GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 27, 2021

Stephanie Hildebrant
Cliffside Company
910 S. Washington Av
Royal Oak, MI 48067

RE: License #: AL110077442
Investigation #: 2021A0579017
Caretel Inns Of Royalton - Dover

Dear Stephanie Hildebrant:

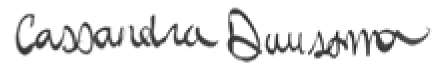
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,



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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110077442
Investigation #:	2021A0579017
Complaint Receipt Date:	02/26/2021
Investigation Initiation Date:	03/01/2021
Report Due Date:	04/27/2021
Licensee Name:	Cliffside Company
Licensee Address:	910 S. Washington Av Royal Oak, MI 48067
Licensee Telephone #:	(248) 330-9598
Administrator:	Stephanie Hildebrant
Licensee Designee:	Stephanie Hildebrant
Name of Facility:	Caretel Inns Of Royalton - Dover
Facility Address:	3905 Lorraine Path Saint Joseph, MI 49085
Facility Telephone #:	(248) 330-9598
Original Issuance Date:	08/13/1998
License Status:	REGULAR
Effective Date:	05/09/2020
Expiration Date:	05/08/2022
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are left in their urine and feces overnight due to staff not toileting them.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/26/2021	Special Investigation Intake 2021A0579017
03/01/2021	Special Investigation Initiated - Letter Complainant
03/01/2021	Contact - Document Received Complainant
03/09/2021	Contact- Face to Face Resident A, B, C, D, E, F, G, H, I, Candice Bearden (Direct Care Worker), Janet Ramirez (Direct Care Worker), Direct Care Worker Z, Direct Care Worker J, and Direct Care Worker K,
03/12/2021	Contact- Document Sent Email to Stephanie Hildebrant, Licensee Designee, requesting staff contact information.
03/12/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, with staff contact information.
03/16/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
03/20/2021	Contact Document Received Text message from Direct Care Worker J
03/22/2021	Contact- Document Received Email response received from Stephanie Hildebrant, Licensee Designee, agreeing to coordinate for an on-site investigation.
03/22/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.

03/23/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
03/31/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
04/08/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
04/09/2021	Contact- Telephone call made Direct Care Worker A
04/09/2021	Contact- Telephone call made Direct Care Worker B
04/09/2021	Contact- Telephone call made Direct Care Worker E
04/09/2021	Contact- Telephone call made Direct Care Worker G
04/09/2021	Contact- Telephone call made Direct Care Worker H
04/09/2021	Contact- Telephone call made Direct Care Worker C
04/09/2021	Contact- Telephone call made Direct Care Worker I
04/09/2021	Contact- Telephone call made Direct Care Worker F
04/09/2021	Contact- Telephone call made Direct Care Worker D
04/09/2021	Contact- Document Received Email response received from Stephanie Hildebrant, Licensee Designee, agreeing to be present for the on-site investigation 04/12/2021.
04/12/2021	Contact- Face to Face

	Stephanie Hildebrant (Licensee Designee), Candice Bearden (Direct Care Worker), Megan Aukerman (Licensing Consultant)
04/14/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, inquiring about staff clock-ins.
04/15/2021	Contact- Document Received Email response from Ms. Hildebrant reporting it would take additional time to receive staff clock-ins.
04/30/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, inquiring about staff clock-ins.
05/03/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, summarizing her review of staff clock-ins.
05/06/2021	Contact- Telephone call made Direct Care Worker O
05/06/2021	Contact- Telephone call made Direct Care Worker P
05/26/2021	Exit Conference Licensee Designee, Stephanie Hildebrant

ALLEGATION: Residents are left in their urine and feces overnight due to staff not toileting them.

INVESTIGATION: On 02/26/2021, I received this referral through the Bureau of Community Health Systems on-line complaint system. The complaint alleged that residents are being neglected by third shift staff and lay in their urine and feces all night. Management is reportedly aware, and the issue has not been addressed.

On 02/26/2021, I received additional information from a second complainant (Complainant 2) stating Complainant 2 has arrived at the facility at 7:00 AM and “for the past month” upon arrival has observed residents sitting in urine and feces with urine-soaked mattresses. Complainant 2 stated these observations were reported to management multiple times, but nothing has changed.

