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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 8, 2021

Ramon Beltran
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS390396198
Investigation #: 2021A0462046
Beacon Home At Augusta

Dear Mr. Beltran:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2021A0462046
Complaint Receipt Date:	08/12/2021
Investigation Initiation Date:	08/13/2021
Report Due Date:	10/11/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Navi Kaur
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Augusta
Facility Address:	817 Webster St. Augusta, MI 49012
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2021
Expiration Date:	05/28/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
While working at the facility on 08/10/2021, Direct Care Worker 1 was informed by her doctor she had shingles. Despite being contagious, Direct Care Worker 1 was instructed to work the remainder of her shift, placing the facility's six residents at risk.	No
The facility does not have sufficient direct care staff on duty to provide for the supervision, personal care, and protection of the residents and to provide the services specified in the residents' Community Mental Health Behavior Treatment Plans.	Yes
Additional finding.	Yes

III. METHODOLOGY

08/12/2021	Special Investigation Intake 2021A0462046
08/13/2021	Special Investigation Initiated – Email exchange with Kalamazoo County Recipient Rights Officer Michele Schiebel.
08/16/2021	Contact- Separate face-to-face interviews with DCWs Sheena Shirley, Jessica Garten, and Taylor Fawley, assistant home manager Heather Cortez, and home manager Marie Ulrich via Microsoft Teams.
08/17/2021	Contact- Face-to-face interview with district director Navi Kaur via Microsoft Teams.
09/22/2021	Contact- Requested and received documentation via email. Contact- Telephone interview with DCW1.
09/27/2021	Unannounced investigation onsite. Face-to-face interview with home manager Marie Ulrich.
09/30/2021	Contact- Separate face-to-face interviews with home manager Marie Ulrich and direct care worker Jessica Garten via Microsoft Teams.
10/08/2021	Exit conference with Ramon Beltran via telephone.

ALLEGATION: While working at the facility on 08/10/2021, Direct Care Worker 1 was informed by her doctor she had Shingles. Despite being contagious, Direct Care Worker 1 was instructed to work the remainder of her shift, placing the facility's six residents at risk.

INVESTIGATION: On 08/12/2021 the Bureau of Community and Health Systems (BCHS) received a written compliant via the BCHS' online complaint system. This allegation was indicated in the written complaint.

I conducted a search of Shingles using the internet search engine Google. According to www.mayoclinic.org, shingles is a nonlife-threatening viral infection that caused a painful rash with blisters. According to information found at mayoclinic.org, Shingles cannot be passed from one individual to another. While the risk is low, exposure to fluid from Shingles blisters could cause those individuals who never had Chickenpox, or never received the Chickenpox vaccine, to contract Chickenpox.

On 08/13, via email, Kalamazoo County Recipient Rights Officer Michele Schiebel informed me she was also investigating this allegation. On 08/16 Ms. Schiebel and I conducted separate face-to-face interviews with direct care workers Sheena Shirley and Jessica Garten, assistant home manager Heather Cortez, and home manger Marie Ulrich via Microsoft Teams.

According to Ms. Shirley, on 08/10 she, Ms. Garten, Direct Care Worker 1 (DCW1), assistant home manager Heather Cortez, and home manager Marie Ulrich worked at the facility during the facility's first shift. Ms. Shirley stated Ms. Cortez and Ms. Ulrich were not counted in the direct care worker to resident ratio, as they worked primarily in their basement office, while she, Ms. Garten, and DCW1 provided personal care, supervision, and protection to the home's six residents. According to Ms. Shirley, at approximately 10:30AM on 08/10 she took a picture of a rash that had developed on DCW1's shoulder so that DCW1 could send the picture to her doctor. Ms. Shirley stated that at approximately 2:00PM, DCW1's doctor confirmed, via text message, DCW1 had Shingles. According to Ms. Shirley, DCW1 asked Ms. Ulrich if she could go home, and was told no. Ms. Shirley stated Ms. Ulrich then left the facility at approximately 3:00PM. According to Ms. Shirley, Ms. Cortez unsuccessfully attempted to get one of the direct care workers scheduled to work the facility's evening shift to report to the facility early, so that DCW1 could go home. Ms. Shirley stated DCW1 left the facility at the end of her shift at 7:15PM, approximately five hours after she was diagnosed with Shingles. According to Ms. Shirley, Ms. Ulrich and/or Ms. Cortez should have instructed DCW1 to go home immediately and then "covered" her shift themselves. Ms. Shirley expressed her concern that by being directed to stay, DCW1 could have exposed residents and other facility staff members to Shingles. According to Ms. Shirley, she instructed DCW1 to not touch anyone or anything. Ms. Shirley stated she and Ms. Garten "picked up the slack" to ensure all residents were properly cared for. According to Ms. Shirley, after DCW1 completed her shift on 08/10, Ms. Ulrich removed DCW1 from the direct care worker schedule for two weeks after locating appropriate coverage.

