GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2021

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007089
Investigation #: 2021A0462023
Park Place Living Centre #A

Dear Mrs. Clauson:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390007089
Investigation #:	2021A0462023
Complaint Receipt Date:	03/02/2021
Investigation Initiation Date:	03/04/2021
Report Due Date:	05/01/2021
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Janet White
Licensee Designee:	Connie Clauson
Name of Facility:	Park Place Living Centre #A
Facility Address:	4214 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
License Status:	REGULAR
Effective Date:	07/19/2019
Expiration Date:	07/18/2021
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There was not a sufficient number of direct care workers scheduled in the facility on 02/25/2021 to keep watch over the residents.	No
Resident A is not eating her food because direct care workers do not put her dentures in her mouth so she can adequately chew her food.	No
Direct care workers do not put Resident A's hearing aids in her ears.	No
The facility offers no resident activities, resulting in the decline of residents' health.	No
The facility is not a clean and sanitary home-like environment.	No
Additional Findings	Yes

III. METHODOLOGY

03/02/2021	Special Investigation Intake 2021A0462023
03/04/2021	Special Investigation Initiated - Email to Complainant.
03/08/2021	Contact – Requested and received IR from administrator Janet White, via email. Contact- Telephone interview with Relative A2.
03/10/2021	Contact – Second telephone interview with Relative A2. Referral made to APS.
03/12/2021	Contact – Additional allegations received via email.
03/17/2021	Unannounced investigation on-site. Interviews with assistant executive director Eric Goodlock, and DCWs Toni Nocera, Juanita Parker, Patricia Velez, and activities director Kaylee Todd. Contact- Requested and received documents while on-site.
03/18/2021	Contact- Received documents from administrator Janet White, via email.

04/02/2021	Contact- Separate telephone interviews with APS Specialist Judith Gilbert and Resident A's physician Dr. Bahram Elami.
04/06/2021	Contact- Telephone interview with administrator Janet White.
04/07/2021	Contact- Separate telephone interview with DCW Susan Lane and Jessica East.
04/21/2021	Contact- Requested and received documentation from APS Specialist Judy Gilbert.
04/23/2021	Exit conference with licensee designee Connie Clauson.

ALLEGATION: There was not a sufficient number of direct care workers scheduled in the facility on 02/25/2021 to keep watch over the residents.

INVESTIGATION: On 03/02/2021 the Bureau of Community and Health Systems (BCHS) received a complaint via the BCHS' on-line complaint system. According to the written complaint, on 02/24 Resident A was pushed by Resident B while in the dining room. Subsequently, Resident A fell and suffered three fractures as a result. The written complaint indicated the primary concern was that because there was not a sufficient number of direct care workers (DCW) scheduled in the facility to keep watch over the residents, this incident occurred.

On 03/04 I informed Complainant via email I was assigned to investigate this allegation.

I reviewed three *AFC Licensing Division- Incident/Accident Reports* (IR) submitted to the department. Documentation on two IRs, written by DCW Susan Lane on 02/25, indicated that on 02/25, not 02/24 as indicated in the written complaint, Resident B was sitting at a table in the dining room when Resident A walked by with her walker. Resident B yelled, "you don't belong here" and pushed Resident A, who subsequently fell. Ms. Lane documented she witness the incident, assessed Resident A, and no injuries were identified. Documentation on a third IR, written by assistant director Eric Goodlock on 02/26, indicated that on the morning of 02/26 Resident A was transported to Borgess Hospital's emergency room (ER) after she started complaining of pain.

