GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 8, 2021

Lisa Murrell
Community Living Centers Inc
33235 Grand River
Farmington, MI 48336

RE: License #: AL630256833
Investigation #: 2021A0988025
CLC Mary Wagner House

Dear Ms. Murrell:

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 (248) 975-5053.

Sincerely,

Kenyatta Lewis, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2078

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630256833
Investigation #:	2021A0988025
Complaint Receipt Date:	06/07/2021
Investigation Initiation Date:	06/07/2021
Report Due Date:	08/06/2021
Licensee Name:	Community Living Centers Inc
Licensee Address:	33235 Grand River Farmington, MI 48336
Licensee Telephone #:	(248) 478-0870
Administrator:	Lisa Murrell
Licensee Designee:	Lisa Murrell
Name of Facility:	CLC Mary Wagner House
Facility Address:	30900 Greening Farmington Hills, MI 48334
Facility Telephone #:	(248) 737-2046
Original Issuance Date:	01/27/2004
License **Status:**	REGULAR
Effective Date:	02/29/2020
Expiration Date:	02/28/2022
Capacity:	15
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident J received substandard care and medical neglect from 07/01/2020 – 02/08/2021, which hastened his death. The staff at CLC Mary Wagner Home (MW) are untrained and unsupervised regarding Resident J's treatment plan and did not provide wound care per his treatment plan and hospice instructions.	**No**
Resident J was injured after falling from his wheelchair. Resident J's wheelchair was soiled.	**Yes**
MW staff did not provide wound care per Resident J's hospice instructions.	**No**
On 08/10/2021, Resident J left the facility with another resident's medication.	**Yes**
On 10/25/2020, Resident J's food was not cut into bite sized portions	**Yes**
Resident J's hands and fingernails are always dirty.	**No**
There is visible overflowing garbage.	**No**
There is a broken table and chair and buckled flooring that poses risk of injury.	**No**
The MW home is dirty.	**No**
There are sticky tables and chairs.	**Yes**
The floors are sticky.	**Yes**
Resident J's linen is soiled.	**Yes**

III. METHODOLOGY

06/07/2021	Special Investigation Intake 2021A0988025

06/07/2021	Special Investigation Initiated - Letter I sent an email to the complainant regarding the allegations.
06/11/2021	Contact - Document Received I received 12 email messages from the complainant that contained notes and pictures of Resident J.
07/20/2021	Inspection Completed On-site I conducted an unannounced onsite where I interviewed the home manager, Shanise Peagler, MORC case manager, Will Harrison, and Resident R. I also observed Resident J's case notes.
07/20/2021	Contact - Document Sent I sent an email to the complainant.
07/22/2021	Contact - Document Received I received an email from Shanise Peagler that contained the CLC Mary Wagner DCW's names and phone numbers.
08/03/2021	Contact - Telephone call made I left messages for DCW's: Amy Udell, Sierra LeFlore, and Talaya Williams.
08/03/2021	Contact - Telephone call made Lisa Murrell, Licensee Designee
08/03/2021	Contact - Telephone call received I spoke to DCW Amy Udell.
08/03/2021	Contact - Document Sent I sent photos of Resident J to Ms. Murrell via text.
08/06/2021	Contact - Document Received I received an email from Lisa Murrell.
08/10/2021	Contact - Document Sent I responded to Lisa Murrell's email.
08/10/2021	Exit Conference I conducted the exit conference via email with Ms. Murrell
08/24/2021	Contact - Telephone call made Diane Stabnick, Hospice of Michigan
08/26/2021	Contact - Document Received

	I received separate emails from Diane Stabnick and Yvette Scales from Hospice of Michigan. (HOM)
08/26/2021	Contact - Telephone call made I spoke to the following HOM RN's: Brenda Sweeny, Bethann Waldrop, Ann Marie Rowden, and Carolyn Price. I left a message for Jack Nickert.
08/26/2021	Exit Conference 2nd exit conference conducted via email with Lisa Murrell
09/08/2021	APS- Referral made to adult protective services

ALLEGATION:

Resident J received substandard care and medical neglect from 07/01/2020 – 02/08/2021, which hastened his death. The staff at MW Mary Wagner Home are untrained and unsupervised regarding Resident J's treatment plan and did not provide wound care per his treatment plan and hospice instructions.

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations. On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed and reviewed a 6-page summary of concerns from 07/01/2020 – 02/08/2021 authored by the complainant. I noted a paragraph stating the complainant sent pictures of Resident J's bedsores to the licensee designee, Lisa Murrell. Ms. Murrell's response was to lose control and yell. Ms. Murrell never took any action because it appeared that she did not want to hear concerns. I also observed and reviewed an 11-page summary authored by Relative A, documenting her concerns with MW home from 08/7/2021 – 08/08/2021. Relative A stated that she observed Resident J with an open wound on his spine, slumped in his wheelchair, sound asleep with no pillows. Relative A also documented that on 08/08/2021, she observed that the bandage on Resident J's wound (on his back) did not completely cover his wound.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler, Macomb Oakland Regional Center (MORC) case manager

Will Harrison, and Resident R. I also observed Resident J's case notes and MW staff training records. I noted that staff were fully trained.

On 07/20/2021, Ms. Peagler stated that all of the staff were trained regarding Resident J's care. The staff at CLC Mary Wagner (MW) worked closely with Hospice of Michigan (HOM) and Resident J's MORC case manager, Will Harrison, and Resident J's family to coordinate care. Ms. Peagler stated that Relative C visited Resident J almost every day and usually complained and berated the MW staff about Resident J's care. There were a few care planning meetings conducted via Zoom to address the complainant's concerns. In February 2021, when Resident J died, Relative C thanked the MW staff and provided lunch to express his appreciation for the care Resident J received. During the onsite, Mr. Harrison arrived, and I conducted a separate interview with him.

