025, I interviewed Kalamazoo County Adult Protective Services specialist, Amber Price-Johnson via telephone who stated Resident A passed away on 02/26/2025. Amber Price-Johnson stated she visited the facility and direct care staff were unable to explain how Resident A obtained her injury.

On 03/03/2025, I interviewed Elizabeth Dravet, Careline Hospice nurse, via telephone. Elizabeth Dravet's statement was consistent with the allegations. She stated Resident A was admitted to the facility on or around November 2024 and had been non ambulatory since approximately August 2024. She confirmed Resident A passed away on 02/26/2025. Elizabeth Dravet also confirmed Resident A required a Hoyer lift when being transferred and utilized half bed rails.

Elizabeth Dravet stated Resident A had been stable on hospice prior to obtaining the leg injury. She stated Resident A was not a candidate for surgery to repair the injury because she was on hospice. She stated in order for surgery to have taken place, Resident A would have to have been discharged from hospice, which was not in Resident A's best interest. Elizabeth Dravet stated after sustaining the injury, Resident A was constantly in pain and gradually stopped eating. Elizabeth Dravet stated Resident A's injury contributed to her decline in health, which led to her dying sooner.

Elizabeth Dravet stated Careline Hospice staff were contacted by the facility's direct care staff at approximately 10:47am on 02/17/2025 to report swelling of Resident A's right ankle. She stated she arrived at the facility at approximately 12:30 pm and after observing the condition of Resident A's leg an order was placed for a mobile x-ray. She stated direct care staff, Jessica [Unknown] and Brooklyn [Unknown], which were later identified as Jessica Kellogg and Brooklyn Rybarczyk, worked together that morning and reported to her Resident A was "combative" and yelling at them to not touch her leg. Elizabeth Dravet stated 90% of the time Resident A's speech is confused; however, Resident A was clear when telling staff to "get off her leg" and to not touch her ankle. Elizabeth Dravet stated Resident A's foot malformation was very obvious, as well. She stated Resident A's foot was not staying up and had dropped. Elizabeth Dravet stated she took a picture of the injury, which she forwarded to me. She stated she left the facility at approximately 1:30 pm and was notified by Careline Hospice's on-call staff at approximately 7:20 pm that evening

that Resident A had a fibula fracture on her right leg near her ankle. Elizabeth Dravet stated the fibula is one of the major bones on a person's leg.

Elizabeth Dravet stated none of the facility's direct care staff could report what happened to Resident A. She stated staff, Brooklyn Rybarczyk, reported to her she worked all weekend and observed Resident A's leg swollen on 02/16/2025; however, Elizaeth Dravet stated Brooklyn Rybarczyk reported to her she "didn't think anything of it". Elizabeth Dravet stated Resident A's swollen leg was not reported to Careline Hospice until staff, Jessice Kellogg, observed the swelling on 02/17/2025 when she and Brooklyn Rybarczyk were providing incontinence care to Resident A.

Elizabeth Dravet stated Careline Hospice had an agency aide come to the facility on 02/15/2025 to provide care to Resident A; however, the hospice aide did not report or note any issues or concerns during her visit.

I reviewed the picture of Resident A's legs taken by Elizabeth Dravet, which confirmed Elizabeth Dravet's description of Resident A's swollen right leg, ankle, and foot. It also confirmed Elizabeth Dravet's description of Resident A's right foot malformation as her right foot was observably pointed in and down.

On 03/03/2025, I interviewed Angela Copeland, Resident A's physician through Careline Hospice. Her statement to me was consistent with Elizabeth Dravet's statement to me. She also stated Resident A had been stable on hospice, but the broken leg led to her death. She stated though Resident A's pain was being controlled; it was only a matter of time before she died. She stated Resident A needed surgery for the injury; however, there would have been no way she would have gotten through given her state at the time the injury was sustained.