Ms. Garten's statements regarding the allegation were consistent with the statements provided to me by Ms. Shirley. Ms. Garten stated that before Ms. Ulrich left the facility on 08/10, she overheard Ms. Ulrich tell DCW1 to "stop stressing" and to keep her shirt over her rash so that she would not expose anyone to Shingles. According to Ms. Garten, Ms. Cortez chose to remain working in the facility's basement instead of covering the remainder of DCW1's shift so that she could go home. Ms. Garten confirmed that after receiving a Shingles diagnosis on 08/10, DCW1 stopped completing "hands-on" work responsibilities so that she would not physically touch any of the residents. According to Ms. Garten, this was difficult as all six residents were present in the facility at this time, and both Residents A and B required 1:1 enhanced supervision by one direct care worker. However, ultimately all six residents' care and supervision needs were met.

Ms. Cortez stated that on 08/10 she split her work time between the facility and another facility, also owned and operated by the licensee. According to Ms. Cortez, after spending time at the other facility, she reported to the facility at approximately 5:45PM. Shortly after this, she received a copy of a written statement from DCW1's physician indicating DCW1 had been diagnosed with Shingles and was to be taken off the schedule for two weeks. Ms. Cortez stated, "it was too late in the shift to do anything". According to Ms. Cortez, she immediately forwarded the written physician's statement to Ms. Ulrich and district director Navi Kaur. Ms. Cortez stated that at approximately 5:50PM, she received a text message from Ms. Ulrich who confirmed she received the written statement and was working on finding coverage for the next two weeks. According to Ms. Cortez, Ms. Ulrich stated "(DCW1) should leave". Ms. Cortez stated she then told DCW1 she could leave. However, DCW1 decided to stay and "talk". Ms. Cortez stated she did not know why she did not insist DCW1 go home at this time and/or why she allowed her to stay at the facility.

Ms. Ulrich confirmed she was working in her basement office at the facility on 08/10 when at approximately 2:00-3:00PM, DCW1 approached her and "nonchalantly" stated, "my doctor thinks I have shingles" and "it's ok, I can stay". Ms. Ulrich stated that, not knowing much about Shingles, she allowed DCW1 to remain working at the facility. According to Ms. Ulrich, she did not receive a copy of DCW1's written physician's statement confirming her official diagnosis of Shingles until "much later" on 08/10, when she was no longer at the facility. Ms. Ulrich stated that had DCW1 told her she was in pain and/or requested to leave the facility, she would have contacted Ms. Cortez, who was at another facility, and requested she report to the facility to cover the remainder of DCW1's shift. According to Ms. Ulrich, there was currently a staffing shortage at the facility, which caused a stressful work environment for facility staff members. Subsequently, direct care workers were upset with her and "filing complaints". Ms. Ulrich admitted DCW1 should have been instructed to leave the facility once Ms. Cortez received a copy of a written physician's statement confirming DCW1's Shingles diagnosis.
On 08/17 Ms. Schiebel and I conducted a face-to-face interview with district director Navi Kaur via Microsoft Teams. According to Ms. Kaur, she was made aware of DCW1's Shingles diagnosis on 08/11. Ms. Kaur stated it was her understanding DCW1 was instructed to leave the facility immediately after it was confirmed she had Shingles. Ms. Kaur acknowledged that if Ms. Ulrich lacked knowledge regarding the prevention and containment of Shingles, she should have called Ms. Kaur for direction following her initial conversation with DCW1.