On 7/20/2021, Mr. Harrison stated that due to COVID 19 restrictions, he did not conduct in-person visits with Resident J at MW, but several virtual visits were conducted each month from 07/2020 – February 2021. Mr. Harrison stated that the relatives made several complaints regarding staff not providing wound care for Resident J, but no one from hospice (HOM) complained about the wound care that the staff provided. Mr. Harrison also stated that Relative C was very rude to the staff. Relative C yelled at the staff and put them down, which caused staff to be nervous when the complainant visited Resident J. Mr. Harrison stated that he has worked with several residents at MW, and this is the only complaint he is aware of in the last two years. The HOM staff came to MW several times each week to assist in Resident J's wound care, which was a huge help for the MW staff. Mr. Harrison stated that Resident J's family thought the MW staff could do more than expected for an AFC home.

On 07/20/2021, according to Ms. Peagler, Resident R, is the only resident currently at MW Mary Wagner who is verbal and has the cognitive ability to participate in an interview. I conducted an interview with Resident R in the privacy of his bedroom. Resident R stated that did not remember Resident J. Resident J stated that the food is good at MW, the staff are good at MW, and sometimes they go on outings. Resident R stated that he does not have any complaints about MW. I did not observe or note any concerns regarding Resident R's care or supervision.

On 07/20/2021, I sent an email to the complainant to ask if an alternative placement was sought for Resident J before he died in February 2021. The complainant stated that alternative placement was not feasible because of the COVID- 19 pandemic.

On 07/22/2021, I received an email from Shanise Peagler that contained the MW DCW's names and phone numbers. On 08/03/2021, I left messages for DCW's: Amy Udell, Sierra LeFlore, and Talaya Williams.

On 08/03/2021, I spoke to CLC licensee designee Lisa Murrell. Ms. Murrell stated that CLC took good care of Resident J for his entire adult life. Resident J moved to MW because after he recovered from COVID 19 he required more care. Due to the pandemic, staffing has been an issue at many CLC homes. There are always three staff

per shift at MW, so it was better for Resident J to move. Resident J's family members did not want Resident J to move and at the beginning of his placement at MW it was rough while the staff were acclimated to Resident J, his family members, and his care plan. Resident J was admitted to MW on July 1, 2020, with hospice and palliative care services in place. Ms. Murrell acknowledged that staff may have made some mistakes but overall, Resident J received good care at MW and staff worked very hard to address all of Relative C's concerns. Ms. Murrell stated that Relative C was verbally abusive to the staff at MW. Zoom meetings were held to address Relative C's concerns and things improved. Ms. Murrell corroborated the information provided by Ms. Peagler regarding Relative C thanking the MW staff when Resident J died. Ms. Murrell stated that all of the staff were familiar with Resident J's plan of care and knew how to provide wound care in addition to the HOM nurses and staff who provided care to Resident J several times per week.

On 08/03/2021, I spoke to DCW Amy Udell. Ms. Udell stated that she did not provide direct care to Resident J, but she was familiar with him, and she witnessed other DCW's provide care for Resident J. Ms. Udell stated that HOM staff came to the home almost every day, at least 4 times each week, to provide care for Resident J's wounds.

On 08/03/2021, I sent photos of Resident J to Ms. Murrell via text that included pictures of several open sores on Resident J's body. There were handwritten dates of the photos of the open sores on Resident J's body; 08/10/2020 (lower back/hip), 02/01/2021, (back) 02/03/2021(elbow), 02/05/2021(back).

On 08/06/2021, I received an email from Lisa Murrell that contained Resident J's health care chronological notes (HCC) as well as HOM notes. Ms. Murrell stated.
"HOM staff were contacted prior to 7/30/20 for a new skin breakdown. HOM staff were in the MW home weekly in the beginning and then multiple times a week the last 3-4 weeks of his life. They were closely monitoring pressure wounds, ordering new medical supplies for the home staff, providing instructions on his dietary needs, etc. The pictures of his skin breakdown were taken on 8/10/2020. HOM staff as well as the group home staff were monitoring the wound site since the end of July. On 8/14/2020 there is a note on the HCC indicating that the complainant and Relative P asked the staff to show them the wound and agreed it looked better. Obviously, staff were following the prescribed treatment plans put in place by Hospice."

On 08/06/2021, I reviewed Resident J's HCC and HOM notes and confirmed the information provided by Ms. Murrell.

On 08/24/2021, I contacted Diane Stabnick RN, Reginal Director HOM. I requested HOM records regarding Resident J as well as contact information for the HOM staff that provided care to Resident J.

On 08/26/2021, I received separate emails from Diane Stabnick and Yvette Scales from HOM. Ms. Scales provided clinical notes and assessment notes from HOM staff from 07/30/2020 – 02/07/2021. I noted the following:

HOM clinical note dated 07/30/2021 authored by Debra Langer, MSW.
The complainant continued to express dissatisfaction. The complainant is aware Pt (Resident J) is declining but seemed to want to focus on blame rather than discuss progression of disease. Visits 2+X's a week so he is seeing the decline for himself.

HOM clinical note "dated 01/31/2021 authored by Carolyn Price, RN.
"Skin Integrity: Pt has multiple sites of impairment. Spine has allevyn on which was changed by CG. Right hip boney prominence is pink but blanchable- cleansed and allevyn on to protect. Left hip has multiple reddened scratches. Cleansed and covered to deter from scratching. Left for arm has scratches from pt. moving about in wheelchair. CG had just covered with Allevyn. Reinforced frequent turning in bed as the pts boney prominences have not adipose and are at risk. CG v/u, she changed his position and placed wedges under him to help move off of high-risk hip area."

HOM clinical note dated 02/07/2021 authored by Tawana Fordham, RN.
"Skin Integrity: changed dressing to mid spine, pt. tolerated well, right hip skin intact, and dressing to right hip reinforced as skin intact and dressing still clean and limited wound care supplies which are on order. Reinforced turning and repositioning as tolerated."

Ms. Stabnick provided the names and phone numbers for several HOM Nurses who provided care to Resident J at MW.

On 08/26/2021, I spoke to the following HOM RN's: Brenda Sweeny, Bethann Waldrop, Ann Marie Rowden, and Carolyn Price. I left a message for Jack Nickert.

On 08/26/2021, Brenda Sweeny, RN, stated that she did not remember Resident J and had no information regarding the allegations.

On 08/26/2021, Bethann Waldrop, RN, stated that Resident J had stage 2 (open) wounds and she felt that staff may not have provided immediate care to his wounds regarding cleaning and changing his bandages, but it was nothing out of the ordinary and she did not think that Resident J's wounds weren't properly cared for or that he was neglected. Ms. Waldrop stated that sometimes, she reinforced wound care training with the MW staff regarding changing his bandages more frequently.