On 02/26/2021, I contacted Complainant 1 and Complainant 2 and left voicemail messages confirming my receipt of the allegations.

On 03/01/2021, Complainant 2 responded with photographs of multiple mattresses with urine stains. There were also photographs of urine-soaked briefs. There was a photograph of a resident (her face was not visible) with pants that appeared wet down her thighs. Complainant 2 reported those photographs were taken at the facility on various occasions when she arrived for her shift in the morning.

On 03/09/2021, I completed an unannounced on-site investigation at the facility. Interviews were completed with Direct Care Workers; Candice Bearden, Janet Ramirez, DCW Z, DCW J, DCW K, and Resident A, B, C, D, E, F, G, H, and I. Each of these residents receives Memory Care at this facility and has impaired cognitive abilities limiting their memories of events and ability to participate in an interview. I spoke with each of these residents but none of them were able to engage in an interview as a result of their limited cognition.

DCW Z has the title of Facility Director and oversees all the facilities located at this address. She stated these allegations are a result of third shift staff and first shift staff not getting along. She stated it was brought to her attention that there was one night on first shift that staff claimed residents were not toileted because their briefs were saturated. I showed DCW Z the photographs sent to me and DCW Z stated the saturated briefs, soiled bedding, and wet clothing was likely from residents being incontinent and urinating excessively within the two-hour time-period between staff rounds. She stated due to residents being incontinent, it is likely they may have had leaks in their briefs. She stated she reviewed the camera footage of the common areas and on the evening that first shift alleged residents were left in urine-soaked briefs and bedding, she observed that staff completed their rounds as required. DCW Z reported third shift staff work alone at Dover if the facility is short-staffed. She stated typically there is a “float staff” available who is not assigned to the facility but can be called to assist if needed.

Ms. Bearden is a DCW with the title of Director of Assisted Living and oversees all the Adult Foster Care facilities located at this address. She confirmed that there are disagreements between first shift and third shift staff and stated Resident I did have a urine-stained mattress that was replaced when it was brought to her attention. She stated residents are toileted every two hours but due to incontinence, they may be excessively wet. She denied having any concerns that residents are not being properly toileted.

Ms. Ramirez is a DCW who with the title of Assistant Director of Assisted Living and oversees all the Adult Foster Care facilities located at this address. She stated she was made aware that residents were not being toileted every two hours and being left in urine-soaked briefs, bedding, and clothing during third shift. She informed me DCW Z stated the camera footage was reviewed and it was noted that third shift staff were not completing their rounds every two hours. I asked for clarification and she confirmed that staff were found to not be completing rounds. She stated she believed these issues were addressed and were not an ongoing problem. She stated

she believes staff are now toileting residents every two hours as required and that Resident I received a new mattress since hers was stained with urine.

Direct Care Worker (DCW) J primarily works first shift but has worked various shifts. She stated she took photographs of residents that showed residents in completely saturated briefs, urine-soaked clothes, and/or urine-soaked mattresses. She stated these photographs were shown to facility management and that this has been an ongoing issue with third shift staff. She stated when DCW L, DCW M and DCW N work third shift, they do not toilet residents during their shift. She stated just this morning, Resident C was found in a completely saturated brief. She stated the expectation is that staff will toilet residents every two hours and that she toilets residents at least every two hours and they never have briefs that are saturated with urine. She stated resident briefs, clothing, and bedding are not soiled when they are toileted as required and she is certain they are not being toileted appropriately during third shift and that is why their briefs, clothing, bedding, and mattresses are soiled. She stated she has worked alone at Dover during the day on weekends when assistance was not available.

DCW K primarily works first shift but has worked other shifts as well/ She stated every day when she comes into work after DCW L, DCW M, DCW N have worked the prior third shift, she observes residents were left in urine and feces. She stated this morning, Resident C was left in urine-soaked briefs and it was apparent he had not been toileted the night before. She confirmed she toilets residents at least every two hours and stated their briefs are never as soiled as they are when she arrives for her shift in the morning.

