GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 13, 2019

Thomas Zmolek
MOKA Non-Profit Services Corp
Suite 201
715 Terrace St.
Muskegon, MI 49440

RE: License #: AS410294135
Investigation #: 2019A0357005
68th Street

Dear Mr. Zmolek:

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

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

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days.

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) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
This report contains quoted profanity

I. IDENTIFYING INFORMATION

License #:	AS410294135
Investigation #:	2019A0357005
Complaint Receipt Date:	12/14/2018
Investigation Initiation Date:	12/14/2018
Report Due Date:	02/12/2019
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201, 715 Terrace St., Muskegon, MI 49440
Licensee Telephone #:	(231) 830-9376
Administrator:	Thomas Zmolek
Licensee Designee:	Thomas Zmolek
Name of Facility:	68th Street
Facility Address:	1777 68th Street, Caledonia, MI 49316
Facility Telephone #:	(616) 554-3091
Original Issuance Date:	02/28/2008
License **Status:**	REGULAR
Effective Date:	08/09/2018
Expiration Date:	08/08/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct Care Staff Rachel Siefken curses at Resident A, refuses to talk to her and told her she did not “give a fuck” what she thought.	Yes
Direct Care Staff, Staff Rachel Siefken, made Resident A shovel snow in the backyard.	Yes
Direct Care Staff, Rachel Siefken made Resident A stay on the exercise bike from 10:00 PM until 11:00 PM.	Yes
If Resident A complains about dinner, Ms. Seifken will dump Resident A’s dinner and then make her eat grits with whatever Ms. Seifken feels like adding into it.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/14/2018	Special Investigation Intake 2019A0357005
12/14/2018	Special Investigation Initiated - Telephone To network 180, Melissa Gekeler.
12/13/2018	Contact - Document Received On 12/13/2018 I received a message from Ms. Gekeler that we would meet at the home at 2:00 PM.
12/13/2018	Inspection Completed On-site Received the complaint and went with Melissa Gekeler to the home. I inspected Resident A's file and other facility documents.
12/13/2018	Contact - Face to Face On 12/13/2018, Conducted interviews with the Program Manager, Milicent Mutisya, Direct Care Staff, Jodi Boire, Resident A and Direct Care Staff, Rachel Siefken.
12/13/2018	Contact - Document Received Received a copy of the Recipient Rights complaint On 12/13/2018.
01/10/2019	Contact - Telephone call made Telephoned the home and spoke with staff.
01/23/2019	Contact - Telephone call made Telephoned the MOKA Regional office.

02/01/2019	Contact - Document Received Received Ms. Gekeler's Report of Investigative Findings.
02/05/2019	Contact - Telephone call made Conducted telephone interviews with Direct Care Staff: Deb Pakkala, Emiley Culbertson, and Reanal Waylee.
02/06/2019	Contact - Telephone call made Conducted telephone interviews with Direct Care Staff, Leonard Chemweno and Francoise Bukasa.
02/06/2019	Contact - Telephone call made To Program Manager, Millicent Mutisya.
02/12 /2019	Exit conference by telephone with Mr. Thomas Zmolek, the Licensee Designee.

ALLEGATION: Direct Care Staff Rachel Siefken curses at Resident A, refuses to talk to her and told her she did not “give a fuck” what she thought.

INVESTIGATION: On 12/13/2018 I received a copy of the Recipient Rights Complaint. "Rachel Siefken sometimes she refuses to talk to (Resident A) and last week she told (Resident A) "She did not give a fuck for what (Resident A) feels."

On 12/13/2018, Ms. Gekeler and I interviewed the Program Manager, Milicent Mutisya. She reported that a staff had reported to her what had occurred between Resident A and Ms. Siefken. Her verbal testimony was consistent with the written complaint. She reported that there were only two staff working on second shift and that the residents, other than Resident A, would not be able to tell us what had happened due to their disability.

On 12/13/2018, Ms. Mutisya provided Resident A's file. I reviewed her Individual/Family Plan of Service (IPS) dated 06/06/2018, signed Assessment Plan, Behavioral Guideline/Maintenance Plan, Behavior Treatment Plan and her Health Care Appraisal signed on 04/16/2018. I also reviewed her document entitled Routines and Personal Preferences. Resident A is diagnosed with Asperger's, Explosive Personality, dementia and chronic insomnia. She has ongoing confusion, disorientation and problems with disorganization. She is prescribed psychotropic medications. The IPS stated that the staff had been trained in her behavioral treatment plan and in her Guidelines. These documents stated that Resident A has been experiencing increased confusion and memory loss and that she benefits from following a daily schedule. She has fears of "corporal punishment," possibly due to events in her past and it is important for staff to reassure her that she is safe. Routine is very important to her.