On 08/26/2021, Ann Marie Rowden, RN stated that she provided care for Resident J once or twice and she didn't notice any issues. The MW staff seemed to be attentive to Resident J and it did not appear as if MW staff weren't caring for Resident J's wounds or turning him frequently. Ms. Rowden stated that she witnessed Resident J's family members being overly aggressive with staff and she remembered phone calls and case notes regarding the complainant constantly complaining about everything. Resident J's family seemed to be in denial about his end stage of life as his illness progressed, and he declined. This was very difficult for Resident J's family to accept.

On 08/26/2021, Carolyn Price, RN, stated that she provided care for Resident J at MW. The home manager, Ms. Peagler, seemed to have more understanding regarding Resident J's care than some of the other staff at MW. Ms. Price stated that she did not notice any negligence of Resident J.

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 on the information that I gathered from interviews with MW staff, the licensee designee, HOM staff, and review of Resident J's HCC notes, HOM clinical notes, MW training records, and pictures of Resident J I cannot conclude that MW staff were not properly trained to care for Resident J based on his plan of care or his HOM plan of care. HOM staff regularly provided wound care for Resident J in addition to the care provided by MW staff. Resident J was at the end of his life after battling COVID-19, in addition to multiple health concerns. I cannot conclude that a lack of care from the MW staff contributed to Resident J's death or that Resident J received substandard care or was medically neglected.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident J was injured after falling from his wheelchair.**
- **Resident J's wheelchair was soiled.**

INVESTIGATION:

On 06/07/2021, I received a complaint alleging that Resident J sustained injuries after falling out of his wheelchair. The complainant alleged that MW staff did not supervise Resident J or provide assistance to prevent him from falling out of his wheelchair. The complainant also alleged that MW staff did not clean Resident J's wheelchair and it was observed to be soiled.

On 06/11/2021, I received an email from the complainant that contained a picture of Resident J. The date of the picture was handwritten 08/01/2020. I observed purplish bruising on the upper side of Resident J's right eye. I also observed two pictures dated 08/10/2020 of Resident J's wheelchair. The wheelchair was blue with a white strap. On

the first picture, I observed several white stains on the backrest area of the chair. On the second picture, I observed a brown stain that looked like feces with an imprint as if someone had sat in the soiled chair.

The email also contained; an 11-page summary of concerns authored by Relative A. Relative A documented that she mentioned her concerns regarding Resident J falling out of his chair to a MW staff person named Robin. Relative A stated that Resident J leans forward in his chair reaching for something on the floor and she was concerned that he would fall. Robin stated that staff will run and catch Resident J.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager, Shanise Peagler and MORC case manager, Will Harrison.

I shared the allegations and I showed Ms. Peagler the pictures of Resident J, the soiled wheelchair. Ms. Peagler stated that Resident J fell out of his chair in July 2020 and injured his eye. The wheelchair did not have a seat belt and it took a few weeks to get a chair restraint approved by MORC. Resident J's body was very contorted which made it difficult for him to sit upright in a chair. Ms. Peagler provided a copy of an incident report (IR) dated 07/30/2020. The IR was signed by Sierra LeFlore, DCW. Ms. LeFlore documented that she went into Resident J's room at 6:40 PM to change and dress him and noted that a small black bruise above his right eye. The corrective measures documented on the IR dated 07/30/2020 indicate that staff will monitor Resident J for safety. I also observed an IR dated 09/04/2021. The IR was written by Robin Hickman, Medication Coordinator. Ms. Hickman documented that at 8:40 AM, she heard a noise while in the medication room. Ms. Hickman exited the medication room and saw that Resident J had fallen from his wheelchair. The corrective measures documented on the IR dated 09/04/2021 indicate that staff will continue to keep Resident J safe and monitor him at all times.

On 07/20/2021, Mr. Harrison stated that HOM ordered a new wheelchair for Resident J.

On 08/03/2021, I spoke to the licensee designee Lisa Murrell. I shared the allegations. Ms. Murrell stated that she was not sure about how Resident J sustained a black eye, but his skin was very thin and fragile. Ms. Murrell stated that she did not have information regarding Resident J's wheelchair being soiled and that she would review his resident record and provide information afterward. Ms. Murrell also stated that Resident J's body was very contorted, and he was almost always bent over in a "C" shape. He had to be propped in his wheelchair with pillows.

On 08/03/2021, I spoke to DCW Amy Udell. Ms. Udell stated she did not know how Resident J injured his eye. Ms. Udell also stated that if Resident J's wheelchair was soiled, it would have been cleaned during the midnight shift. Extensive cleaning of MW home is done at night because staff are very busy during the day taking care of the residents. Ms. Udell stated that there were six residents at MW while Resident J lived there and there were three staff per shift.

On 08/03/2021, I sent photos of Resident J's bruised eye and soiled wheelchair to Ms. Murrell via text.

On 08/06/2021, I received an email from Lisa Murrell stating *"The first document is the Facility Visit and Collaboration Form dated 7/30/20 written by Katie Doherty. She indicated that the staff should no longer use the belts on his old wheelchair because they were causing new skin breakdown on his hip. This would indicate that they were using a seat belt with the previous wheelchair. On 7/31/20 the new wheelchair arrived the pictures you sent me have three pictures of a dirty chair taken on 8/10/20. I spoke with the staff, and they indicated that since 7/31/20. Resident J had no longer used that chair. The wheelchair was not disposed of because it was on hand as a back -up, however it was never needed. Out of the three pictures the one with blue painters' tape across a black surface is not the resident's wheelchair. It never had a blue tape strip on it, so we do not know what that picture is."*

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information that I gathered from interviews with MW staff, and the pictures I observed of Resident J's eye injury and his soiled wheelchair, I concluded that staff observed Resident J's body to be contorted and there was no way that he could sit up in a chair without risk of falling, action should have been taken to address his safety in the chair prior to him falling and injuring himself. Furthermore, there is not a reasonable explanation regarding staff saving a chair as a backup when the chair was deemed unsafe. Additionally, saving a soiled chair is not sanitary. I concluded that Resident J's personal needs, protection, and safety were not attended to at all times by MW staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

MW staff did not provide wound care per Resident J's hospice instructions.