On 03/08, via email to facility administrator Janet White, I requested and received Resident A's ER discharge paperwork regarding her fall on 02/25. According to documentation on Resident A's ER discharge paperwork, Resident A had a diagnosis of Alzheimer's and was 95 years old at the time of her fall. Resident A's ER discharge paperwork confirmed that as a result of her fall, she obtained multiple nondisplaced pelvic fractures. Documentation on Resident A's ER discharge

paperwork indicated that due to her Alzheimer's diagnosis, Resident A was unable to answer questions. Upon examination in the ER, Resident A appeared well developed and well nourished. According to documentation on Resident A's ER discharge paperwork, medical staff members established Resident A's injuries did not require surgical intervention. Documentation on Resident A's ER discharge paperwork indicated that hospital medical staff contacted Relative A1, Resident A's durable power of attorney for healthcare decisions (DPOA), and informed him Resident A would require pain control, as well as physical therapy (PT) and mobility limitation, for recovery and that these components of care would likely be achieved at the facility. According to documentation on Resident A's ER discharge paperwork, Relative A1 verbalized wanting Resident A to return to the facility. Therefore, Resident A was discharged back to the facility with an order for PT.

Included in the written complaint, was contact information for Relative A2. I conducted a telephone interview with Relative A2, who stated she was one of Resident A's five children, and all five of Resident A's children were appointed DPOAs for decisions regarding Resident A's health care. Relative A2 stated she was told the facility scheduled three DCWs to work on first and second shifts, and two DCWs to work on third shift. According to Relative A2, this was not adequate. Relative A2 confirmed that as a result of her fall in the facility on 02/25, Resident A was ordered in-home PT to be conducted at the facility at least once a week. Relative A2 stated DCWs were to also work on PT exercises with Resident A, as directed by the physical therapist. Relative A2 stated she did not believe there were enough DCWs scheduled in the facility to be able to work on PT exercises with Resident A.

On 03/10 I received a telephone call from Relative A2, who informed me Resident A was not safe at the facility. According to Relative A2, she believed Resident A should be admitted to either a long-term care facility for short-term rehabilitation or transferred to another adult foster care facility that could better meet her needs. Relative A2 requested my assistance with moving Resident A out of the facility. I informed Relative A2 I did not have the authority to assist her with this request and suggested Resident A's DPOAs make these arrangements. I also suggested Relative A2 seek the assistance of Resident A's physician Dr. Bahram Elami, who regularly saw Resident A in the facility. I informed Relative A2 I would report her concerns to Kalamazoo County Adult Protective Services (APS).

Upon ending my conversation with Relative A2, I made a referral to APS' Centralized Intake Department.

On 03/17 AFC licensing consultant Nile Khabeiry and I conducted an unannounced investigation on-site and interviewed Mr. Goodlock and DCW Toni Nocera separately. Mr. Goodlock denied the allegation the incident between Residents A and B on 02/25, resulting in Resident A falling and sustaining injuries, occurred because of inadequate DCW staffing. According to Mr. Goodlock, at the time of the incident there were 17 residents residing in the facility. Both Mr. Goodlock and Ms.

Nocera confirmed three DCWs were scheduled to work in the facility on first and second shift, and two DCWs were scheduled to work in the facility on third shift. According to Mr. Goodlock, one of the three DCWs scheduled to work on 02/25 was not present in the facility at the time Resident A fell, as she was in a meeting at a neighboring facility. Mr. Goodlock confirmed Ms. Lane was present in the dining room when the incident occurred, and stated DCW Jessica East was "down the hall" assisting other residents. According to Mr. Goodlock and Ms. Nocera, in addition to Ms. Lane and Ms. East, Ms. Nocera was also present in the facility at the time of Resident A's fall but did not witness the incident. Mr. Goodlock and Ms. Nocera stated Resident A's physician Dr. Elami also happened to be present at the facility at the time of the incident and assessed Resident A for injuries. According to Mr. Goodlock, at the time of assessment, Resident A appeared fine. However, later in the evening and early morning hours of 02/26, Resident A began complaining of pain. Subsequently, she was transported to the ER. Mr. Goodlock confirmed Resident A was discharged back to the facility the same day, with an order for in-home PT. However, Resident A was experiencing extreme pain, making it impossible for her to participate in PT. Subsequently, Resident A's PT was discontinued, and she was admitted to hospice services, with the goal of better managing her extreme pain. Mr. Goodlock and Ms. Nocera stated that, due to a dementia diagnoses, Resident B was often agitated and frequently displayed verbal out busts. However, the incident on 02/25 was unusual, as Resident B did not have a known history of being physically aggressive towards other residents.