On 09/22 I conducted a telephone interview with DCW1, whose statements regarding the allegation were consistent with the statements Ms. Shirley and Ms. Garten provided to me. DCW1 acknowledged she should have been more assertive when she verbally informed Ms. Ulrich of her Shingles diagnosis on 08/10. When asked to clarify, DCW1 stated she did not specifically communicate to Ms. Ulrich she needed to go home. According to DCW1, she "beat around the bush" by telling Ms. Ulrich she was in pain, Shingles was contagious, and subsequently she should not be around the residents. However, Ms. Ulrich responded by instructing DCW1 to

“stop stressing out” and to “stay away from the residents”. DCW1 stated Ms. Cortez was at the facility at 4:00PM on 08/10 when DCW1 received a physician’s written statement, via email, confirming her Shingles diagnosis. According to DCW1, the written statement indicated she was to be excused from work for 10 days, starting 08/10. DCW1 stated she used her personal cellular telephone to take a “screen shot” of the written statement and then texted it to Ms. Cortez, who was working in the facility’s basement. According to DCW1, Ms. Cortez did not offer her the option of leaving the facility until approximately 6:45PM, almost three hours after she provided Ms. Cortez with a copy of the written physician’s statement confirming her Shingles diagnosis and restrictions. DCW1 stated that since her shift ended between 7:00-7:30PM, she decided to stay at the facility for the remainder of her shift. DCW1 confirmed her Shingles rash, which was located on her shoulder, was not exposed and was covered by her t-shirt. According to DCW1, she was concerned for the residents who have little to no impulse control and like to give facility staff members spontaneous hugs. However, she made sure not to touch any residents during her shift on 08/10.

Via email, I requested and received from Ms. Kaur a copy of DCW1’s written physician’s statement. Documentation on the written statement indicated Jenny Opdycke PA-C confirmed DCW1 was diagnoses with Shingles and was also immunocompromised. According to documentation on the written statement, Ms. Opdycke requested the facility excuse DCW1’s absence from work on 08/10 through 08/24, so that DCW1 could recover and seek additional treatment. There was no documentation on the written statement indicating DCW1 was highly contagiously and at high risk of spreading the Chickenpox virus to residents and/or her coworkers.

On 09/24 licensee designee Ramon Beltran emailed me verification that prior to 08/10, Ms. Shirley, Ms. Garten, Ms. Cortez, and Ms. Ulrich received .25 hours of training on the area of “Blood Borne Pathogens and Exposure Control”. Mr. Beltran emailed me verification that prior to 08/10, Ms. Corbitt received an hour of training on the facility’s training module G, which included the areas of “Basic Health, Bloodborne Pathogens, and Medications”. I reminded Mr. Beltran that, per administrative licensing rule 400.14204(3), direct care workers were to be provided with training on the area of “prevention and containment of communicable diseases”. This training area was to include the prevention and containment of common communicable diseases, and not just those that are “bloodborne”. I provided Mr. Beltran with technical assistance by suggesting he review and adjust his training materials to ensure this.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(1) A licensee, direct care staff, administrator, other employees, those volunteers under the direction of the

	licensee, and members of the household shall be in such physical and mental health so as not to negatively affect either the health of the resident or the quality of his or her care.
ANALYSIS:	Based upon my investigation, it has been established that while working at the facility on 08/10, DCW1 was diagnosed with Shingles. Shingles cannot be passed by one individual to another. While the risk is low, exposure to fluid from Shingles blisters could cause those individuals who never had Chickenpox, or never received the Chickenpox vaccine, to contract Chickenpox. During DCW1's shift on 08/10, medical professional Jenny Opdycke PA-C's requested in writing the facility excuse DCW1's absence from work on 08/10 through 08/24, so that DCW1 could recover and seek additional treatment for a diagnosis of Shingles. There was no documentation on the written request indicating concerns regarding DCW1's diagnosis negatively affecting her coworkers and/or the health of the residents and their quality of care. It has been established that upon receiving Ms. Opdycke's written request, DCW1 was not directed to leave, and was subsequently allowed to stay at the facility for the remainder of her shift. DCW1's Shingles rash was covered and not exposed. DCW1 did not physically touch any of the six residents present in the facility at the time. Both direct care workers Sheena Shirley and Jessica Garten stated that on 08/10 they worked together to ensure all of the residents' care and supervision needs were meet. While neither home manager Marie Ulrich and assistant home manager Heather Cortez considered the health and well-being of DCW1, who was also immunocompromised, by immediately sending her home once made aware of her Shingles diagnosis, there is not enough evidence to substantiate the allegation that by allowing DCW1 to work the remainder of her shift on 08/10, it placed residents at risk and/or negatively affected their health and quality of care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility does not have sufficient direct care staff on duty to provide for the supervision, personal care, and protection of the residents and to provide the services specified in the residents' Community Mental Health Behavior Treatment Plans.