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW. The complainant alleged that MW staff did not follow instructions from HOM staff regarding Resident J's wound care or tending to his chapped lips. The complainant also alleged that Resident J's hearing aids were never in his ears and staff had to go find Resident J's hearing aids.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations. On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed that Resident J's lips looked chapped on one of the pictures.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler, Macomb Oakland Regional Center (MORC) case manager Will Harrison, and Resident R. I also observed Resident J's case notes and MW staff training records. I noted that staff were fully trained.

On 07/20/2021, Ms. Peagler stated that all of the staff were trained regarding Resident J's care. The staff at CLC Mary Wagner (MW) worked closely with Hospice of Michigan (HOM) and Resident J's MORC case manager, Will Harrison, and Resident J's family to coordinate care. Ms. Peagler stated that staff kept Resident J's lips as moisturized as they could. Resident J's lips were regularly dry and often it was hard for staff to get Resident J to drink water and HOM said staff should not force food or water. Ms. Peagler stated that she and her staff followed hospice instructions regarding Resident J's wound care. MW staff changed his bandages, cleaned his wounds, and notified HOM if a wound was leaking or if there were questions regarding wound care. Ms. Peagler stated that Resident J was constantly removing his hearing aids. Staff tried to keep his hearing aids in his ears.

On 07/20/2021, Mr. Harrison stated that due to COVID 19 restrictions, he did not conduct in-person visits with Resident J at MW, but several virtual visits were conducted each month from 07/2020 – February 2021. Mr. Harrison stated that The complainant made several complaints regarding staff not providing wound care for Resident J, but no one from hospice (HOM) complained about the wound care that the staff provided. The HOM staff came to MW several times each week to assist in Resident J's wound care, which was a huge help for the MW staff. Mr. Harrison stated that Resident J's family thought the MW staff could do more than expected for an AFC home.

On 07/20/2021, during the onsite investigation, I observed several health care chronological notes (HCC). I observed an HCC note dated 08/18/2020, initialed by "NH". NH documented that MW staff checked on Resident J at 9:00 PM and noticed that Resident J had ripped off his bandage and was digging in his wound. I also observed an HCC note dated 08/19/2020, authored by Ms. Peagler. Ms. Peagler documented the

HOM evaluated Resident J's tongue after Relative C reported that Relative J had thrush. The HOM nurse (name not documented) reported that the dryness on Resident J's tongue could be caused by the antibiotics (Cipro 500mg) that Resident J is taking. MW staff also reported to HOM that Resident J digs in his wounds. I also noted several Health Care Chronological notes (HCC) authored by various MW staff. I noted that MW staff documented that Resident J removed his hearing aids on the following dates: 08/06/2020, 08/18/2020, and 08/28/2020

On 07/20/2021, I sent an email to the complainant to ask if an alternative placement was sought for Resident J before he died in February 2021. The complainant stated that alternative placement was not feasible because of the COVID- 19 pandemic.

On 07/22/2021, I received an email from Shanise Peagler that contained the MW DCW's names and phone numbers. On 08/03/2021, I left messages for DCW's: Amy Udell, Sierra LeFlore, and Talaya Williams.

On 08/03/2021, I spoke to CLC licensee designee Lisa Murrell. Ms. Murrell stated that all of the staff were familiar with Resident J's plan of care and knew how to provide wound care in addition to the HOM nurses and staff who provided care to Resident J several times per week.

On 08/03/2021, I spoke to DCW Amy Udell. Ms. Udell stated that she did not provide direct care to Resident J, but she was familiar with him, and she witnessed other DCW's provide care for Resident J. Ms. Udell stated that HOM staff came to the home almost every day, at least 4 times each week, to provide care for Resident J's wounds.

On 08/03/2021, I sent photos of Resident J to Ms. Murrell via text that included pictures of several open sores on Resident J's body. There were handwritten dates of the photos of the open sores on Resident J's body; 08/10/2020 (lower back/hip), 02/01/2021, (back) 02/03/2021(elbow), 02/05/2021(back).

On 08/06/2021, I received an email from Lisa Murrell that contained Resident J's health care chronological notes (HCC) as well as HOM notes. Ms. Murrell stated.
"HOM staff were contacted prior to 7/30/20 for a new skin breakdown. HOM staff were in the MW home weekly in the beginning and then multiple times a week the last 3-4 weeks of his life. They were closely monitoring pressure wounds, ordering new medical supplies for the home staff, providing instructions on his dietary needs, etc. The pictures of his skin breakdown were taken on 8/10/2020. HOM staff as well as the group home staff were monitoring the wound site since the end of July. On 8/14/2020 there is a note on the HCC indicating that the complainant and Relative P asked the staff to show them the wound and agreed it looked better. Obviously, staff were following the prescribed treatment plans put in place by Hospice."

On 08/06/2021, I observed Resident J's HCC and HOM notes and confirmed the information provided by Ms. Murrell.

On 08/24/2021, I contacted Diane Stabnick RN, Reginal Director HOM. I requested HOM records regarding Resident J as well as contact information for the HOM staff that provided care to Resident J.

On 08/26/2021, I received separate emails from Diane Stabnick and Yvette Scales from HOM. Ms. Scales provided clinical notes and assessment notes from HOM staff from 07/30/2020 – 02/07/2021. I noted the following:

HOM clinical note dated 08/19/2021, authored by Jack Nickert, RN.
Signs of Disease Progression: Weakness, Incontinence
Primary Caregiver/Family Instructed in Disease Progression: "Identify and discuss the symptoms, Tell Hospice staff when symptoms begin to occur, offer foods and fluids when the Patient is hungry/thirsty, do not force food or fluids."

HOM clinical note dated 07/30/2021 authored by Debra Langer, MSW.
"The complainant continued to express dissatisfaction. The complainant is aware Pt (Resident J) is declining but seemed to want to focus on blame rather than discuss progression of disease. Visits 2+X's a week so he is seeing the decline for himself."