Mr. Goodlock stated that shortly before our arrival, he was notified that Resident A's family members requested Resident A be discharged from hospice services and transported to the ER. Mr. Goodlock stated it was his understanding this request was made so that Resident A could be admitted into the hospital and subsequently referred to a long-term care facility for short-term rehabilitation. According to Mr. Goodlock, DCWs were in the process of making arrangements to transport Resident A to the ER.

While on-site, in additional to Mr. Goodlock and Ms. Nocera, Mr. Khabeiry and I established DCWs Juanita Parker and Patricia Velez were working in the facility. Activities director Kaylee Todd was also present in the facility.

Before Resident A was transported to the ER, Mr. Khabeiry and I attempted to interview Resident A. However she was sleeping in her bedroom. We observed Resident A, who appeared clean and well groomed. At the time of our observation, Resident A was resting peacefully and did not appear to be in any pain and/or discomfort.

Mr. Khabeiry and I observed several residents eating their lunch and engaging in an activity with Ms. Todd. The residents appeared to be clean and well groomed.

I requested and received a copy of the DCWs' schedule for the month of February and all 17 residents' *AFC Assessment Plans for AFC Residents* (assessment plans).

I established the facility utilizes an electronic resident service planning software system through the company Matrix Care. I reviewed the resident service planning function of this system and established it contained all the components of the department's *Assessment Plan for AFC Residents* form. I reviewed all 17 residents' care needs as indicated in their assessment plans. Documentation on the DCWs' February schedule confirmed that for the month of February, at least three DCWs were scheduled to work in the facility on first and second shifts, and two DCWs were scheduled to work in the facility on third shift.

On 03/18, Ms. White submitted the facility's quarterly fire drill records. Documentation on one fire drill record indicated that on 12/18/2020, a practice drill was conducted on the facility's first shift. Five facility staff members evacuated 17 residents in 4 minutes and 30 seconds. Documentation on a second fire drill record indicated on 12/12/2020, a practice fire drill was conducted on the facility's second shift. Four facility staff members evacuated 15 residents in two minutes. Documentation on the third fire drill record indicated that on 12/21/2020, a practice fire drill was conducted during resident sleeping hours. Three DCWs evacuated 17 residents from the facility in eight minutes. There were no practice fire drills conducted during this quarter at a time when only two DCWs were working in the facility. Therefore, I was unable to establish whether or not two DCWS were able to adequately evacuate 17 residents from the facility in case of a fire.

On 04/02 I conducted separate telephone interviews with APS Specialist Judith Gilbert and Dr. Elami. Ms. Gilbert informed me that on 03/17 Resident A was admitted to Borgess Hospital where she later passed away.

According to Dr. Elami, he did not witness the incident on 02/25, as he was entering the facility as the incident occurred. Dr. Elami stated DCWs responded to Resident A immediately after the incident occurred and it did not appear as though there was an inadequate number of DCWs in the facility at that time. Dr. Elami confirmed he assessed Resident A, who was able to be assisted up off the floor and appeared to have no notable injuries. However, Dr. Elami confirmed Resident A was later transported to the ER when she expressed feeling pain. According to Dr. Elami, it was not unusual for the ER to discharge Resident A back to the facility on 02/26 after it was established she sustained multiple fractures as a result of falling, as the type of fractures Resident A sustained often healed on their own over time. Therefore, the plan was to manage Resident A's pain while her injuries healed. However, managing Resident A's pain with medication became challenging. Dr. Elami stated Resident A was appropriate for hospice care and was admitted to hospice with the goal of better managing her pain to help her feel comfortable, as her injuries continued to heal. Dr. Elami stated DCWs were greatly concerned about Resident A's pain and communicated to him regularly. Dr. Elami confirmed that on 03/17 Resident A's family members requested Resident A be discharged from hospice services and transported to the ER, where Resident A was subsequently admitted. Dr. Elami stated that while in the hospital, Resident A's health significantly declined, and she passed away. According to Dr. Elami, he had no reason to believe