INVESTIGATION: Included in the written complaint filed with the BCHS on 08/12, was the allegation that on 08/11, the facility did not have sufficient direct care staff on duty for the supervision, personal care, and protection of the residents and to provide the services specified in the residents' Community Mental Health Behavior Treatment Plans.

On 08/13, via email, Ms. Schiebel informed me she was also investigating this allegation. On 08/16 Ms. Schiebel and I conducted separate face-to-face interviews with Ms. Garten, direct care worker Taylor Fawley, Ms. Cortez, Ms. Ulrich, and Ms. Kaur via Microsoft Teams.

Ms. Garten stated she and Ms. Fawley were the only facility staff members scheduled to work first shift at the facility on 08/11. According to Ms. Garten, there were five residents present at this time. However, per their Community Mental Health Behavioral Treatment Plans (BTP), both Residents A and B required 1:1 enhanced supervision from one direct care worker. Therefore, it was necessary to schedule at least three direct care workers to work during the facility's first shift. Ms. Garten stated that on 08/11, Resident C had a prescheduled doctor's appointment at 12:15PM. Both her and Ms. Fawley were under the impression that either Ms. Cortez or Ms. Ulrich, who were both offsite attending a meeting, would report to the facility and take Resident C to his appointment. However, following their meeting, Ms. Cortez and Ms. Ulrich decided to go to lunch with Ms. Kaur instead. Subsequently, at approximately 11:25AM Ms. Fawley was instructed to take Resident C to his appointment. According to Ms. Garten, Ms. Fawley left with Resident C at approximately 11:30AM and returned to the facility at 1:15PM. During this time, Ms. Garten was left alone in the facility to provide supervision, personal care, and protection to Residents A, B, D, and E. Ms. Garten stated that while Ms. Fawley was away from the facility, Resident A began to display disruptive and aggressive behaviors, such as hitting the walls and threatening to harm Resident D. According to Ms. Garten, she texted Ms. Cortez twice to inform her of the situation and was instructed to "ignore" Resident A's behavior. Ms. Garten stated, "I did the best I could" and "I was able to eventually deescalate the situation". However, according to Ms. Garten, she wouldn't have felt comfortable using a physical crisis intervention, if needed, to protect herself and/or other residents while at the facility by herself. Ms. Garten stated Ms. Ulrich returned to the facility at approximately 1:30PM and Ms. Cortez returned at approximately 3:00PM. However, both Ms. Ulrich and Ms. Cortez worked in their basement office and were not counted in the direct care worker to resident ratio.

The statements Ms. Fawley provided regarding the allegation were consistent with the statements Ms. Garten provided to me and Ms. Scheibel. According to Ms. Fawley, she got Resident C to his doctor's appointment seven minutes late. Therefore, Resident C missed his appointment, which was subsequently rescheduled. Ms. Fawley stated had she'd been given adequate notice she would have gotten Resident C to his appointment on time.