On 03/03/2025, I conducted an unannounced inspection at the facility. I interviewed the facility's Administrator, Sara Johnson. Her statement to me was consistent with Elizabeth Dravet's statement. She stated direct care staff, Jessica Kellogg, requested she look at Resident A's leg on 02/17/2025 after she discovered it was swollen. Sara Johnson stated after she observed Resident A's leg, she and Jessica Kellogg determined Careline Hospice needed to be contacted. Sara Johnson stated she did not work that weekend; therefore, she did not have any information relating to how Resident A could have sustained her injury.

I interviewed staff, Jessica Kellogg, who stated direct care staff, Melvina Higgins, contacted her the morning of 02/16/2025 to report the facility was short staffed and needed her assistance. Jessica Kellogg stated she came in at approximately 8 am or 8:30 am and when she arrived, Resident A was in the facility's common area sitting in her Broda chair. Jessica Kellogg stated she did not provide any personal care to Resident A while she was in the facility until 4 pm as staff, Brooklyn Rybarczyk, provided her care. Jessica Kellogg stated Brooklyn Rybarczyk would have assisted Resident A with all her personal care on 02/16/2025. Jessica Kellogg

denied assisting Brooklyn Rybarczyk with any of Resident A's personal care like changing her incontinence briefs or transferring her using the Hoyer lift.

Jessica Kellogg stated Resident A seemed "fine" when she was working in the facility. She denied Resident A appearing in any kind of pain or expressing any pain. She stated Resident A did not appear uncomfortable and did not attempt to communicate to staff anything was wrong with her. Jessica Kellogg stated Resident A was dressed and covered with a blanket; therefore, she did not observe any observable injuries on 02/16/2025. She stated Resident A was also eating and drinking like normal.

Jessica Kellogg stated she arrived to work again on 02/17/2025 at approximately 6 am. She stated she checked on Resident A at approximately 6:30 am, but Resident A was "snoring" and "sleeping like usual"; therefore, she allowed Resident A to sleep in, which was common behavior. Jessica Kellog stated around 10 am, she attempted to get Resident A dressed and ready for the day. Jessica Kellogg stated she took Resident A's blanket off and got her changed, but when she lifted her right leg to put it in her pants, Resident A said, "get off my leg right now". Jessica Kellogg stated she immediately put Resident A's leg down and when she took Resident A's sock off, she observed her swollen ankle. Jessica Kellogg stated she contacted the facility's Administrator, Sara Johnson, via text and asked her to come look at Resident A's leg. She stated she directed Brooklyn Rybarczyk to contact Careline Hospice. Jessica Kellogg stated she put pajama pants on Resident A and waited for Careline Hospice to arrive.

Jessica Kellogg stated Resident A can become "agitated" if she is left in bed too long and will therefore kick her feet around her bed. Jessica Kellogg stated when she observed Resident A that morning in bed, Resident A was on her back, with a pillow under her feet. She stated Resident A's half bed rails were up and in place. She stated she spoke to both the overnight staff, Faith and Julia Flemming-Thompson, who both denied observing anything wrong or concerning with Resident A's lower extremities. Jessica Kellogg stated both of these staff denied Resident A being in any kind of pain or discomfort during the overnight shift. Jessica Kellogg stated if Resident A was changed during the overnight shift her blankets would have to have been moved, and her feet would have to have been manipulated so her incontinence brief could have been changed. Jessica Kellogg stated Resident A's incontinence brief was dry when she arrived to work that morning; therefore, Resident A was changed at some point during the overnight shift.

During the inspection, Jessica Kellog provided me with an updated staff schedule identifying multiple direct care staff working in the facility the weekend of 02/14 through 02/17.