While on-site, I reviewed the assessment plans for Resident A, B, C, D, E, F, G, H, and I. It was noted Resident A uses a wheelchair, needs assistance from one staff person with transferring and with toileting, and must be checked for incontinence every two hours. Resident B needs supervision from one staff person with ambulating and toileting. Resident C needs staff assistance from one staff with transferring. Resident D needs staff assistance with transferring using a gait belt and must be checked for incontinence every two hours. Resident E needs “extensive assistance from two” with toileting and transferring. Resident F needs limited assistance from one staff person with toileting and transferring. Resident G needs limited assistance from one staff with transferring. Resident H utilizes a wheelchair, her additional needs were not listed on the assessment plan. Resident G needs supervision with toileting and transferring.

DCW Z provided a list of the times DCW L, toileted residents on 02/26/2021, noting she toileted two residents at 3:35 AM and two additional residents at 5:50 AM. I asked DCW Z if it was true that it was not just a onetime incident of staff reporting residents were not toileted on third shift, as DCW Z had previously stated. DCW Z then acknowledged this problem had been reported to her on multiple occasions. She stated “every time” it was brought to her attention; she reviewed the recordings from the common areas and observed staff providing adequate care.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW) A. DCW A reported she has worked various shift times at the facility but primarily works third shift, and she has worked alone on multiple occasions at Dover overnight and during the day. She stated she was unable to provide adequate care to residents while working alone. She stated since she was alone, she did not have the physical assistance to toilet or transfer residents which led to residents being left in bed and/or in soiled briefs until the next shift arrived.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW) B. DCW B stated she works various shifts at the facility but primarily works second shift. She stated staff regularly work alone at Dover during third shift or during first shift if someone does not show up for their shift or they leave early, even though there are residents who need the assistance of two people to transfer. She stated when working alone residents are unsafe should there be a fire. She stated staff also use being “short-staffed” as an “excuse” to not toilet or transfer residents. She stated she has observed residents that were left in urine-soaked clothing and urine-soaked bedding/mattresses when she arrives for her shift.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW) E. DCW E reported she works various shift and denied working alone or having concerns for residents being left in urine-soaked clothing or bedding. She stated she did have concerns regarding the facility not having sufficient gloves for staff and briefs for residents to ensure staff could provide adequate care. She stated Ms.

Bearden and DCW Z were made aware when equipment was needed but the supply was not always refilled timely which negatively impacted the care residents received.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW) D. DCW D works various shifts but primarily works first shift, and stated she has witnessed residents who have been left in urine-soaked briefs, clothing, and bedding “all of the time”. She stated it is known that third shift staff do not provide the necessary toileting and care for residents.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW H). DCW H works various shifts but primarily works second shift. She stated she has witnessed times when only one staff person was working at Dover on various shifts. She stated when there is only one staff person working, residents are not provided with adequate care, such as toileting and dressing, and are unsafe should a fire happen because of their transferring needs.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW) C. DCW C reported she works various shifts but primarily works second or third shift. She stated staff do work alone at times in Dover during third shift. She stated residents are regularly left in briefs soiled by urine and feces when staff work alone because staff cannot complete their assigned duties on their own. She denied leaving residents in soiled briefs at the end of her shift, but stated she knows from working third shift, that there are multiple other third shift workers who regularly do not complete their job duties and leave residents in soiled briefs. She refused to provide the names of the third shift workers who do not complete their job duties.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW) I. DCW I reported working various shifts but primarily works third shift. She stated she has witnessed third shift staff sleeping through their shift. She stated she has left residents in urine or feces soiled briefs when working alone because she cannot physically transfer them. She stated she has witnessed other staff leave residents in urine and feces soiled briefs either because they were sleeping or because they physically could not provide care for the residents by themselves. She stated if she is working and residents are soiled at the time her shift ends, she typically stays late to toilet residents with the help of the next shift. She stated there are third shift who do not toilet residents at all.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW) F. DCW F works various shifts but primarily works first and second shift. She stated there is regularly insufficient staffing at Dover, for all shifts. She stated residents are not able to receive adequate care with only one person on duty and are unsafe should there be a fire. She stated residents are regularly left in urine-soaked briefs during third shift. She stated it has been reported by numerous staff to Ms. Bearden and DCW Z that third shift staff sleep through their shift and do not provide care for residents. She stated she knows this because other staff members on first shift staff have taken photographs of residents to show DCW Z and Ms. Bearden that

residents are not toileted overnight which leads to them being soaking wet in the morning.