Ms. Cortez confirmed that although Residents A and B both required 1:1 enhanced supervision by one direct care worker, Ms. Garten and Ms. Taylor were the only direct care workers scheduled to provide supervision, personal care, and protection to Residents A, B, C, D and E during the facility's first shift on 08/11. Ms. Cortez stated she recalled that at approximately 9:10AM on 08/11, either she or Ms. Ulrich, who were both offsite attending a meeting, received either a telephone call or a text message from Ms. Garten asking who was transporting Resident C to his 12:15PM appointment. Ms. Cortez was unable to recall whether or not it was ever communicated to either Ms. Garten or Ms. Taylor that she or Ms. Ulrich would take Resident C to his appointment. Ms. Cortez was also unable to recall who directed Ms. Taylor to take Resident C to his appointment. However, according to Ms. Cortez, she believed Ms. Taylor was instructed to do so "closer to 11:00AM". Ms. Cortez confirmed that following their offsite meeting, she went to lunch with Ms. Ulrich and Ms. Kaur. Ms. Cortez also confirmed that while at lunch, she received texts messages from Ms. Garten regarding Resident A's behavior. According to Ms. Cortez, Ms. Garten wanted to use a physical crisis intervention on Resident A and Ms. Cortez told her, "you shouldn't have to".

Ms. Ulrich confirmed that to adequately meet the care and supervision needs of the facility's six residents, three direct care workers were required to work the facility's first shift (7:00AM to 7:30PM). Ms. Ulrich admitted she was aware Ms. Garten and Ms. Fawley were the only direct care workers scheduled to work the facility's first shift on 08/11. According to Ms. Ulrich, the facility was experiencing a staffing shortage. Subsequently, there were occasions when there were less than the required number of direct care workers scheduled to work at the facility. According to Ms. Ulrich, Ms. Kaur gave the "final approval" to schedule less than the required amount of direct care workers on each shift. However, Ms. Ulrich was unable to explain how Ms. Kaur made this determination. Ms. Ulrich stated that along with completing her management related tasks, she regularly covered open shifts at the facility and was currently averaging 50-60 hours a week. Ms. Ulrich confirmed that on 08/11 she, Ms. Cortez, and Ms. Kaur went to lunch following their meeting offsite. According to Ms. Ulrich, she was not aware she needed to transport Resident C to his doctor's appointment at 12:15PM. Ms. Ulrich stated that while she was aware there were not enough direct care workers scheduled to work the facility's first shift on 08/11, she did not consider instructing Ms. Cortez to forgo the meeting and subsequent lunch offsite, and to report to the facility to provide needed coverage. According to Ms. Ulrich, Resident A's BTP indicated facility staff members were to ignore Resident A's target behaviors. Therefore, Ms. Cortez relayed this information to Ms. Garten, via text message, when Ms. Garten informed Ms. Cortez of Resident A's disruptive and aggressive behaviors.

On 08/17 Ms. Schiebel and I conducted a face-to-face interview with Ms. Kaur, who also confirmed that to adequately meet the care and supervision needs of the facility's six residents, three direct care workers were required to work the facility's first shift (7:00AM to 7:30PM). Ms. Kaur confirmed the facility was currently

experiencing a staffing shortage. According to Ms. Kaur, on 08/11 she attended an offsite meeting and subsequent lunch with Ms. Cortez and Ms. Ulrich. However, she was not aware Ms. Garten and Ms. Fawley were the only direct care workers scheduled to work the facility's first shift at this time. Subsequently, Ms. Kaur stated she was not aware this would leave only Ms. Garten at the facility with Residents A, B, D, and E while Ms. Fowley transported Resident C to his 12:15PM doctor's appointment. Ms. Kaur denied ever giving "approval" to schedule less that the required amount of direct care workers on each shift. According to Ms. Kaur, she was aware of only one occasion, on 07/04, when not enough direct care workers were scheduled to work in the facility and she reported this to licensee designee Ramon Beltran. Ms. Kaur admitted Ms. Ulrich had previously requested her assistance with covering open shifts at the facility. However, according to Ms. Kaur, she was never able to assist Ms. Ulrich as Ms. Kaur was covering open shifts in other facilities owned and operated by the licensee when her assistance was requested. Ms. Kaur acknowledged Ms. Cortez and Ms. Ulrich should have ensured the facility was appropriate staffed before attending an offsite meeting and lunch on 08/11.