On 12/13/2018, Ms. Gekeler and I conducted an interview with Direct Care Staff, Jodi Boire. She stated she worked with Ms. Siefken last week Wednesday and Friday, (12/05 and12/07/2018). She reported that Resident A attempted to talk to Ms. Siefken and she observed Ms. Siefken turn her back on her and Ms. Sidfken stated she would not talk to her unless she had too. She stated further that Resident A complained to her (Ms. Boir) that Ms. Siefken would not talk to her. Ms. Boire said she heard Resident A say "Hi," to Ms. Sidfken who turned and walked away. Ms. Boire stated that Ms. Siefken swears at Resident A by saying to her, "I don't give a fuck how you feel," and she told Resident A "to shut the fuck up." She said there were no other witnesses.

On 12/13/2018, Ms. Gekeler and I conducted an interview with Direct Care Staff, Rachel Siefken and she denied that she had ignored Resident A. She also denied swearing at Resident A or using the word "Fuck." She then said she has told Resident A that she could not talk to her right now and explained that when she says this, she is trying to tell her that she is busy. Ms. Siefken acknowledged that she probably has turned her back to Resident A.

On 12/13/2018, Ms. Gekeler and I conducted an interview with Resident A. Resident A denied that Ms. Siefken ignores her or swears at her.

On 02/01/2019, I received a copy of Ms. Gekeler's investigative report. She found a preponderance of evidence to substantiate a violation of Dignity and Respect by Rachel Siefken

On 02/05/2019, I conducted a telephone interview with Deb Pakkala, the Records Assistant. She stated that she had worked shifts with Ms. Siefken and has witnessed her ignoring Resident A and not not answering her if Resident A spoke to her. Ms. Pakkala confronted her behavior toward Resident A and she said, Ms. Siefken told her that Resident A had to learn to respect her back. Ms. Pakkala reported that she has not heard Ms. Siefken swear at Resident A. She also reported that due to her mental illness, and symptoms of dementia, Resident A has problems with her memory, but she does remember what has happened to her the night before and she does tell staff what has happened to her.

On 02/05/2019, I conducted a telephone interview with Direct Care Staff, Emily Culbertson. She stated she had worked second shifts with Ms. Siefken and has frequently observed Ms. Seifken ignore Resident A. She said that Ms. Seifken came to work and Resident A would say 'Hi' to her and she would walk away from Resident A and ignore her. She said that Resident A would say to Ms. Seifken, 'You told me I was going to hell and I can't talk to you when I am in hell.' She said Ms. Seifken did not respond to Resident A. She reported she had heard Ms. Seifken call Resident A an "Ass hole" to her face and this happened several times.

On 02/12 /2019 I conducted a telephone exit conference with the Licensee Designee, Thomas Zmolek, and he agreed with my findings because the said here was a preponderance of evidence.

APPLICABLE RULE	
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: **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	A Recipient Rights complaint alleged that Direct Care Staff, Rachel Siefken, ignores and swears at Resident A. Direct Care Staff, Jodi Boire, and Emily Culbertson acknowledged that Ms. Siefken ignores and swears at Resident A.

	Ms. Siefken denied ignoring or swearing at Resident A but acknowledged that she probably has turned her back to Resident A. Resident A denied the allegations, but she has been diagnosed with dementia, confusion and memory loss. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Siefken was verbally abusive and emotionally cruel to Resident A by ignoring and swearing at her.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct Care Staff, Staff Rachel Siefken, made Resident A shovel snow in the backyard.

INVESTIGATION: On 12/14/2018, I received a complaint that read: "…Rachel makes (Resident A) go outside and shovel snow in the back yard…Also on 12/5/2018, Rachel dumped water on the floor and made (Resident A) wash the entire floor throughout the home."

On 02/06/2019, I conducted a telephone interview with Records Assistant, Deb, Pakkala. She explained that on 12/06/2018, Resident A told her that she and Ms. Siefken went out to shovel but she (Resident A) did the shoveling and she shoveled to the back fence by herself. She then asked Resident A about this and Resident A said, "I had to go by myself, in the dark to shovel."