Resident A's health declined because of improper care from facility staff members and/or medical staff members at the hospital. Dr. Elami stated he typically observed two to three DCWs working in the facility every time he conducted his rounds there. Dr. Elami stated that while conducting rounds in the facility, with the exception of a few residents who regularly refused assistance with care, he observed the residents to be clean and well groomed.

On 04/06 I conducted a telephone interview with Ms. White, who denied the allegation the incident between Residents A and B on 02/25, resulting in Resident A falling and sustaining injuries, occurred because of inadequate DCW staffing. According to Ms. White, she was not aware of any previous incidents when Resident B was physically aggressive with other residents. Ms. White's statements regarding DCW staffing in the facility was consistent with the statements Mr. Goodlock and Ms. Nocera provided to us during our interview with them.

On 04/07 I conducted separate telephone interviews with Ms. Lane and Ms. East. Both Ms. Lane and Ms. East denied the allegation the incident between Residents A and B on 02/25, resulting in Resident A falling and sustaining injuries, occurred because of inadequate DCW staffing. Ms. Lane confirmed that on 02/25 she witnessed Resident B push Resident A while in the dining room. Ms. Lane's stated she immediately responded to Resident A and assessed her for injuries. Ms. Lane confirmed Dr. Elami also responded. Ms. Lane's statements regarding the assessment of Resident A immediately following her fall were consistent with the statements Dr. Elami provided to me. Ms. Lane stated, "it made no sense to me why he pushed her." According to Ms. Lane, after assessing Resident A for injuries, she asked Resident B why he pushed Resident A. Ms. Lane stated that due to a diagnosis of dementia, Resident B denied pushing Resident A and appeared to have no recollection of the incident. According to Ms. Lane, she felt "bad" when she later learned Resident A was transported to the ER after she began to complain of pain. Ms. Lane stated, "we could've had 20 staff there and I don't think it could've been prevented."

Ms. East confirmed she did not witness the incident on 02/25, as she was assisting other residents to dining room at that time. However, according to Ms. East, she responded to Ms. Lane and Resident A "moments" after the incident occurred. Ms. East confirmed Dr. Elami also responded to Resident A after she fell. Both Ms. Lane's and Ms. East's statements regarding Resident B having no known history of physical aggression towards other residents, was consistent with the statements Mr. Goodlock, Ms. Nocera, and Ms. White provided to me and Mr. Khabeiry.

On 04/21 I requested and received, via email from Ms. Gilbert, Resident A's *Certificate of Death*, which confirmed that on 03/24 Resident A passed away at Borgess Hospital, seven days after being admitted. Documentation on Resident A's *Certificate of Death* indicated the "chain of events-diseases, injuries or complication-that directly caused death" were sepsis, bacteremia, and acute Hypoxic Respiratory failure. The listed "approximate interval between onset and death" were "days".

According to documentation on Resident A's *Certificate of Death*, the manner of death was "natural". However, no autopsy was performed.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours. **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with Relative A2, APS Specialist Judith Gilbert, Dr. Bahram Elami, and multiple facility staff members, as well as a review of pertinent documentation relevant to this investigation, there is no evidence to substantiate the allegation there was not a sufficient number of DCWs scheduled in the facility on 02/25/2021 to keep watch over the residents, subsequently resulting in an incident between Residents A and B that resulted in Resident A sustaining injuries.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

- **Resident A is not eating enough food at mealtimes because direct care workers do not put her dentures in her mouth so she can adequately chew her food.**

- **Direct care workers do not put Resident A's hearing aids in her ears.**

INVESTIGATION: During my telephone conversation with Relative A2 on 03/10, Relative A2 reported Resident A was not eating enough food at mealtimes because DCWs did not put her dentures in her mouth so she could adequately chew her food.