HOM clinical note dated 01/31/2021 authored by Carolyn Price, RN.
Skin Integrity: "Pt has multiple sites of impairment. Spine has allevyn on which was changed by CG. Right hip boney prominence is pink but blanchable- cleansed and allevyn on to protect. Left hip has multiple reddened scratches. Cleansed and covered to deter from scratching. Left for arm has scratches from pt. moving about in wheelchair. CG had just covered with Allevyn. Reinforced frequent turning in bed as the pts boney prominences have not adipose and are at risk. CG v/u, she changed his position and placed wedges under him to help move off of high-risk hip area."

HOM clinical note dated 02/07/2021 authored by Tawana Fordham, RN.
Skin Integrity: "Changed dressing to mid spine, pt. tolerated well, right hip skin intact, and dressing to right hip reinforced as skin intact
and dressing still clean and limited wound care supplies which are on order. Reinforced turning and repositioning as tolerated."
Ms. Stabnick provided the names and phone numbers for several HOM Nurses who provided care to Resident J at MW.

On 08/26/2021, I spoke to the following HOM RN's: Brenda Sweeny, Bethann Waldrop, Ann Marie Rowden, and Carolyn Price. I left a message for Jack Nickert.

On 08/26/2021, Brenda Sweeny, RN, stated that she did not remember Resident J and had no information regarding the allegations. Bethann Waldrop, RN, stated that Resident J had stage 2 (open) wounds and she felt that staff may not have provided immediate care to his wounds regarding cleaning and changing his bandages, but it was nothing out of the ordinary and she did not think that Resident J's wounds weren't properly cared for or that he was neglected. Ms. Waldrop stated that sometimes, she

reinforced wound care training with the MW staff regarding changing his bandages more frequently.

On 08/26/2021, Ann Marie Rowden, RN stated that she provided care for Resident J once or twice and she didn't notice any issues. The MW staff seemed to be attentive to Resident J and it did not appear as if MW staff weren't caring for Resident J's wounds or turning him frequently. Ms. Rowden stated that she witnessed Resident J's family members being overly aggressive with staff and she remembered phone calls and case notes regarding The complainant constantly complaining about everything. Resident J's family seemed to be in denial about his end stage of life as his illness progressed, and he declined. This was very difficult for Resident J's family to accept.

On 08/26/2021, Carolyn Price, RN, stated that she provided care for Resident J at MW. The home manager, Ms. Peagler, seemed to have more understanding regarding Resident J's care than some of the other staff at MW. Ms. Price stated that she did not notice any negligence of Resident J. She did note that there were times when Resident J did not have his hearing aids inserted and she had to ask MW staff to insert his hearing aids.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on the information that I gathered from interviews with MW staff and HOM staff, there is not substantial evidence to confirm that MW staff did not follow hospice wound care instructions provided for Resident J. None of the hospice nurses provided information to indicate that there were concerns about Resident J's wound care from MW staff. Additionally, hospice staff visited Resident J multiple times each week to provide care for Resident J's wounds.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 8/10/2021, Resident J left the facility with another resident's medication.

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations.

On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed a summary of concerns authored by The complainant from 07/01/2020 – 02/08/2021. I noted a paragraph regarding a medication error. The complainant documented that the second time Resident J was picked up to visit his home for the weekend, MW staff gave him Resident I's medication. I also observed two pictures with a handwritten date of 08/10/2021, of Resident I's pill pack of medication in a clear Ziploc bag labeled Resident J's PM meds and Resident I's pill pack of medication in a clear Ziploc bag labeled Resident J's AM med.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler.

Ms. Peagler stated that the allegations regarding the medication mix up was true. The complainant came to pick Resident J up for a weekend visit and one of the MW staff put Resident I's medication in Resident J's bag by mistake. MW staff met Relative C to retrieve the medications and provided Resident C with the correct medications. Resident J never consumed Resident I's medication and Resident I did not miss any of her prescribed medications.

On 08/06/2021, I received an email from Lisa Murrell that contained an incident report (IR) dated 08/10/2020. Ms. Murrell stated "In regard to the situation with the wrong packet of medication being sent home to the family. The staff called the family when they discovered the error and arranged to meet the complainant and exchange the packages." I observed the IR, which documented that DCW Marquita received a call regarding Relative C having the wrong medications. Marquita called Relative C, who stated that Resident J had not taken any of the medication provided. The IR was signed by the home manager, Ms. Peagler.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative,

	the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on the information that I gathered from the complainant, the home manager, Ms. Peagler, and the licensee designee, Ms. Murrell, I concluded that Relative C was not provided with the correct medication. Resident J did not consume the medication that was provided to Relative C in error. The MW staff did not take reasonable care to assure that Relative J had the proper medication while out of the MW home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 10/25/2020, Resident J's food was not cut into bite sized portions

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations.

On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed a summary of concerns authored by the complainant from 07/01/2020 – 02/08/2021. I noted a paragraph regarding Resident J's food not being cut in bite sized pieces. The complainant documented that on 07/08/2020, MW staff were given a photo depicting the way Resident J's food should be cut. I also observed a picture of food with the handwritten date of 10/25/2020. I observed a piece of meat that resembled a sausage patty or hamburger. The meat was not cut into bite sized pieces.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler and I observed Resident J's record. I noted that Resident J's food was to be cut in bite sized portions to prevent choking.

Ms. Peagler stated that MW staff followed the food portion instructions and there may have been times when family members complained that Resident J's food should be cut in smaller portions. I showed Ms. Peagler the photo dated 10/25/2020. Ms. Peagler acknowledged that Resident J's food was not properly cut on 10/25/2020.

On 08/06/2021, I received an email from Lisa Murrell that contained a statement regarding Resident J's food portions. Ms. Murrell stated, "The home manager has a book created for staff on this resident's treatment. On a daily basis they documented blood pressure, weight (weekly), wound care and bathing, bowel movements, temperature, teeth brushing and eating and drinking. There are pictures of food and the size the individual pieces should be cut into. I cannot explain why, on 10/25/20 there was a plate of food not cut to specifications. I do know that staff were instructed to sit next to him during all meals and hand fed him. There were zero choking incidents during the time he lived at Wagner."