On 12/13/2018, Ms. Gekeler and I conducted an interview with Direct Care Staff. Jodi Boire. She explained that she worked second shift with Ms. Siefken on 12/05/2018. Resident A started screaming and Ms. Siefken said, "I'll take her, and she will listen to me and she will fall in step." Ms. Boire stated Ms. Siefken then went and got the shovel and went to the patio with Resident A and instructed Resident A to shovel the snow to the fence. Ms. Boire stated that while Resident A was shoveling Ms. Siefken stood there and watched her shovel. We asked Ms. Boire if Ms. Siefken had asked Resident A if she wanted to shovel and she reported, "No, she just told (Resident A) what to do." Ms. Boire explained that Resident A is to have a choice on what activity she engages in, but Ms. Siefken did not offer her a choice but told her she was going to shovel the snow in the back yard. Ms. Boier explained on 12/05/2018, Ms. Siefken told her that Resident A had a bad night and she was resistive, so she had a bucket of water and she threw the water all over the floor for her to clean up. Ms. Boier stated Ms. Siefken told her she had to keep (Resident A) busy with an activity, so she had her mop the entire floor, even though it was not an action chore listed on her activity list.

On 12/13/2018, I reviewed Resident A's Behavior Treatment Plan. "The Definition of Behavior for Verbal Outburst: This behavior is defined as times when (Resident A) screams for longer than 5 minutes during the day or longer than 2 minutes consecutively. It may also include threatening to harm others or herself. A new episode is counted after 5 minutes of calm or after 15 consecutive minutes of the behavior." The proactive measures/setting up the environmental for success: (Resident A) should have a visual schedule that she sets up with staff at the beginning of each day. The schedule should have a balance of activities she completes independently and those she does with staff. Remember (Resident A) enjoys spending time with staff even if they are just checking on her when she is doing something, she can do for herself." According to Ms. Boire, Ms. Siefken did not follow the plan. She just told Resident A to shovel the snow.

On 1213/2018, I reviewed Resident A's Assessment Plan for AFC Residents signed by the Licensee on 05/31/2018 and by Resident A's Legal Guardian on 06/25/2018. Under the section of "Participates in Household Chores," the following was typed: "(Resident A) requires partial assistance from staff to complete housework. She needs several reminders to help her stay focused. (Resident A) is able to assist with completing laundry including switching clothes to the dryer. She needs assistance with sorting clothes, putting laundry soap in the washer and setting the washing machine to the correct setting. Some days, (Resident A) has behavioral concerns that make assisting with laundry a challenge as this overwhelms her." There was no mention of shoveling snow or mopping the floor.

On 12/13/2018, Ms. Gekeler and I conducted an interview with Ms. Siefken. She reported that Resident A was screaming, and this can be very challenging. Ms. Siefken stated that Resident A "wants all the attention to be on her." With regard to making her shovel, Ms. Siefken explained that there has to be a pathway shoveled to the fence in the back yard for fire drills, so she asked Resident A if she wanted to help. She explained that when Resident A is kept busy it helps her keep calm. Ms. Siefken stated that Resident A did not object, so she shoveled. She thought she had followed Resident A's plan. When we asked her about the bucket of water, she said she put a little of water down and then helped her with mopping. She said that Resident A mopped her own bedroom.

On 02/06/2019, I conducted a telephone interview with Ms. Pakkala. She said one time, date unknown. Ms. Seifken told her that Resident A had a bad night and she was resistive, so she put water all over the floor to keep her busy mopping the entire floor. Ms. Pakkala said this was not an action chore.

On 02/06/2019, I conducted a telephone interview with Direct Care Staff, Leonard Chemweno and he reported that during his 3rd shift, (date unknown) unsolicited, Resident A told him that she shoveled snow and she washed the floors.