On 03/12, via email, Complainant informed me that while "cleaning up old notes" she discovered a previous complaint reported to her prior to the allegation she reported to the department on 03/02. The allegation was that DCWs did not assist Resident A

with placing her hearing aids in her ears. According to Complainant, this allegation was reported to her and she did not witness this allegation herself.

Documentation on Resident A's ER discharge paperwork indicated that upon examination in the ER on 02/26, Resident A appeared well developed and well nourished.

During our unannounced on-site investigation on 03/17, Mr. Khabeiry and I conducted separate interviews with Mr. Goodlock, Ms. Nocera, Ms. Parker, and Ms. Velez regarding these allegations. According to Mr. Goodlock and Ms. Nocera, Resident A was not a "good eater" prior to her fall on 02 /25. Prior to Resident A's fall, DCWs verbally prompted Resident A to eat her meals, which were "prepped" for her. Mr. Goodlock and Ms. Nocera stated that as a result of her fall on 02/25, Resident A experienced a great deal of pain, which affected her appetite. Therefore, DCWs started physically feeding Resident A her meals. According to Mr. Goodlock, Resident A often resisted this assistance from DCWs at mealtime, and he suspected this was due to the unmanaged pain she was experiencing. Mr. Goodlock stated DCWs also voluntarily began documenting Resident A's daily food intake to report to Dr. Elami, if requested. Mr. Goodlock confirmed Resident A wore dentures that, before her fall on 02/25, she was able to take in and out on her own without the assistance of DCWs. According to Mr. Goodlock, following her fall on 02/25, one of Resident A's family members reported being upset when she discovered Resident A did not have her dentures in during mealtime. Mr. Goodlock stated he personally located Resident A's dentures in her bedroom and put them in for Resident A, per this family member's request. However, it was difficult to put the dentures in for Resident A, as she expressed being very painful. Ms. Nocera denied the allegation Resident A was not eating enough food at mealtimes because DCWs were neglectful by forgetting to put her dentures in her mouth. Ms. Nocera stated that prior to her fall on 02/25, Resident A preferred to keep her dentures in at all times and DCWs would have to verbally encourage Resident A to remove her dentures so that they could be cleaned. However, after her fall on 02/25, Resident A could no longer put her dentures in herself and began "fighting" DCWs when they attempted to assist her with this. According to Ms. Nocera, Dr. Elami verbally instructed DCWs to do their best to keep Resident A has comfortable as possible. Therefore, they did not force Resident A to wear her dentures if she refused and/or was expressing pain.

Ms. Parker's and Ms. Velez' statements regarding Resident A's appetite before and after her fall, as well as the allegation Resident A did not eat enough food at mealtimes because DCWs were neglectful by forgetting to put her dentures in her mouth were consistent the statements Mr. Goodlock and Ms. Nocera provided to us.

Mr. Goodlock, Ms. Nocera, Ms. Parker, and Ms. Velez all denied the allegation DCWs acted neglectful by failing to assist Resident A with putting her hearing aids in her ears. According to Mr. Goodlock and Ms. Nocera, Resident A was sometimes resistant to assistance from DCWs with putting her hearing aids in and would occasionally take them out herself.

While on-site, Mr. Khabeiry and I attempted to interview Resident A. However she was sleeping in her bedroom.