On 04/09/2021, I completed a telephone interview with Direct Care Worker (DCW) G. DCW G works first and second shift and stated third shift staff are "not doing what they are supposed to be doing". She stated she has observed residents left in extremely saturated briefs in the morning when she arrives for her shift.

On 04/12/2021, I asked Ms. Bearden about our discussion on 03/09/2021 and how she reported she did not have concerns about staff not providing adequate care for residents overnight. Ms. Bearden stated third shift staff needed coaching on how to appropriately complete their job duties and she began arriving unannounced on third shift to ensure staff were completing their job duties.

On 05/06/20201, I completed a telephone interview with DCW O who stated he primarily works third shift but has covered various shifts. He stated he has observed residents are regularly left in urine or feces soiled briefs during all of the shifts he works but primarily second and third shift. He stated he has also had to leave residents in urine saturated briefs when working alone, which he does regularly, because there are two residents who require two-person assistance and a third resident who is combative and will not always comply with toileting. He stated he has witnessed staff sleeping.

On 05/06/2021, I exchanged text message with DCW P who stated she primarily works second and third shift. She stated she has worked alone on third shift approximately two months ago, and she was unable to toilet residents. She stated she reported her concerns about working alone to Ms. Bearden and DCW Z. She stated she has witnessed a third shift worker sleeping previously and had to wake her up to complete her job duties. She stated she has witnessed residents left in urine and feces soiled briefs. She stated she has had to leave residents in urine and feces soiled briefs because she could not toilet them on her own. She stated staff working alone continues to happen regularly to this day.

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:	Resident A, B, C, D, F, G, H and I require assistance from staff with transferring and/or toileting. Resident E needs "extensive assistance from two" with transferring and toileting. Resident M needs "total assistance" from two with transferring and toileting.

	Although two residents were documented as needing assistance from two Direct Care Workers, DCW Z, DCW A, DCW B, DCW C, DCW D, DCW H, DCW I, DCW J, DCW L, DCW M, DCW N, DCW O, and DCW P reported staff work alone during third shift or when staffing is not available. DCW F reported there is regularly insufficient staffing. DCW J, DCW K, DCW D, and DCW G reported primarily working first shift. They reported that they have come into the facility and discovered residents left in urine and/or feces soiled briefs. DCW A, DCW I, DCW O, and DCW P reported they primarily work third shift. They each reported they have left residents in urine and/or feces soiled briefs overnight when they have worked alone because they could not physically transfer residents by themselves. DCW C stated she toilets residents but has witnessed other third shift staff sleeping through their shift and not providing care to residents. DCW B, DCW H, and DCW F reported working second shift. They each expressed concern related to insufficient staffing and residents not receiving adequate care when staff work alone. Based on the interviews completed and documentation observed, there is sufficient evidence to support the allegation that residents did not receive sufficient supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 03/20/2021, DCW J sent me a text message stating DCW Z is *'trying to fill [staff] sign in sheets with people they know are not going to show up and are not even in town just so [Licensing] think[s] that [the home] is fully staffed.'*

On 04/09/2021, DCW A stated employee schedules are intentionally falsified by DCW Z to make it appear as if there are sufficient staff on duty although the facility is "severely short-staffed." She stated she knows the schedules are intentionally falsified because on multiple occasions staff names have been placed on the schedule even though it is a shift they do not work. She stated staff are not notified they were placed on the schedule and therefore they do not show up to work. She stated there were multiple occasions where she had to call someone whose name was on the schedule, only to find out they would not be coming in because they did

not know they were on the schedule and no one had contacted them. She stated staff who are known to have ended their employment will continue to be written on the schedule as well. She stated it is well known the employee has quit but their name will continue to be written down as if they were working. She stated any written or printed schedule would not be accurate. She stated the only accurate way to confirm who worked, would be to review staff clock-ins because anything managed by DCW Z would be falsified.

On 04/09/2021, DCW B stated staff schedules are intentionally falsified by DCW Z. She gave the example of DCW Q, whose name has been written on the schedule during weekdays to make it appear the schedule is full. She stated DCW Q only works two weekends a month and is not notified when she is placed on the schedule outside of those two weekends, so she does not arrive to work although her name is written on the schedule. She stated people who are no longer employed by the facility are written on the schedule as well.