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Based on the information that I gathered from the complainant, the home manager, Ms. Peagler, and the licensee designee, Ms. Murrell, I concluded that on 10/25/2020, the MW staff did not cut Resident J's food into bite sized portions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident J's hands and fingernails are always dirty.

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations.

On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed a summary of concerns authored by the complainant from 07/01/2020 – 02/08/2021. I noted a paragraph regarding Resident J's hands and nails being dirty all the time. The complainant documented that Resident J ate with his hands. The complainant also documented that

Resident J was not bathed enough. I observed pictures of Resident J on the following handwritten dates:
07/06/2020- I observed Resident J's left hand. His hand and nails appeared clean.
07/27/2020- I observed Resident J's hand (I could not identify right or left due to the position of the picture) Resident J's nails look discolored, however I did not observe that his hand was dirty or that his nails were not trimmed or clean.
08/01/2020 -I observed Resident J's hand (I could not identify right or left due to the position of the picture) Resident J's hands and nails were dirty with brownish, reddish stains.
08/06/2020- I observed Resident J's right hand. His hand was clean, and his nails were clean and trimmed.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler, and Macomb Oakland Regional Center (MORC) case manager Will Harrison. I also observed Resident J's case notes.

Ms. Peagler stated that Resident J was bathed regularly. MW staff and hospice staff provided assistance with grooming, including trimming Resident J's nails.

Mr. Harrison stated that he conducted monthly virtual visits with Resident J and several other residents at MW. Resident J appeared to be clean and well-groomed during the virtual visits.

On 07/22/2021, I received an email from Shanise Peagler that contained the MW DCW's names and phone numbers.

On 08/03/2021, I left messages for DCW's: Amy Udell, Sierra LeFlore, and Talaya Williams.

On 08/03/2021, I spoke to CLC licensee designee Lisa Murrell. Ms. Murrell corroborated the information provided by Ms. Peagler.

On 08/03/2021, I spoke to DCW Amy Udell. Ms. Udell stated that she did not provide direct care to Resident J, but she was familiar with him, and she witnessed other DCW's provide care for Resident J. Ms. Udell stated that HOM staff came to the home almost every day, at least 4 times each week, to provide care for Resident J's and he received bathes at least 4 times each week or more often if needed.

On 08/24/2021, I contacted Diane Stabnick RN, Reginal Director HOM. I requested HOM records regarding Resident J as well as contact information for the HOM staff that provided care to Resident J.

On 08/26/2021, I received separate emails from Diane Stabnick and Yvette Scales from HOM. Ms. Scales provided clinical notes and assessment notes from HOM staff from 07/30/2020 – 02/07/2021. I did not observe any documentation regarding Resident J being unclean, not groomed, or that his nails were dirty or untrimmed.

On 08/26/2021, I spoke to the following HOM RN's: Brenda Sweeny, Bethann Waldrop, Ann Marie Rowden, and Carolyn Price. I left a message for Jack Nickert. None of the RN's confirmed the allegations regarding Resident J's grooming or hygiene. None of the RN's reported that they observed Resident J to be ungroomed or unclean.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(3) A licensee shall afford a resident opportunity, and instructions, when necessary, to obtain haircuts, hair sets, or other grooming processes.
ANALYSIS:	Based on the information that I gathered, I cannot conclude that MW staff failed to properly groom, bathe, or trim Resident J's nails. The complainant provided four pictures of Resident J's hands, dated 07/06/2020, 07/27/2020, 08/01/2020, and 08/06/2021. I observed Resident J's nails dirty one of the pictures provided dated 08/01/2020.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is visible overflowing garbage.

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW. The complainant alleged that MW home was dirty and that there was visible overflowing garbage.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations.

On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed a summary of concerns authored by the complainant from 07/01/2020 – 02/08/2021. There was no mention of overflowing trash in the 6-page summary of concerns. There were no pictures of overflowing trash.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler, Macomb Oakland Regional Center (MORC) case manager Will Harrison, and Resident R. I also observed the physical plant at MW home. I did not see any overflowing trash.

On 07/20/2021, Ms. Peagler stated that the trash is emptied on a regular basis, and she did not recall a time when the trash was overflowing.

On 07/20/2021, Mr. Harrison stated that due to COVID 19 restrictions, he did not conduct in-person visits with Resident J at MW, but several virtual visits were conducted each month from 07/2020 – February 2021. Mr. Harrison stated that he visits MW home several times a month now that pandemic restrictions have been lifted and he has not seen the trash overflowing.

On 07/20/2021, according to Ms. Peagler, Resident R, is the only resident currently at MW Mary Wagner who is verbal and has the cognitive ability to participate in an interview. I conducted an interview with Resident R in the privacy of his bedroom. Resident R stated that the staff empty the garbage all day.

On 07/22/2021, I received an email from Shanise Peagler that contained the MW DCW's names and phone numbers. On 08/03/2021, I left messages for DCW's: Amy Udell, Sierra LeFlore, and Talaya Williams.

On 08/03/2021, I spoke to CLC licensee designee Lisa Murrell. Ms. Murrell stated that staff work very hard to keep the home clean and the trash is emptied on a daily basis.

On 08/03/2021, I spoke to DCW Amy Udell. Ms. Udell stated that extensive cleaning of the home is done during the midnight shift. There are times when the staff will empty the trash, change the bags, and move the trash towards the door to be taken outside at one time, but the trash does not overflow.

On 08/24/2021, I contacted Diane Stabnick RN, Reginal Director HOM. I requested HOM records regarding Resident J as well as contact information for the HOM staff that provided care to Resident J.

On 08/26/2021, I spoke to the following HOM RN's: Brenda Sweeny, Bethann Waldrop, Ann Marie Rowden, and Carolyn Price. I left a message for Jack Nickert. None of the RN’s confirmed the allegations regarding overflowing trash. None of the RN’s stated that they saw trash overflowing at MW home.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(4) All garbage and rubbish that contains food wastes shall be kept in leakproof, nonabsorbent containers. The containers

	shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.
ANALYSIS:	Based on the information that I gathered from interviews with MW staff and HOM staff and an onsite inspection, there is not substantial evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is a broken table and chair and buckled flooring that poses risk of injury.