On 02/12/2019 I conducted a telephone exit conference with Thomas Zmolek, the Licensee Designee, and he said he agreed with my conclusions, but he did not

agree that Mr. Chemweno was a witness because Resident A told him about the incident.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(2) All work that is performed by a resident shall be in accordance with the written assessment plan.
ANALYSIS:	It was alleged that Direct Care Staff, Rachel Siefken, made Resident A shovel the snow in the back yard. Ms. Siefken also put water on the floor for Resident A to mop. Direct Care Staff, Ms. Pakkala stated that Resident A told her that Ms. Siefken made her shovel snow. Direct Care Staff, Ms. Boire stated that when she worked with Ms. Seifken, Ms. Seiffken told Resident A to shovel snow in the back yard and did not provide her with a choice. Direct Care Staff, Jodi Boire and Deb Pakkala both stated that Ms. Siefken told them that she put water on the floor for Resident A to mop up. Ms. Siefken acknowledged that she had Resident A shovel the snow in the back yard and she put water on the floor for Resident A to mop up because she had to keep her busy. Resident A's behavior Treatment Plan indicates that if Resident A screams for five minutes or longer than 2 minutes consecutively a new episode begins. The home is required to have scheduled visual activities that Resident A does independently and other activities with staff. Ms. Siefken did not follow the plan to have scheduled activities. According to Ms. Boire and Ms. Pakkala, shoveling was not on the plan. The same was true for the mopping the floor. Ms. Siefken told Ms. Boire and Ms. Pakkala that she put water on the floor, and this was not a scheduled activity. Based on the investigative findings, there is sufficient evidence to support the rule violation that Ms. Siefken did not follow the Behavior Treatment Plan in having visible activities that are scheduled either for shoveling the snow or mopping the floor. The assessment plan only identified for Resident A to help with laundry, not shoving snow or mopping the floor.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: **Direct Care Staff, Rachel Siefken made Resident A stay on the exercise bike from 10:00 PM until 11:00 PM.**

INVESTIGATION: On 12/14/2018, I received a complaint that read: "(Resident A's) bedtime is scheduled for 9:30 P.M. Last Wednesday, 12/15/18, Rachel made (Resident A) stay-up until 11 PM riding an exercise bike as punishment."

On 12/13/2018, I reviewed Resident A's file. She is a female, age 64 and diagnosed with dementia, and chronic insomnia and occasionally she does not understand or remember what she has been told.

On 12/13/2018, Ms. Gekeler and I conducted an interview with Direct Care Staff, Jodi Boire. She explained to us that she had worked with Ms. Seifken last Wednesday and Friday (12/5, and 12/7/2018). She said that on 12/05/2019, Ms. Seifken made Resident A get on the exercise bike from 9:00 PM to 12:00 PM. She reported that Ms. Seifken told Resident A; "You're going to be on the bike until 3rd shift gets here." She said every time Resident A got off the bike Ms. Seifken told her she has to get back on that bike and she told Resident A that her time had to start over. Ms. Boire stated that she perceived this to be a punishment for Resident A. Ms. Boier said that when Direct Care Staff, Leonard Chemweno, arrived for his third shift, he asked why Resident A is on the bike and she (Resident A) informed him that "Rachel made me stay on it."

On 12/13/2018, Ms. Gekeler and conducted an interview with Ms. Seifken. We asked about Resident A and the exercise bike. She reported that Resident A chose to ride the exercise bike to stay awake. She did not think it was a big deal and it was not planned. She said that Resident A use to be overweight. She said when she got off, she offered her to ride the bike again and she did. She said she did not make Resident A get back on the bike again. She said Resident A was up until 11:00 PM and she was not really tired, and she had done other things like wiping off the table and sweeping.

On 02/06/2019, I conducted a telephone interview with Direct Care Staff, Leonard Chemweno, who reported that he has worked in this home for six years. He explained that he did find Resident A on the exercise bike when he arrived at 10:55 PM. He said he asked why she was on the bike at this time and Ms. Seifken told him that Resident A had had a behavior. He stated that he asked Resident A to go to use the restroom and get ready for bed and then go to bed. He explained that Resident A has some guideline and can identify what she likes to do, and staff can do those activities with her. He said that Resident A has choices and options to make on what she wants to do. He reported that the staff will help her make her choices and then they will work with her. He also reported that Resident A's bedtime is 10:00 PM and she can start getting ready for bed at 9:30 PM.