On 08/17 Ms. Ulrich emailed me a copy of Resident A's and B's BTPs. Documentation on Resident A's and B's BTPs confirmed that both Resident A and B were to be provided 1:1 enhanced supervision by one direct care worker during the facility's first shift. Documentation on Resident A's BTP indicated one of Resident A's target behaviors was physical aggression towards people and personal property, which often escalated quickly without any "clear trigger". There was no documentation in Resident A's BTP indicating direct care workers were to ignore Resident A's target behaviors.

At 1:30PM on 09/27 I conducted an unannounced investigation at the facility. Upon Ms. Ulrich opening the facility door, Resident D attempted to elope by exiting the facility and running into the front yard and towards the road. Ms. Ulrich quickly followed after Resident D, who had stopped running, as Resident C followed behind Ms. Ulrich. Resident D did not leave the property. Ms. Ulrich was able to verbally redirect Resident D and all three returned to the inside of the facility. I conducted an interview with Ms. Ulrich who informed me that in addition to Residents C and D, Resident A, who was in his bedroom sleeping, was also present in the facility. According to Ms. Ulrich, Resident B was at school and direct care worker Josh Terpstra was at an offsite appointment with Resident E. Subsequently, Ms. Ulrich was the only facility staff member at the facility. Ms. Ulrich stated two other direct care workers scheduled to work in the facility that day had been removed from the schedule pending a Kalamazoo County Office of Recipient Rights' investigation. According to Ms. Ulrich, direct care worker Jamie Kniss agreed to cover part of the facility's first shift. However, Ms. Kniss was unable to report to the facility until 2:00-2:30PM. Ms. Ulrich acknowledged that even with Mr. Terpstra physically present with her at the facility, there was not enough facility staff members currently working at the facility to adequately provide supervision, personal care, and protection to Residents A, C, and D.

Upon leaving the facility, I reported this information to Ms. Schiebel via telephone. Via email, Ms. Schiebel informed Beacon Specialized Living, Inc.'s Compliance Team of the current staffing situation at the facility.

On 09/28 Ms. Schiebel, Adult Protective Services Specialist Melissa Brown, and I conducted separate face-to-face interviews with Ms. Ulrich and Ms. Garten via Microsoft Teams. Ms. Ulrich stated she "misspoke" yesterday when she reported the reason the facility was not adequately staffed on 09/27 was because two direct care workers had been removed from the schedule pending a Recipient Rights investigation. According to Ms. Ulrich, although three direct care workers were required to work the facility's first shift, Ms. Garten and Mr. Terpstra were the only direct care workers available to work on the facility's first shift on 09/27, until Ms. Kniss was to report to the facility sometime between 2:00-2:30PM. However, on the morning of 09/27 Ms. Cortez informed Ms. Ulrich that an unlicensed facility, also owned and operated by the licensee, did not have enough direct care workers to work on their first shift. Subsequently, Ms. Ulrich directed Ms. Garten to report to work at the unlicensed facility instead. According to Ms. Ulrich, she then reported to the facility to work with Mr. Terpstra. Ms. Ulrich stated that on 09/27 Mr. Terpstra left the facility with Resident E sometime between 12:30-1:00PM and returned to the facility shortly after I left, at approximately 2:00PM. According to Ms. Ulrich, she was supposed to contact Ms. Kaur every time the facility was short-staffed. Ms. Ulrich stated that per the facility's "unofficial policy", facility staff members were to follow their "chain of command" and were not to contact Mr. Beltran for assistance and/or regarding any issues in the facility, unless Ms. Kaur was unable to address these issues. Ms. Ulrich admitted to not consistently reporting staffing shortages to Ms. Kaur. According to Ms. Ulrich, this was because when she did so in the past, "nothing was done about it".

Ms. Garten's statements were consistent with the statements Ms. Ulrich provided to me, Ms. Scheibel, and Ms. Brown. Ms. Garten stated direct care worker staffing had not improved at the facility since Ms. Scheibel and I last interviewed Ms. Garten on 08/16. According to Ms. Garten, the facility was adequately staffed approximately 3-4 out of 7 days.