On 03/04/2025, I interviewed direct care staff, Cat Ware, who confirmed working in the facility on 02/15 and 2/16 during the evening and overnight shifts. She stated on 02/16, at approximately 6 pm or 6:30 pm, she and Brooklyn Rybarczyk were using a

Hoyer lift to transfer Resident A into her bed after dinner. She stated while they were changing her clothes and removing her pants, Brooklyn Rybarczyk commented to her that Resident A's foot was swollen. Cat Ware stated she and Brooklyn Rybarczyk had to move Resident A's foot to change her incontinence briefs; however, Resident A did not appear to be in any pain or discomfort during that time. Cat Ware stated she did not recall observing Resident A's foot in any compromising positions either or recall Resident A's foot hitting anything while they were transferring her in the Hoyer lift. Cat Ware denied contacting anyone, including Careline Hospice, regarding the swelling in Resident A's foot.

On 03/05/2025, I reviewed Resident A's Careline Hospice records. According to my review of these records, Elizabeth Dravet, visited Resident A at the facility on 02/10/2025. She documented Resident A's pain was managed at an acceptable level and no concerns were noted. She documented in her narrative that staff were instructed "TO CALL CARELINE 24/7 WITH QUESTIONS, CONCERNS, CHANGES IN PATIENT CONDITION, FALLS, OR SYMPTOMS NOT CONTROLLED". Resident A was also visited with a Careline Hospice aide for approximately 30 minutes at approximately 4 pm on 02/10/2025 whereas no issues or concerns were identified.

Careline Hospice records confirmed another agency hospice aide came to the facility on 02/15/2025, stayed for approximately 54 minutes and left at approximately 12:38 pm. There were no issues or concerns identified in the documents while the hospice aid visited Resident A.

There were no Careline Hospice records documenting any facility staff contacted Careline Hospice to report Resident A's swollen leg prior to 02/17.

The Careline Hospice records, dated 02/17/2025, completed by Elizabeth Dravet, documented Brooklyn Rybarczyk contacted the agency's office to "REPORT SWOLLEN AND PAINFUL RIGHT LOWER EXTREMITY". Elizabeth Dravet documented Resident A did not appear to be in pain at rest but was in "OBVIOUS PAIN AND SAYING "STOP TOUCHING THAT ANKLE" when Elizabeth Dravet attempted to assess her ankle/leg. Elizabeth Dravet documented Resident A's foot was resting "AT AN ODD ANGLE AND INCREASED PAIN IN LOWER LEG WHEN PALPATED". She documented Resident A's left leg had no swelling and was not painful to Resident A. Elizabeth Dravet documented she encouraged ice if Resident A could tolerate it. She stated after contacting Angela Copeland, an x-ray of the right hip to right ankle was ordered, in addition to, the medication Norco for pain management. Elizabeth Dravet documented Resident A was not administered any PRN or as needed pain medication in the past 24 hours. She documented staff were unable to explain what happened, but documented Brooklyn Rybarczyk "…WAS ON ALL WEEKEND AND STATES SHE NOTICED THE INJURY YESTERDAY."

Careline Hospice records, dated 02/20/2025, completed by Elizabeth Dravet, documented the necessity to implement "COMFORT MEASURES" for Resident A as it would be difficult for her to overcome her current status. Elizabeth Dravet

documented Resident A had “UNCONTROLLED PAIN AND ANXIETY WITH NEW BROKEN LEG.”

On 03/06/2025, I interviewed Heather Adrianson, Careline Hospice aide, who visited Resident A on 02/15/2025. She stated she visited with two other residents on hospice at the facility but visited with Resident A last. She could neither recall the actual time she visited Resident A in the facility nor the names of facility staff working at the time of her visit. She stated when arrived at the facility, Resident A was already in her Broda chair. She stated Resident A was covered with a blanket; therefore, she did not observe any injuries. She denied Resident A expressing any pain or discomfort; therefore, she did not have any concerns. She also denied staff reporting any concerns regarding Resident A; however, she stated she only interacted with staff when they were letting her in and out of the facility.