On 02/06/2019, I again reviewed Resident A's Behavioral guideline/maintenance plan. The Goal of the guideline was for Resident A to maintain health sleep routines and sleep hygiene rituals to reduce sleep disruption. The Rationale: "(Resident A) had a goal in her behavior treatment plan over the past year which targeted improving (Resident A's) sleep hygiene…Behavioral guidelines were developed to maintain this success and to ensure environmental modifications remain in place to reduce sleep disruption as much as possible." The "Proactive Strategies/Environmental Controls: 1. Each evening before (Resident A) goes to bed, staff should continue to encourage her to follow her bedtime routines which include: Help (Resident A) brush her teeth, wash her face, and get dressed for bed. Offer (Resident A) progressive muscle relaxation exercises or abdominal breathing techniques. Offer (Resident A) a warm, decaffeinated tea and light snack (Greek yogurt, cheese and crackers, avoid sugar and simple carbs alone). Assist (Resident A) in getting in bed, remind her if she cannot fall asleep, she can continue her relaxation exercises for 5-10 minutes. If these do not work, ask her to come to talk to staff. 2. (Resident A) does best if she remains up until 10:00 PM each evening. Going to be earlier has resulted in worsening sleep cycles…" Resident A has a diagnosis of Chronic insomnia.

On 02/12/2019, I conducted a telephone interview with the Licensee Designee, Thomas Zmolek and he stated that he agreed with my findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	It was alleged that Direct Care Staff, Ms. Seifken kept Resident A up until 11:00 PM by riding the exercise bike from 9:00 PM to 11:00 PM. Ms. Boire stated that Ms. Seifken had Resident A ride the exercise bike from 9:00 PM to 11:00 PM and every time Resident A stopped Ms. Seifken told her that she would have to start over on her time. Ms. Boire reported it was for punishment of Resident A. Ms. Seifken stated Resident A wanted to ride the bike and she got off the bike she offered Resident A to ride the bike again.

	Direct Care Staff, Mr. Chemweno stated that he observed Resident A on the exercise bike when he arrived at 10:55 PM. Based on the investigation findings, there is sufficient evidence to support a rule violation that Ms. Seifken had Resident A, ride the exercise bike past her bed time. These activities and the interactions between Ms. Seifken and Resident A did not promote and encourage cooperation, self-esteem, self-direction, independence and normalization for Resident A, because Ms. Seifken choose all the activities and did not leave any choice for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: If Resident A complains about dinner, Ms. Seifken will dump Resident A's dinner and then make her eat grits with whatever Ms. Seifken feels like adding into it.

INVESTIGATION: On 12/14/2018, I received a complaint stating the following: "If (Resident A) complaints about dinner, Rachel will dump (Resident A's) dinner and then makes her grits with whatever Rachel feels like adding in to it, such as spices and various powers. Rachel will then make (Resident A) eat the grit concoction."

On 12/13/2018, Ms. Gekeler and I conducted an interview with Direct Care Staff, Jodie Borie. She reported that when she works with Ms. Seifken and Resident A complains of the meal, Ms. Seifken takes her plate with the food on it and throws the food away then she says, "you will eat grits." Then Ms. Seifken gets some grits and adds spices and other things to it and then gives it back to Resident A. She stated further that Ms. Deb Pikkala told her that she had heard Ms. Seifken say to (Resident B), "You either put your hand in your lap or I'll take your food away."

On 12/13/2018, Ms. Gekeler and I conducted an interview with Ms. Seifken, concerning Resident B. She stated, "A few times I have said I'll take your food away if you don't put your hand in your lap." Ms. Seifken also acknowledged that she has actually taken Resident B's food away but stated she then gave it back when he "settled down." We asked her about what happens when Resident A does not like the food prepared for her. She said that Resident A will ask her to make her a new meal. Ms. Seifken stated; "We can't do that, so I give her cereal and she does not like that either. I just keep asking her what she wants. Sometimes she chooses grits." She acknowledged that she does throw Resident A's food away when she refuses to eat it.

On 02/06/2019, I conducted a telephone interview with Direct Care Staff, Emily Culberrtson. She stated that when Resident A has complained about the food, Ms. Seifken has taken her plate and thrown the food out and then gave her a can of

beets. “She would add spices to it and all kinds of weird stuff and then give it to (Resident A).” She said that Ms. Seifken also gave Resident A cream of wheat with spices in it to make a “horrible concoction.” She said this happened more than once. Ms. Cullbertson said she provided Resident A with the proper food after each incident. She also reported that Ms. Seifken made Resident A stand outside in the pouring rain in her night gown and slippers and her feet were soaked. She did this because to her because Resident A was screaming. She said Ms. Seifken was screaming at her and swearing at her. She was not able to provide a date for this incident and she said there were no other witnesses. Ms. Culbertson also reported that Resident D would leave the table before he was done eating and Ms. Seifken would throw his food away. She said she gave him more food. She also stated that Resident C has Pica and he eats his fecal material, so she said that Ms. Seifken told her that she gave him a really cold shower. She then bragged to her how Resident C was afraid of her and he did not do any pica behaviors on her shift. She said there were no other witnesses to hear what Ms. Seifken had told her and Resident C can’t talk.