During my telephone interview with Ms. White on 04/06, Ms. White denied both allegations. According to Ms. White, Resident A, who was never a good eater, did not eat very much at mealtimes following her fall on 02/25, which resulted in several fractures, due to extreme pain. Ms. White also stated that several of the pain medications prescribed to Resident A following her fall on 02/25 caused a decrease in Resident A's appetite. According to Ms. White, an allegation regarding Resident A's hearing aids was previously investigated by the department when Resident A resided in the neighboring facility. Ms. White stated it was her understanding this issue had been resolved. According to Ms. White, at one point Resident A's family members requested DCWs assist Resident A with putting her hearing aids in her ears for family visits only. Ms. White stated she was not aware of any current issues regarding Resident A's hearing aids. Documentation in Special Investigation Report (SIR) #2020A0581045, dated 08/20/2020, confirmed the department investigated an allegation regarding Resident A's hearing aids when she resided in the neighboring facility.

The statements Ms. Lane and Ms. East provided to me during my interviews with them regarding both allegations were consistent with the statements Mr. Goodlock, Ms. Nocera, Ms. Parker, Ms. Velez, and Ms. White provided.

While on-site I requested and received a copy of Resident A's *food intake log* for the month of March, as well as her monthly weight records from the time of her admission into the facility. Documentation on Resident A's March *food intake log* confirmed that on most days, Resident A ate very little at mealtimes. However, there were also a few days when Resident A ate all or most of her food at mealtimes. Documentation on Resident A's March *food intake log* indicated that on 03/03, 03/06, and 03/15, Resident A refused her breakfast meal. According to documentation on Resident A's March *food intake log*, on 03/16 Resident A refused her lunch meal. According to Resident A's monthly weight records, Resident A lost approximately 10 pounds since her admission into the facility.

I reviewed Resident A's assessment plan and established facility staff members did not complete an assessment on Resident A upon her admission into the facility and/or after Resident A's fall on 02/25. The most recent assessment completed on Resident A was done on 12/16/2020 when she resided in the neighboring facility. There was no documentation in Resident A's previous assessment plan indicating DCWs assisted Resident A with denture care. Documentation in Resident A's previous assessment plan read in part, "insert aid into ears at the request of the family only during family visits. Remove hearing aid and batterie promptly after family visit, family will make staff aware when visit is complete, and place hearing aid in cup provided by the med-cart. Family will call prior to visit to alert staff they will be visiting."

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Relative A2, and multiple facility staff members, as well as a review of pertinent documentation relevant to this investigation, there is not enough evidence to substantiate the allegation that the reason Resident A did not eat enough food at mealtimes was because DCWs did not put her dentures in her mouth so she could adequately chew her food, or the allegation DCWs did not put Resident A's hearing aids in her ears.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility offers no resident activities, resulting in the decline of residents' health.

INVESTIGATION: On 03/12, via email, Complainant informed me that while "cleaning up old notes" she discovered a previous complaint reported to her prior to the allegation she reported to the department on 03/02. The allegation was that the facility offered no resident activities, resulting in the decline of residents' health. According to Complainant, this was reported to her and she did not witness this allegation herself.

During our unannounced on-site investigation on 03/17, Mr. Khabeiry and I conducted separate interviews with Mr. Goodlock, Ms. Nocera, Ms. Velez, and Ms. Parker regarding this allegation. According to Mr. Goodlock, the facility specialized in caring for residents with dementia and/or other memory impairments. Mr. Goodlock stated he believed this allegation was already investigated. According to Mr. Goodlock, a similar allegation was recently investigated by the department when Resident A resided in the neighboring facility. Documentation on SIR #2021A1024018, dated 02/19/2021, confirmed the department investigated the neighboring facility regarding an allegation involving Resident A and resident activities.

Mr. Goodlock, Ms. Nocera, and Ms. Velez denied the allegation. According to Ms. Nocera, "there could be more going on here." Ms. Nocera clarified that due to precautions taken during the COVID-19 pandemic, less outside entertainment, such as musicians, etc., had been brought into the facility for the residents to enjoy. According to Ms. Nocera, during the pandemic, activities staff members also stopped taking residents on group outings like they had in the past. Ms. Nocera stated that during the pandemic, activities staff members spent a great amount of

time assisting residents and their loved ones with virtual visits, as on-site visits from loved ones were not permitted. According to Ms. Nocera, activities staff members currently conduct activities in the facility such as throwing resident birthday parties, physical activities, and coloring, etc. In addition to this, DCWs did residents' nails and hosted resident "spa days". Ms. Velez stated, "I believe the residents have enough to do." According to Ms. Velez, Ms. Todd conducted various activities with residents such as bowling, coloring, and painting. Ms. Velez stated DCWs also hosted Karaoke, pajama, and movie nights for the residents.