On 03/07/2025, I interviewed direct care staff, Tatiana Reed, who worked 02/14 and 02/15 in the facility. She stated she worked on 02/15 from approximately 3 pm until approximately 6:15 am on 02/16. She stated nothing unusual occurred with Resident A during that time nor was she aware of any incidences that could have caused or contributed to Resident A’s leg injury. She denied Resident A expressing any pain or discomfort during that time.

On 04/02/2025, I interviewed direct care staff, Brooklyn Rybarczyk, via telephone. Her statement was consistent with staff, Cat Ware’s, statement; however, Brooklyn Rybarczyk, identified staff, Tandra McKinney, as working rather than Cat Ware. Brooklyn Rybarczyk stated she and staff, Tandra McKinney, worked 02/16 from approximately 6 am until 2 pm. She stated near the end of her shift, she assisted Resident A with getting into bed and getting dressed when she observed Resident A's swollen leg, which she recalled was her left leg. She stated Resident A’s leg was observably “tight”; however, she stated she did not observe any discoloration or obvious wounds. Brooklyn Rybarczyk stated she was able to get Resident A’s pants on fine; however, while putting on Resident A’s socks, Resident A reported “ow, ow, ow” and “don’t touch it”. Brooklyn Rybarczyk stated she “didn’t think anything of it” and attributed it to Resident A retaining water. She denied Resident A expressing any pain other than when staff touched her leg. She denied giving Resident A any PRN or as needed pain medication either. She stated she only discovered Resident A broke her leg when she came into work approximately three days later. Brooklyn Rybarczyk stated she was aware Resident A was on hospice.

Brooklyn Rybarczyk’s statement was inconsistent with Cat Ware’s and Jessica Kellogg’s statements as she stated Tandra McKinney instructed her to contact Jessica Kellogg after she observed Resident A’s swollen leg. Brooklyn Rybarczyk stated Jessica Kellogg instructed her to contact Resident A’s physician, as well, which she stated she did. She stated Resident A’s physician instructed her to monitor Resident A and put ice on the leg to reduce swelling. She stated Resident A’s physician ordered x-rays via a portable machine, which Brooklyn Rybarczyk stated showed up the next day.

On 04/04/2025, I re-interviewed direct care staff, Tandra McKinney, who confirmed she did not work on 02/16 or 02/17 in the facility.

I reviewed the facility's staff schedule and Paycor time sheets for 02/15 and 02/16 and determined Tandra McKinney, Brooklyn Rybarczyk, Tatiana Reed, and Cat Ware worked in the facility on 02/15 while Jessica Kellogg, Brooklyn Rybarczyk, Cat Ware, Faith Flemming-Thompson, and Julia Flemming-Thompson worked in the facility on 02/16.

On 04/04/2025, I re-interviewed direct care staff, Jessica Kellogg. She stated Brooklyn Rybarczyk did not contact her on 02/16 to report any concerns regarding Resident A. She stated she only became aware of Resident A's swollen leg on 02/17 at approximately 10 am. Jessica Kellogg stated if Brooklyn Rybarczyk or any other direct care staff contacted her on 02/16 about Resident A's leg being swollen, she would have contacted Careline Hospice to inform them and followed their instruction and direction on what kind of medical attention Resident A needed.

According to SIR #2024A0581026, dated 08/02/2024, the facility was in violation of Adult Foster Care administrative Rule 400.15310(4) when it was established after interviews with the facility's direct care staff and Transitions Hospice personnel that the facility's direct care staff did not obtain medical attention for a resident or contact the resident's hospice agency after the facility's staff observed the resident being held down by a facility staff member and significant bruises were observed on the resident's hands, wrists and arms after the incident occurred.