On 04/09/2021, DCW H reported staff schedules are intentionally falsified. She stated names of employees are just written down, even if they are not notified that they were placed on the schedule or if they had ended their employment. She stated she knows this because it happened to her on one occasion. She stated she is “contingent” which means she only works two weekends a month. She stated one weekday, she was contacted by someone inquiring why she was not present for her shift. She stated her name was on the schedule, but she was not informed by anyone that she was assigned to work. She stated she has another job and was working that job. She stated she believes she was written in as a “no call, no show” but it is unfair because she was not notified that she was scheduled, nor is that a schedule she typically works.

On 04/09/2021, DCW C stated she has witnessed staff schedules being intentionally falsified by DCW Z. She stated that employee names are frequently just written down without notifying the employee or with knowledge that the employee no longer works at the facility. She stated although there is a name on the schedule, the person does not show up. She stated this happens “all the time.”

On 04/09/2021, DCW I reported staff schedules are intentionally falsified. She stated “names are just put down” to make it appear there is sufficient staffing. She stated names of people who do not typically work that shift and are not notified that they were scheduled, are written in. She stated names of people who are known to have quit also continue to be written in to make the facility appear fully staffed.

On 04/09/2021, DCW F staff schedules are intentionally falsified by DCW Z. She stated names are written down for shifts or days employees typically do not work. She stated the written and printed staff schedules do not accurately reflect who is present for the shift.

On 04/09/2021, DCW G stated the staff schedule is not accurate. She stated often, names are written down and employees are unaware they are expected to be working because they were not notified. She stated this is done intentionally to make the schedule appear sufficiently staffed.

On 04/12/2021, I reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules appeared to note schedule changes, the hours worked, the names of staff on duty, the job titles of staff on duty, and the date and hours worked.

On 04/12/2021, Ms. Hildebrant stated she was not aware of the allegation that staff schedules were being falsified. I reported that I had sufficient evidence to support that staff schedules were intentionally being falsified. She stated that she would review the record of employee clock-ins and provide that information to me.

On 04/14/2021, I inquired of Ms. Hildebrant via email if the record of employee clock-ins were available for my review. Ms. Hildebrant responded that it would take additional time for her to receive and review the employee clock-in record.

On 04/30/2021, I inquired again via email to Ms. Hildebrant if employee clock-in records were available for my review.
On 05/03/2021, Ms. Hildebrant responded to my email from 04/30/2021, that she had gone through timecards and realized there were primarily concerns with adequate staffing on the midnight shift. She stated they have started having management supervision on the midnight shift. She stated the evening supervision has been replaced and staff with problematic behavior were released from duty. Ms. Hildebrant did not include any mention of providing me with the employee “clock-in” record in her 05/03/2021 email.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(c) Hours or shifts worked.** **(e) Any scheduling changes.**
ANALYSIS:	I reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules appeared to note schedule changes, the hours worked, the names of staff on duty, the job titles of staff on duty, and the date and hours worked.

	DCW A, DCW B, DCW H, DCW C, DCW I, DCW F and DCW G reported staff schedules are falsified to make the facility appear sufficiently staff. Each reported that the names of individuals who do not typically work certain shifts, certain days, or have knowingly ended their employment continue to be written down on the schedule without informing the individual they are scheduled. I asked Ms. Hildebrant multiple times to provide employee clock-in forms. Ms. Hildebrant did not provide those forms and instead summarized her findings from her own review of the clock-in forms noting there were primarily concerns with the staffing on third shift. Based on the interviews of staff who reported schedules are falsified, there is sufficient evidence to indicate that staff schedules do not accurately include the names of all staff on duty, hours and shifts worked, and any scheduling changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 04/09/2021, DCW Z reported there are typically three staff working at Dover during resident waking hours. She stated at night, there is one person scheduled to Dover. She stated there is also a “float” staff during third shift, who is not assigned specifically to Dover, but is available to be called to the facility if assistance is needed with transfers.

DCW J primarily works first shift. She stated she worked alone at Dover when management is not available on the weekend or when someone does not arrive to work, arrive to work on time, or leaves early. She stated she cannot provide adequate care to residents when working alone.