According to Special Investigation Report (SIR) #2020A0462058, dated 10/1/2020, it was established the facility was in violation of Special Certification rule 330.1806(1) when it was established a former resident (identified as Resident A in SIR #2020A0462058) was to be supervised by direct care workers while away from the facility. The former resident eloped from the facility unsupervised on 09/15/2020 and again on 09/24/2020. According to the facility's approved corrective action plan, dated 10/15/2020, former licensee designee Patricia Miller ensured the following actions:

- "Resident supervision and completing appropriate checks" were reviewed by Ms. Ulrich and Ms. Kaur at a 10/06/2020 facility staff meeting.

- Pending Community Mental Health and legal guardian approval, the former resident would transfer to a more appropriate setting by 10/23/2020. Until this time, the former resident would receive 1:1 enhanced supervision by one direct care worker.
- Moving forward, facility staff members would receive training on residents' BTPs.
- Facility leadership would explore additional staffing and placing options for the former resident.

APPLICABLE RULE	
R 400.14206	**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:	Based upon my investigation, which consisted of interviews with multiple facility staff members, a review of pertinent documentation relevant to this investigation, as well as an unannounced investigation onsite, it has been established the facility does not consistently schedule a sufficient number of direct care workers to provide for the supervision, personal care, and protection of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.

ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, a review of pertinent documentation relevant to this investigation, as well as an unannounced investigation onsite, it has been established that per their BTPs, Residents A and B require 1:1 enhanced supervision from one direct care worker during the facility's first shift. It has been established the facility does not consistently schedule a sufficient number of direct care workers to provide for both the supervision, personal care, and protection of all the residents and to provide the services specified in Resident A and B's BTPs.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2021A0462058 DATED 10/01/2020, AND CAP DATED 10/15/2020.]**

ADDITIONAL FINDING:

INVESTIGATION: The facility's entire back yard is enclosed by a fence. Residents are able to exit the facility's sliding glass door on the main floor into the facility's enclosed backyard. Residents can also enter the enclosed backyard from inside the facility from an egress located in the basement. The fence is equipped with an unlocked gate to ensure the residents' right to freedom of movement. During my unannounced investigation at the facility on 09/27, I discovered a mobile water hose reel cart had been placed in front of the outside gate leading into the enclosed backyard to prevent residents from being able to exit through the gate from inside the enclosed backyard. Ms. Ulrich stated she was not aware of this and acknowledged the cart should not be placed there.

According to Special Investigation Report #2021A0462036, during an onsite licensing renewal inspection on 05/12, it was discovered a large rock had been placed in front of the outside gate leading into the enclosed backyard to prevent residents from being able to exit through the gate from inside the enclosed backyard. Ms. Kaur informed me she was unaware the rock had been placed there and believed the lawn care company contracted by the facility had placed the rock there while mowing the lawn. Ms. Kaur acknowledged the rock should not have been there and immediately removed the rock, allowing for unobstructed egress through the gate from inside the enclosed the fence, and subsequently allowing for the freedom of residents' movement. However, it was later established the facility was in violation of AFC administrative licensing rule 400.14304(1)(b) and 400.14304(2) when at an unannounced investigation on 06/07, it was discovered the large rock had once again been placed in front of the outside gate leading into the enclosed backyard, thus again preventing residents from being able to exit through the gate from inside the enclosed backyard. The facility's approved corrective action plan, dated 08/06, indicated "not blocking paths of egress in the home and yard will be reviewed will all Augusta staff in the next staff meeting. This meeting will occur by 08/31/21". On

08/09 I submitted to licensee designee Ramon Beltran, via email, a corrective action plan approval letter. Documentation on the letter indicated that the department would verify implementation and compliance with the facility's approved corrective action plan regarding rules 400.14304(1)(b) and 400.14304(2) at their next onsite inspection/investigation.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	During an unannounced investigations on 09/27 it was discovered a mobile water hose reel cart had been placed in front of the outside gate leading into the enclosed backyard, which prevented residents from being able to exit through the gate from inside the enclosed backyard.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2021A0462036 DATED 07/22, AND CAP DATED 08/06]**

On 10/08 I conducted an exit conference with licensee designee Ramon Beltran and shared with him the findings of this investigation.

IV. RECOMMENDATION

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

09/30/2021

Michele Streeter Date
Licensing Consultant

Approved By:

10/05/2021

Dawn N. Timm Date
Area Manager