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW. The complainant alleged that there was a broken table and chair left out that posed potential danger to residents.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations. On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed a summary of concerns authored by the complainant from 07/01/2020 – 02/08/2021. The complainant documented that his wife fixed the table leg that was about to fall off because she was concerned that a resident would lean against it and fall. I also observed a summary of concerns dated 08/07/20- 08/08/2020, authored by Relative A. Relative A documented that she observed many dining chairs propped up against the wall needing repair. There were no pictures of broken furniture provided.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler, Macomb Oakland Regional Center (MORC) case manager Will Harrison, and Resident R. I also observed the physical plant at MW home. I did not see any broken furniture. I observed that the MW home was under construction. There was a plastic barrier around the kitchen area.

On 07/20/2021, Ms. Peagler stated that the kitchen was being remodeled and that all of the flooring is being replaced. The flooring was replaced a few years ago by volunteers, but it did not last very long. There was no one available to replace flooring during the pandemic. Ms. Peagler stated that if the staff notice a chair that needs repair, a work order is completed, and the chair is moved out so that the residents can't use it. Ms. Peagler stated that during the pandemic it was difficult to get repairs completed or get furniture delivered.

On 07/20/2021, Mr. Harrison stated that due to COVID 19 restrictions, he did not conduct in-person visits with Resident J at MW, but several virtual visits were conducted each month from 07/2020 – February 2021. Mr. Harrison stated that he visits MW home several times a month now that pandemic restrictions have been lifted and he has not seen any broken furniture at MW.

On 07/20/2021, according to Ms. Peagler, Resident R, is the only resident currently at MW Mary Wagner who is verbal and has the cognitive ability to participate in an interview. I conducted an interview with Resident R in the privacy of his bedroom. Resident R stated that he has not seen any broken furniture and the floors seem ok to him.

On 07/22/2021, I received an email from Shanise Peagler that contained the MW DCW's names and phone numbers. On 08/03/2021, I left messages for DCW's: Amy Udell, Sierra LeFlore, and Talaya Williams.

On 08/03/2021, I spoke to CLC licensee designee Lisa Murrell. Ms. Murrell corroborated the information provided by Ms. Peagler. Ms. Murrell added that all of the flooring has been replaced and this is the 2nd time in in 10 years that the floors have been replaced at MW home.

On 08/03/2021, I spoke to DCW Amy Udell. Ms. Udell stated corroborated the information provided by Ms. Peagler. Ms. Udell also stated that the floors were due to be repaired right before the pandemic. The repair was put on hold because no one could come into MW. The floors are now brand new.

On 08/24/2021, I contacted Diane Stabnick RN, Reginal Director HOM. I requested HOM records regarding Resident J as well as contact information for the HOM staff that provided care to Resident J.

On 08/26/2021, I spoke to the following HOM RN's: Brenda Sweeny, Bethann Waldrop, Ann Marie Rowden, and Carolyn Price. I left a message for Jack Nickert. None of the RN's confirmed the allegations regarding broken furniture. None of the RN's stated that they saw broken furniture or mentioned buckled flooring at MW home.

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 on the information that I gathered from interviews with MW staff and HOM staff, I cannot conclude that there was a broken table, or broken chairs that were out in the open for the residents' use. There were no pictures provided and none of the HOM or MW staff corroborated the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **The MW home is dirty.**
- **There are sticky tables and chairs.**
- **The floors are sticky.**

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW. The complainant alleged that the furniture and flooring was sticky and disgusting.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations.

On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed a summary of concerns authored by the complainant from 07/01/2020 – 02/08/2021. The complainant documented that "Everything in the MW home was dirty and sticky, the chairs, table, and floors were disgusting." I also observed a summary of concerns dated 08/07/20-08/08/2020, authored by Relative A. Relative A documented that the tabletop is sticky, grimy and needs refinishing. ("The lack of cleanliness there is unacceptable")

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler. I also observed the physical plant at MW home. I did observe that the dining room table and chairs were sticky. I did not observe debris or stains. The flooring was sticky as well. I observed that the floor in the great room/dining room was dirty and needed to be mopped

Ms. Peagler stated that the kitchen was being remodeled and that the MW home gets dirty because of the current stage of remodeling. Ms. Peagler stated that she thinks a new table and chairs have been ordered as well.

On 07/22/2021, I received an email from Shanise Peagler that contained the MW DCW's names and phone numbers. On 08/03/2021, I left messages for DCW's: Amy Udell, Sierra LeFlore, and Talaya Williams.

On 08/03/2021, I spoke to CLC licensee designee Lisa Murrell. Ms. Murrell corroborated the information provided by Ms. Peagler. Ms. Murrell added that “the tables are a mess” and acknowledged that the furniture and floors are sticky because of the cleaning products they use. The cleaning products are strong because of the disinfectant levels required due to the pandemic. The cleaners have stripped the varnish from the tables and chairs.

On 08/03/2021, I spoke to DCW Amy Udell. Ms. Udell’s statements corroborated the information provided by Ms. Peagler and Ms. Murrell. Ms. Udell stated that the tables and chairs were sticky.

On 08/24/2021, I contacted Diane Stabnick RN, Reginal Director HOM. I requested HOM records regarding Resident J as well as contact information for the HOM staff that provided care to Resident J.

On 08/26/2021, I spoke to the following HOM RN's: Brenda Sweeny, Bethann Waldrop, Ann Marie Rowden, and Carolyn Price. I left a message for Jack Nickert.

On 08/26/2021, Brenda Sweeny, RN, stated that she did not remember Resident J and had no information regarding the allegations.

On 08/26/2021, Bethann Waldrop, RN, stated that her overall impression was that the MW home was not a very clean place.