While on-site, I reviewed the assessment plan for Resident A, B, C, D, E, F, G, H, and I. It was noted Resident A uses a wheelchair and requires assistance from one staff person with transferring and with toileting. Resident B requires supervision from one staff person with ambulating and toileting. Resident C requires staff assistance from one staff with transferring. Resident D requires staff assistance (number of staff needed is not noted) with transferring using a gait belt. Resident E requires “extensive assistance from two” with toileting and transferring. Resident F requires limited assistance from one staff person with toileting and transferring. Resident G requires limited assistance from one staff with transferring. Resident H utilizes a wheelchair, her additional needs were not listed on the assessment plan. Resident I requires supervision with toileting and transferring. Resident M was documented as requiring “total assistance” from two staff. Resident N was documented as toileting

and transferring independently. Resident J, Resident K, and Resident L did not have assessment plans available.

On 04/09/2021, DCW A reported she worked various shift times at the facility but primarily works third shift. She stated she has worked alone at Dover and was unable to provide adequate care to residents while working alone. She stated since she was alone, she did not have the physical assistance to toilet or transfer residents which led to residents being left in bed in soiled briefs and soiled clothing until the next shift arrived.

On 04/09/2021, DCW B stated staff work alone at Dover during third shift despite the fact that there are residents who require the assistance of two people to transfer. She stated when working alone residents are unsafe should there be a fire.

On 04/09/2021, DCW H stated sometimes there is only one staff person working at Dover on third shift. She stated that when there is only one staff working, residents cannot be provided adequate care, such as toileting and dressing, and are unsafe should a fire happen.

On 04/09/2021, DCW C stated staff does work alone in Dover on third shift. She stated residents are regularly left in briefs soiled by urine and feces because staff cannot complete their assigned duties on their own.
On 04/09/2021, DCW F stated there is regularly insufficient staffing at Dover. She stated residents do not receive adequate care with only one person on duty at Dover and are unsafe should there be a fire. She stated residents are regularly left in urine-soaked briefs during third shift.

On 04/12/2021, I reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules noted there were three Direct Care Workers from 7:00 AM to 3:00 PM on 03/24/2021 and 03/31/2021. There were two workers from 7:00 AM to 3:00 PM on 04/09/2021. There were two Direct Care Workers from 3:00 PM to 11:00 PM on 03/24/2021, 03/31/2021, and 04/09/2021. There were two Direct Care Workers from 11:00 PM to 7:00 AM on 03/24/2021 and 03/31/2021. There was one Direct Care Worker initialed as working on 04/09/2021 with a name written in but it was not initialed nor were the hours listed so it is believed only one Direct Care Worker worked from 11:00 PM to 7:00 AM on 04/09/2021.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(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:	Resident A, Resident B, Resident C, Resident F, Resident G, and Resident I require assistance from one staff person with transferring and/or toileting. Resident D and Resident H assessment plans did not specify the number of staff needed for assistance with transferring and toileting. Resident J, Resident K, and Resident L did not have assessment plans available for review. Resident E requires "extensive assistance from two" with transferring and toileting. Resident M requires "total assistance" from two with transferring and toileting. DCW Z reported staff may work alone on third shift and there is a "float staff", who is not assigned to the home, who can be called to assist with transfers and toileting if needed. DCW J, DCW K, DCW A, DCW B, DCW H, DCW C and DCW F reported Direct Care Workers do work alone at Dover. The staff schedule for 11:00 PM to 7:00 AM noted one Direct Care Worker working on 04/09/2021 and two Direct Care Workers working on 03/24/2021 and 03/31/2021. However, it has been determined that the staff schedules do not accurately reflect the staff or number of staff who have worked in the facility. Based on the interviews completed and documentation observed, it is confirmed there are two residents who require the assistance of two Direct Care Workers, and six residents who require the assistance of one Direct Care Worker for transferring and/or toileting. In addition, there are five residents whose supervision, protection, and personal care staffing needs were not documented. Staff also confirm (in addition to the written schedule from 04/09/2021 11:00 PM to 7:00 AM) that Direct Care Workers work alone at the facility. Due to the findings summarized above there is sufficient evidence to indicate the facility is not sufficiently staffed at all times to provide supervision, personal care, and protection of residents and to provide the services specified in the residents' assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 03/09/2021, DCW J reported Resident I has told her that she wishes to die because she is left in urine saturated briefs. DCW J reported residents are regularly left in urine-soaked briefs, clothing, and bedding overnight. She expressed her opinion that residents are not safe when left with only one DCW on staff.