The facility's approved Corrective Action Plan (CAP), dated 08/26/2024, documented the facility's staff would attend a mandatory in-service, no later than 10/15/2024, to review the appropriate steps to take in the event of a sudden adverse change in a resident's physical condition. The CAP also documented that no later than 10/15/2024, staff would review proper notification procedures by when a resident is receiving hospice services, these staff would practice appropriate documentation of incidents, and the facility's Resident Care Manager and the leadership team would review and improve procedures to follow when a resident experiences a change in physical condition. The CAP documented the procedure would be implemented to ensure proper response to a change in condition no later than 10/15/2024.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on my investigation, which included interviews with Complainant, Careline Hospice registered nurse and case manager, Elizabeth Dravet, Careline Hospice physician, Angela Copeland, Careline Hospice aide, Heather Adrianson, multiple direct care staff, and a review of Resident A's Careline Hospice documentation, the facility's direct care staff did not attend to Resident A's personal needs, or provide her with protection and safety when staff were unable to report how Resident A suffered a leg injury that resulted in a fractured fibula sometime between 02/15/2025 and 02/17/2025. Despite direct care staff, Brooklyn Rybarczyk, admitting to both licensing and Careline Hospice she was aware of Resident A's leg being visibly swollen on 02/16 there is no record of her contacting any staff to report her observations of Resident A's injury or any record of her contacting Resident A's physician through Careline Hospice despite Careline Hospice informing the facility's staff to notify them if there were any changes to Resident A's physical condition on 02/10/2025. Subsequently, due to Resident A being on hospice, she was unable to obtain surgery to fix her fractured fibula. Additionally, based on interviews with Careline hospice personnel, it is believed Resident A's broken leg and uncontrollable pain associated to the injury contributed to her subsequent death on 02/26/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Direct care staff, Brooklyn Rybarczyk, worked at the facility on 02/16/2025 and stated to both Licensing and Careline Hospice nurse, Elizabeth Dravet, that she was aware of Resident A's swollen leg on 02/16; however, she "thought nothing of it". Additionally, direct care staff, Cat Ware, also stated she observed Resident A's swollen leg on 02/16. Though Brooklyn Rybarczyk stated she notified other direct care staff of Resident A's swollen leg there is no record any direct care staff reported Resident A's change in physical condition to Careline Hospice despite staff being instructed to do so. Subsequently, the facility's direct care staff, specifically Brooklyn Rybarczyk and Cat Ware, did not seek medical attention or notify Resident A's hospice agency upon discovering Resident A's change in physical condition on 02/16, as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SEE SIR 2024A0581026, DATED 08/02/2024, CAP DATED 08/26/2024**

ALLEGATION: The licensee did not notify Resident A's responsible person after Resident A suffered an injury.

INVESTIGATION: The complaint alleged no one from the facility notified Resident A's responsible person, Relative A1, after Resident A suffered a leg injury on or around 02/15 through 02/17. The complaint alleged it took the facility's Administrator four days before speaking to Relative A1.

According to Careline Hospice's documentation, dated 02/17/2025, Elizabeth Dravet informed Resident A's Durable Power of Attorney (DPOA), Relative A1, of Resident A's injury. It documented Relative A1 agreed to Careline Hospice's request for an x-ray and pain management orders to address the injury.

I reviewed the facility's AFC Licensing Division – Incident / Accident Report (IR), dated 02/17/2025, which was completed by direct care staff, Jessica Kellogg. According to the IR, Jessica Kellogg documented she "…told the med tech to call hospice + family, and take vitals". The IR identified the other staff involved as Brooklyn Rybarczyk. The IR, which has lower section identified for person(s) notified, did not document how or when hospice and Relative A1 were notified of the incident.

Jessica Kellogg's statement to me was consistent with what she documented in the facility's IR; however, Brooklyn Rybarczyk, stated she only contacted Careline Hospice on 02/17/2025.

According to my review of Resident A's DPOA documentation, dated 09/03/2010, Relative A1 was appointed as Resident A's DPOA.

Resident A's *Resident Care Agreement* (RCA) did not identify Resident A's DPOA or responsible person as there were no required signatures on the RCA; however, the facility's Administrator, Sara Johnson, stated Relative A1 was Resident A's responsible person and DPOA. She stated she spoke to Relative A1 the day of Resident A's injury was discovered and assessed by Careline Hospice.