Ms. Parker stated she believed there was not enough activities offered to the residents in the facility but could not explain why she thought that. Ms. Parker stated, "they do bingo, crafts, and coloring."

During our unannounced investigation on-site, Mr. Khabeiry and I observed Ms. Todd hosting a resident birthday party in the facility's living room area. We observed several residents, who were offered cupcakes and lemonade. It appeared the residents participating in the party had varying levels of cognitive deficits making it difficult for them to socialize with each other, and most participating residents required some level of assistance.

While on-site, Mr. Khabeiry and I also conducted a separate interviewed with Ms. Todd, who denied the allegation. According to Ms. Todd, she conducted at least one resident activity at the facility every day.

I requested and received a copy of the facility's February 2021 and March 2021 *resident activity calendars.* Documentation on these calendars indicated at least one to two resident activities were scheduled in the facility every day, with the exception of a few Saturdays and Sundays in March. Some activities listed were balloon volleyball, evening movies and popcorn, boxing classes, manicures, relaxing chair yoga, hot cocoa bar, bingo, coloring, puzzles, bowling, etc.

Ms. White denied the allegation during my telephone interview with her on 04/06. According to Ms. White, when Resident A resided at the neighboring facility, Ms. Todd, who also conducted resident activities at the neighboring facility, informed Resident A's family members during a care conference that, due to what she believed was a progression of Resident A's dementia, Resident A had a difficult time participating in resident activities. Ms. White stated some of Resident A's family members took this information "personally" and accused Ms. Todd of disliking Resident A. According to Ms. White, this issue was investigated by the department and subsequently resolved. However, while she did not know this for certain, she believed this to be the reason for the recent reporting of this allegation.

Ms. Lane denied this allegation during my telephone interview with her on 04/07. Ms. Lane acknowledged that "since covid, it's been hard". According to Ms. Lane, activities staff members conducted activities with residents such as movie nights, crafts, and coloring. In addition to this, and when the weather permitted, DCWs took

residents outside as much as possible. Regarding resident activities, Ms. Lane stated, “given covid, we are all doing the best we can”.

APPLICABLE RULE	
R 400.15317	**Resident recreation.**
	(1) A licensee shall make reasonable provision for a varied supply of leisure and recreational equipment and activities that are appropriate to the number, care, needs, age, and interests of the residents.
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, an observation of a resident activity conducted during an unannounced investigation on-site, as well as a review of pertinent documentation relevant to this investigation, there is not enough evidence to substantiate the allegation the facility offers no resident activities, resulting in the decline of residents’ health.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility is not a clean and sanitary home-like environment.

INVESTIGATION: On 03/12, via email, Complainant informed me that while “cleaning up old notes” she discovered a previous complaint reported to her prior to the allegation she reported to the department on 03/02. The allegation was that the facility was not a clean and sanitary home-like environment. According to Complainant, this was reported to her and she did not witness the allegation herself.

During our unannounced on-site investigation on 03/17, Mr. Khabeiry and I inspected the facility’s physical plant, including Resident A’s bedroom. Mr. Khabeiry and I observed the facility to be clean and adequately maintained to provide for the health, safety, and well-being of the residents.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based upon my investigation, which consisted of an inspection of the facility’s physical plant, as well as Resident A’s bedroom, during an unannounced investigation, there is no evidence to substantiate the allegation the facility was not a clean and sanitary home-like environment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: As part of my investigation, I requested and reviewed Resident A's assessment plan and established facility staff members did not complete an assessment plan for Resident A upon her admission into the facility. I also established facility staff members did not complete an assessment plan for Resident A following her fall on 02/25, which resulted in Resident A sustaining multiple fractures, even though it was evident some of Resident A's care needs had changed, due to these injuries. The most recent assessment plan completed on Resident A was done on 12/16/2020 when she resided in the neighboring facility.