On 03/09/2021, DCW K reported Resident I has told her that she wishes to die because she does not want to continue to be left in urine saturated briefs. DCW K reported residents are regularly left in urine-soaked and feces soiled briefs, clothing, and bedding overnight. She expressed her opinion that residents are not safe when left with only one DCW on staff.

On 04/09/2021, DCW A stated she has worked alone at Dover and was unable to provide adequate care to residents while working alone because she did not have the physical assistance to toilet or transfer residents which led to residents being left in bed in soiled briefs and/or clothing until the next shift arrived. She expressed her opinion that residents are not safe when left with only one DCW on staff.

On 04/09/2021, DCW B stated she has observed residents left in urine-soaked clothing and urine-soaked bedding/mattresses. She expressed her opinion that residents are not safe when left with only one DCW on staff.

On 04/09/2021, DCW D stated residents are left in urine-soaked briefs, clothing, and bedding “all of the time.” She expressed her opinion that residents are not safe when left with only one DCW on staff.

On 04/09/2021, DCW H stated when there is only one staff working, residents are not provided with adequate care, such as toileting and dressing, and are unsafe should a fire happen.

On 04/09/2021, DCW C stated residents are regularly left in briefs soiled by urine and feces. She expressed her opinion that residents are not safe when left with only one DCW on staff.

On 04/09/2021, DCW I stated two DCWs are needed to safely complete evacuations.

On 04/09/2021, DCW F stated residents are regularly left in urine-soaked briefs during third shift. She stated two DCWs are needed to safely complete evacuations.

On 05/06/2021, DCW O stated he has witnessed residents left in soiled briefs during second and third shift. He stated residents are “absolutely not safe” when there is only one DCW on staff at Dover.

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:	DCW J and DCW K reported Resident I stated she wishes to die so she will not be left in urine-soaked briefs. DCW J, DCW K, DCW A, DCW B, DCW D, DCW H, DCW C, DCW F, DCW G, and DCW O all reported knowledge of residents being left in urine-soaked briefs overnight and expressed that residents are not safe should a fire occur while staff is working alone. Based on the interviews completed, there is sufficient evidence to established that residents were not treated with dignity when left in urine-soaked briefs, clothing, and bedding as a result of not being toileted as necessary overnight. In addition, there is sufficient evidence to indicate that residents' protection and safety are not attended to when only one staff was on duty.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

03/09/2021, DCW Z reported to me that there was one known complaint about third shift staff leaving residents in urine saturated briefs. She stated footage was viewed and third shift staff were found to be completing their assigned duties. She provided handwritten times that she stated staff completed their assigned duties on 02/26/2021 which she reported was the one incident she was aware of. After speaking to staff, I inquired with DCW Z about this being an ongoing issue and not only one time as she previously reported. DCW Z then stated "every time" this was brought to her attention she reviewed the camera footage and found no concerns.

On 03/09/2021, Ms. Ramirez reported it was brought to her and DCW Z's attention that third shift staff were not toileting residents appropriately. She stated camera footage was reviewed and it was confirmed third shift staff were not toileting residents appropriately.

On 03/09/2021, both DCW J and DCW K reported they were the only staff providing care for residents at Dover. They stated DCW Z brought over an additional employee from a connected facility to make it appear there was sufficient staff on duty when they learned I would be coming into the facility. They both stated they overheard this being discussed by Ms. Bearden and DCW Z.

On 03/20/2021, I received a text message from DCW J that stated, *'[DCW Z] is telling us [Licensing] are not our friend and we need to tell you guys that we never work alone.'* She also stated, *'DCW Z is trying to fill [staff] sign in sheets with people they know are not going to show up and are not even in town just so [Licensing] think[s] that [the home] is fully staffed.'*

On 04/08/2021, I exchanged emails with Ms. Hildebrant coordinating an on-site investigation. I requested DCW Z not participate in the scheduled on-site investigations as I had concerns for her being intentionally deceitful and obstructive with the investigative process.

On 04/09/2021, DCW B denied that DCW Z recently told her to give false information to licensing. She stated, however, that the staff schedules are intentionally falsified by DCW Z.