On 08/26/2021, Ann Marie Rowden, RN stated that she did not notice any issues, there was no excessive dirtiness.
On 08/26/2021, Carolyn Price, RN, stated that the MW home could be messy, and that Resident J’s room was messy and unorganized. The staff could have done a better job at keeping his room clean. The MW home had minimal standards of cleanliness.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	Based on the information that I gathered from the complainant, Relative A, MW staff, HOM staff and my own observations, I concluded that the furniture was sticky. The furniture was not stained or did not appear dirty. It was reported by the facility staff that the cleaning products cause the furniture to have a sticky residue. The MW staff and licensee designee should seek other disinfectant cleaning solutions that do not leave an unpleasant sticky residue or replace the furniture that has been damaged.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	Based on the information that I gathered from the complainant, Relative A, MW staff, HOM staff and my own observations, I concluded that the flooring at MW home was sticky. Whether the stickiness was caused by a lack of cleaning, or the cleaning products used, the flooring should not have a sticky residue. The MW staff and licensee designee should seek other disinfectant cleaning solutions that do not leave an unpleasant sticky residue on the floors. The floors should be swept and mopped regularly, and perhaps more often during the remodeling of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident J's linen is soiled.

INVESTIGATION:

On 06/07/2021, received a complaint from the BCAL online complaint unit reporting neglect of Resident J by CLC Mary Wagner (MW) staff. Resident J was diagnosed with downs syndrome, scoliosis, arthritis, osteoporosis, and dementia/Alzheimer's. Resident J relocated from CLC Code AFC Home on 07/01/2021 to MW. The complainant alleged that Resident J's linen was soiled.

On 06/07/2021, I initiated the investigation by sending an email to the complainant regarding the allegations. On 06/11/2021, I received 12 email messages from the complainant that contained multiple allegations and pictures of Resident J. I observed a picture of Resident J's pillowcase that had several crusty dry yellowish stains. The picture had a handwritten date of 08/25/2020.

On 07/20/2021, I conducted an unannounced onsite where I interviewed the home manager Shanise Peagler. I also observed the physical plant and bed linens in several bedrooms. I did not observe any dirty bed linens.

On 07/20/2021, Ms. Peagler stated that the residents' bed linens are washed on a daily basis. Ms. Peagler stated that the pillowcase could have been stained from Resident J's wound drainage as staff used a pillow to prop him in his wheelchair. Resident J was checked on an hourly basis. I asked if Resident J was checked, staff should have noticed the stained pillowcase before the stains became crusted and dry.

On 07/22/2021, I received an email from Shanise Peagler that contained the MW DCW's names and phone numbers. On 08/03/2021, I left messages for DCW's: Amy Udell, Sierra LeFlore, and Talaya Williams.

On 08/03/2021, I spoke to CLC licensee designee Lisa Murrell. Ms. Murrell corroborated the information provided by Ms. Peagler.

On 08/03/2021, I spoke to DCW Amy Udell. Ms. Udell stated that residents are checked every two hours and sometimes more often than that if a resident requires it. Soiled bed sheets and pillowcases are washed daily.

On 08/06/2021, I received an email from Lisa Murrell. Ms. Murrell stated "Regarding the picture on 8/25/20 regarding a soiled pillowcase, I counted the number of visitors in the home specifically to see this resident from July 6, 2020- October 8, 2020 (I stopped counting after that). There were 73 people in that period of time. During that whole time the complainant took one picture of a soiled pillowcase. He did not provide a time or explanation. According to our visitor logs he and his wife arrived at 9:55am. There could have been a multitude of things going on inside the home, up to and including laundry for 8 other residents, breakfast being cleaned up, transport for some of the residents who had just started going back to their vocational programs, etc. One picture over several months does not support an allegation of staff not taking care of someone. Resident J soiled his linens daily and staff were constantly changing his bedding, his clothes, etc. Because the picture was taken with this resident out of the bed, I can only assume that they were in the process of doing laundry, cleaning, providing personal care to him and others and since it was only 10am, they had not gotten the opportunity to finish their shift tasks for the day. Morning staff arrive at 6am and do not leave until 2pm. They could very well had been in the process of doing their work when the family arrived." Ms. Murrell also documented "I hope you can see with all the documentation, the amount of family visits that occurred and with the assistance of the Hospice staff

that the Wagner staff tried to stay on top of everything and provide the resident with the highest quality of love and care during his final stages of life. He came into Wagner House with hospice services and diagnosed with Alzheimer's disease, Down's Syndrome, COVID-19, Hypotension, incontinence, disoriented, generalized weakness with a prognosis of less than 6 month of life. He survived a little of 7 months. I realize the family is grieving, as is the CLC staff. This resident came into our organization in 1988, he was a long standing, loved resident."

On 08/10/2021, I responded to Ms. Murrell's email and conducted the 1st exit conference. I shared my initial findings.

On 08/24/2021, I contacted Diane Stabnick RN, Reginal Director HOM. I requested HOM records regarding Resident J as well as contact information for the HOM staff that provided care to Resident J.

On 08/26/2021, I spoke to the following HOM RN's: Brenda Sweeny, Bethann Waldrop, Ann Marie Rowden, and Carolyn Price. I left a message for Jack Nickert.

On 08/26/2021, Brenda Sweeny, RN, stated that she did not remember Resident J and had no information regarding the allegations.

On 08/26/2021, Bethann Waldrop, RN, stated that her overall impression was that the MW home was not a very clean place and maybe once or twice, his linen needed to be changed.

On 08/26/2021, Ann Marie Rowden, RN stated that she did not notice any issues, there was no excessive dirtiness.

On 08/26/2021, Carolyn Price, RN, stated that the MW home could be messy, and that Resident J's room was messy and unorganized. The staff could have done a better job at keeping his room clean. The MW home had minimal standards of cleanliness.

On 08/26/2021, I conducted a 2nd exit conference with Ms. Murrell via email. I shared my findings and requested a corrective action plan based on the licensing rule violations I referenced in my findings.

On 09/08/20'21, I made a referral to adult protective services (APS) to report the complainant's allegations regarding the facility being dirty.

APPLICABLE RULE	
R 400.15411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed

	linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	Based on the information that I gathered from the complainant, Relative A, MW staff, HOM staff and the photo of the pillowcase dated 08/25/2020, I concluded that Resident J's pillowcase was stained and not changed or cleaned in a timely manner. I observed from a picture a dry crusty yellowish substance in several areas of Resident J's pillowcase.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

09/08/2021

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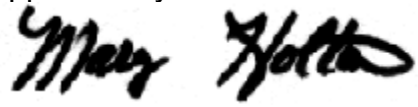
Kenyatta Lewis Date
Licensing Consultant

Approved By:



09/08/2021

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Mary E. Holton Date
Area Manager