On 02/06/2019, I conducted a telephone interview with Deb Pakkala. She reported that the staff have to sit next to Resident B so he does not put too much food in his mouth at one time and he tries to eat his food with his hands. She said she observed Ms. Seifken sitting across from Resident B and she told Resident B to put his hands in his lap or she would take his food away.

Since I received this compliant on 12/14/2018, after our interview with Ms. Seifken, I was unable to interview Ms. Seifken concerning these issues, because she resigned her position with the home effective 01/16/2019. Ms. Gekeler’s report identified that Ms. Seifken had told Resident B to put his hands on his lap or she would take his food away. Her report stated there was a preponderance of evidence to substantiate a violation of Abuse Class III by Rachel Siefken.

On 02/12 /2019, I conducted a telephone exit conference with Mr. Zmolek, the Licensee Designee and he said he agreed with my findings.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A license shall provide a minimum of 3 regular, nutritious, meals daily, Meals shall be of proper form, consistency and temperature. Not more that 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	It was alleged that when Resident A complaints about dinner, Ms. Seifken dumps Resident A's dinner and then makes her eat grits. Direct Care Staff, Ms. Boire stated that she has witnessed Ms. Seifken, throw Resident A's meal away and make her eat grits. Ms. Seifken acknowledged she offered Resident A cereal if she did not like the meal that had been prepared. Ms. Culbertson stated that Ms. Seifken threw Resident A's food way and then gave her a can of beets with spices added to it. Based on the investigative findings, there is sufficient evidence to support the rule violation that two staff reported that Ms. Seifken threw Resident A's meals away and they were not replaced with the food items on the menu.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITTIONAL FINDINGS:

INVESTIGATION: On 12/13/2018, Ms. Gekeler and I conducted an interview with Direct Care Staff, Jodi Boire. She said last week she saw Ms. Seifken push Resident B onto the couch. She reported that Direct Care Staff, Emily Culbertson told her that she has seen Ms. Seikfen grab and twist Resident B's ear.

On 12/13/2018, Ms. Gekeler and I conducted an interview with Ms. Siefken and she denied twisting Resident B's ear and she denied that she pushed him onto the couch or the floor.

On 02/01/2019, I received a copy of Ms. Gekeler's investigative report. Her report stated that there was a preponderance of evidence to substantiate a violation of Abuse Class II-Non-Accidental Act by Rachel Siefken.
On 02/06/2019, I conducted a telephone interview with Direct Care Staff, Emily Culbertson. She reported that she saw Ms. Seifken grab, and twist Resident B's ear and push him to the floor. She also shoved him onto the couch before.

On 02/08/2019, I conducted a telephone interview with Direct Care Staff, Lana Buffer. She reported that she had seen Ms. Seifken grab Resident B's ear and twist it several times. She said she did not see her force him onto the couch or the floor.

On 02/12/2019, I conducted a telephone exit conference with Mr. Zmolek, the Licensee Designee and he said he agreed with my findings.

APPLICABLE RULE	
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: (b) Use any force other than physical force other than physical restraint as defined in these rules.
ANALYSIS:	It was alleged that Ms. Seifken had grabbed and twisted Resident B's ear and then push him down onto the couch or the floor. Direct Care Staff, Jodi Boire stated that she has observed Ms. Seifken push Resident B onto the couch. Direct Care Staff, Emily Culbertson stated that she has observed Ms. Seifken grab and twist Resident B's ear and push him to the floor. Direct Care Staff, Lana Buffer stated that she has observed Ms. Seifken grab and twist Resident B's ear several times. Ms. Seifken denied that she twisted Resident B's ear and she denied she pushed him onto the couch or the floor. Based on the investigative findings, there is sufficient evidence to support the rule violation that Ms. Seifken has used physical force by twisting Resident B's ear more than once and that she had pushed him onto the couch or the floor.
CONCLUSION:	**VIOLATION ESTABLISHED**

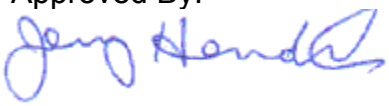
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Arlene B. Smith 02/12/2019

Arlene B. Smith Date
Licensing Consultant

Approved By:



02/13/2019

Jerry Hendrick Date
Area Manager