On 04/09/2021, DCW A stated DCW Z "lies about everything" and "falsifies paperwork to cover up concerns" within the facility. She stated the staff schedule is falsified because names of employees who do not work a certain shift, a certain day, or have knowingly ended their employment will continue to be placed on the schedule without notifying the scheduled individual. She stated the written schedule does not accurately note who worked, rather it makes it appear the facility is sufficiently staffed when it is not.

On 04/09/2021, DCW H reported staff schedules are intentionally falsified and she witnessed it firsthand when her name was put down for a day she does not work. She stated she found this out when staff called and asked why she was not at work. She stated the staff schedules are approved by DCW Z.

On 04/09/2021, DCW C stated she has witnessed staff schedules being intentionally falsified by DCW Z. She stated that employee names "are frequently just written down" without notifying the employee or with knowledge that the employee no longer works at the facility.

On 04/09/2021, DCW I reported staff schedules are intentionally falsified. She stated "names are just put down" to make it appear there is sufficient staffing and DCW Z is aware.

On 04/09/2021, DCW F stated staff schedules are intentionally falsified by DCW Z. She stated names are intentionally written down for people on shifts or days employees typically do not work without notifying the employee to make it appear the facility is adequately staffed. She stated when she and other staff members bring concerns to DCW Z, DCW Z does not address them, rather DCW Z "covers everything up."

On 04/09/2021, DCW G stated often, names are written down and employees are unaware they are expected to be working because they were not notified. She stated this is done intentionally to make the schedule appear sufficiently staffed and DCW Z is aware.

On 04/20/2021, DCW B inquired why I had completed my investigation without any changes being made within the facility and implored me to investigate further. I inquired what she meant and reported that my investigation was not completed. She stated DCW Z held a “threatening meeting” on 04/19/2021, stating she “was aware of what staff had said” and that “all concerns have been addressed” and “licensing said everything was fine.” DCW B was advised that was not accurate and that my investigation was ongoing.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	DCW Z initially told me that there was only one incident on 02/26/2021, where there were concerns about third shift staff not completing their job duties and neglecting residents. DCW Z provided handwritten documentation she stated she obtained from reviewing film footage for 02/26/2021. After speaking with staff, it was inquired why she only reported one incident when staff reported there was an ongoing issue brought up multiple times. DCW Z then stated “every time” concerns were brought to her attention, she reviewed footage and found staff had properly completed their job duties. Ms. Ramirez confirmed, twice, that when camera footage was reviewed it was found third shift staff were not completing their job duties. DCW J reported DCW Z advised staff not to cooperate with licensing. DCW B reported DCW Z held a “threatening meeting” on 04/19/2021 where she told staff she was “was aware of what staff had said” and that “licensing said everything was fine.” DCW J and DCW K both stated they overheard DCW Z and Ms. Bearden discuss bringing an additional staff person to the facility, who was not previously working at that facility, to make it

	appear that there was sufficient staff while licensing was present on 03/09/2021, because there was insufficient staffing. DCW A noted DCW Z "lies about everything." DCW B stated DCW Z "lies all of the time." DCW F stated DCW Z "covers everything up." DCW J, DCW A, DCW B, DCW F, DCW H, DCW C, DCW G, and DCW I reported staff schedules are intentionally falsified with DCW Z's knowledge. Based on the interviews completed, there is sufficient evidence to indicate that not all employees who are under the direction of the licensee, primarily DCW Z, are suitable to assure the welfare of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 04/12/2021, I observed the assessment plan for each resident at Dover. Resident J moved into the facility on 03/17/2021. Resident K moved into the facility on 02/04/2021. Resident L moved into the facility on 02/24/2021. Resident J, K and L did not have assessment plans completed.

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. **(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.**
ANALYSIS:	Resident J, K and L were observed to not have written assessment plans on file. Based on my review of documentation, Resident J, K and L were accepted for care without written determination that they were suitable for the personal care, supervision, and personal care available, nor that the services, skills, and physical accommodations required were available, nor that residents are compatible with other residents. Additionally, a written assessment plan was not completed at the time of the resident admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/26/2021, I completed an exit conference with Licensee Designee, Ms. Hildebrant, who reported she disputes my findings pending further review of the written report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license be modified to a provisional license.

05/26/2021

Cassandra Duursma　　Date
Licensing Consultant

Approved By:

05/27/2021

Jerry Hendrick　　Date

Area Manager