During my telephone interview with Relative A2 on 03/08, Relative A2 stated that approximately two years ago, Resident A's children had a meeting with facility management staff members, who suggested transferring Resident A from the neighboring facility, also operated by Pleasant Homes I L.L.C, to the facility. At this time, Resident A's children, who were also DPOAs for Resident A's healthcare decisions, did not approve of this transfer. According to Relative A2, despite her disapproval, sometime in December of 2020, Ms. White transferred Resident A from the neighboring facility to this current facility. Relative A2 expressed she was upset Resident A was still living in the facility.

During my face-to-face interview with Mr. Goodlock on 03/17, Mr. Goodlock stated the facility specialized in caring for residents with dementia and/or other memory impairments. According to Mr. Goodlock, while residing at the neighboring facility, Resident A's dementia progressed, and she began to wander. Subsequently, it was determined it was no longer safe for Resident A to reside there, and Resident A was transferred to the facility. Mr. Goodlock stated Resident A's five children often disagreed with decisions related to Resident A's care, resulting in inconsistent requests made to the facility.

During my telephone interview with Dr. Elami on 04/02. Dr, Elami stated he primarily communicated with Relative A1, who was Resident A's oldest child and DPOA, regarding Resident A's healthcare needs.

On 04/05, via email, Ms. White confirmed that on 01/26/2021, Resident A was transferred from the neighboring facility to the facility, not in December as reported by Relative A2. According to Ms. White, upon Resident A's admission into the facility, the AFC monthly payments for services received remained the same as it was when Resident A resided at the neighboring facility. However, facility staff members did not complete a new written *Resident Care Agreement* with Resident A and Relative A1 upon her transfer to the facility.

The statements Ms. White provided to me during my telephone interview with her on 04/06, regarding the reason Resident A was transferred to the facility on 01/26, were consistent with the statements Mr. Goodlock provided to us during our interview with him on 03/17. Ms. White confirmed Resident A had five children who often disagreed

with decisions related to Resident A's care. According to Ms. White, Resident A's oldest son, Relative A1, was Resident A's enacted DPOA. Ms. White stated that following approximately three incidents when Resident A wandered away from the neighboring facility, Relative A1 agreed with Ms. White's recommendation Resident A be transferred to the facility, where there was a greater DCW to resident ratio, as well as a delayed egress system.

APPLICABLE RULE	
R 400.15301	**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.** **(c) The resident appears to be compatible with other residents and members of the household.** **(3) A group home shall not accept or retain a person who requires isolation or restraint as specified in R 400.15308.** **(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.**
ANALYSIS:	Based upon my investigation, which included a review of pertinent documentation relevant to this investigation, it has been established facility staff members did not complete a written assessment on Resident A upon her admission into the facility. It has also been established facility staff members did not conduct an assessment of Resident A following her fall on 02/25, which resulted in Resident A sustaining multiple fractures, even though it was evident some of Resident A's care needs had changed, due to her injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**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: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident** **as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**

ANALYSIS:	Based upon my investigation, which consisted of interviews with Relative A2, Dr. Bahram Elami, and multiple facility staff members, as well as a review of pertinent documentation relevant to this investigation, it has been established that when Resident A was transferred from the neighboring facility, also operated by Pleasant Homes I L.L.C., to the facility on 01/26, facility staff members did not complete a written *Resident Care Agreement* with Resident A and Relative A2.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/23 I conducted an exit conference with licensee designee Connie Clauson, via telephone, and shared with her the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 04/21/2021

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 04/21/2021

Dawn N. Timm Date
Area Manager