APPLICABLE RULE	
R 400.15311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(a) Unexpected or unnatural death of a resident.** **(b) Unexpected and preventable inpatient hospital admission.** **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.** **(d) Natural disaster or fire that results in evacuation of residents or discontinuation of services greater than 24 hours.** **(e) Elopement from the home if the resident's whereabouts is unknown.**
ANALYSIS:	Relative A1 was appointed Resident A's Durable Power of Attorney on 09/03/2010 and was identified as Resident A's designated representative and DPOA by the facility's Administrator, Sara Johnson. Despite Resident A sustaining an injury on or around 02/17/2025, it did not constitute the licensee reporting the injury to Relative A1 within 48 hours because Resident A was not admitted to the hospital for treatment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: I reviewed Resident A's *Resident Care Agreement* (RCA); however, there were no signatures on the RCA from any of the required parties including the licensee designee, Resident A and/or Resident A's designated representative and/or Resident A's responsible agency, if applicable, to demonstrate all the required parties participated in the review of the RCA at the time of Resident A's admission to the facility on 11/27/2024, as required.

On 04/08/2025, Administrator, Sara Johnson, reiterated via telephone what she documented in an email sent to me on 04/08/2025, which was Resident A's RCA was not signed because Resident A passed away prior to her obtaining signatures. She stated she was unable to locate the RCA completed for Resident A at the time of her admission to the facility.

According to the facility's 2024 Renewal Licensing Study report (LSR), dated 09/05/2024, the facility was in violation of Adult Foster Care administrative Rule 400.15301(9) when it was established resident RCA's were not being reviewed and signed by the appropriate persons/parties, as required. The renewal LSR documented the licensee designee did not review five out of six of the RCA's as they were either signed by the licensee's Regional Director or the licensee's formerly identified Executive Director; neither of which had been appointed as the facility's Administrator or designated by the licensee to sign AFC documents. Additionally, four residents had outdated RCAs and had not been reviewed annually, as required and one resident did not have an RCA available for review.

The facility's approved CAP, dated 10/07/2024, documented the licensee designee would appoint in writing a person designated to sign on behalf of the licensee, and the designation would be updated anytime there was a change in personnel. The CAP also documented all overdue annual RCA's would be completed and signed by the Administrator, or the person designated by the licensee designee, the resident or the resident's designated representative, and responsible agencies no later than 10/30/2024. Additionally, the CAP documented all annual RCA's would be completed and signed by January of each year and placed in the resident's file. The CAP documented the Administrator or person designated by the licensee designee would be responsible for ongoing compliance with this plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.

ANALYSIS:	Resident A's Resident Care Agreement was not reviewed or signed by the appropriate parties like the licensee designee, Resident A or Resident A's designated representative or Resident A's responsible agency, as required; despite her being admitted to the facility on or around 11/27/2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SEE RENEWAL LSR DATED, 09/05/2024, CAP DATED, 10/08/2024.**

On 04/21/2025, I conducted the exit conference with Administrator, Sara Johnson, via telephone after being unable to contact the licensee designee, Connie Clauson, via telephone or email on 04/17 or 04/21. I explained my findings and recommendation to Sara Johnson. She stated she conducted a staff meeting on 04/03, which addressed the licensee's expectation of staff when a resident experiences a change in condition. She stated she reiterated to staff they need to contact the facility's managers, the resident's care provider, and the resident's responsible person, if applicable, when there is a change in condition. She stated due to the facility hiring more staff, she planned to conduct another staff meeting on 04/23 to go over this instruction and expectation again. I recommended Sara Johnson provide staff with examples of changes in conditions for further clarification.

IV. RECOMMENDATION

Due to the continued quality of care violations and repeat violations, I recommend revocation of the facility's license.

Cathy Cushman

04/09/2025

Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

04/14/2025

Dawn N. Timm Date
Area Manager