GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 29, 2021

Gregory Richards
Parkside Estates LLC
2211 Parkside Street
Trenton, MI 48183

RE: License #: AS820313332
Investigation #: 2021A0101025
Parkside Estates

Dear Mr. Richards:

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 (313) 456-0380.

Sincerely,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820313332
Investigation #:	2021A0101025
Complaint Receipt Date:	08/02/2021
Investigation Initiation Date:	08/10/2021
Report Due Date:	10/01/2021
Licensee Name:	Parkside Estates LLC
Licensee Address:	2211 Parkside Street Trenton, MI 48183
Licensee Telephone #:	(734) 692-0877
Administrator:	Gregory Richards
Licensee Designee:	Gregory Richards
Name of Facility:	Parkside Estates
Facility Address:	2211 Parkside Street Trenton, MI 48183
Facility Telephone #:	(734) 692-0877
Original Issuance Date:	07/12/2011
License **Status:**	REGULAR
Effective Date:	08/14/2020
Expiration Date:	08/13/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED

	AGED

II. ALLEGATION(S)

	Violation Established?
Licensee designee, Gregory Richards, was passed out at the facility and no other staff was present. Residents were unsupervised and not provided care.	Yes
Licensee designee, Gregory Richards, did not administer a resident's medications.	No
Additional Findings	Yes

III. METHODOLOGY

08/02/2021	Special Investigation Intake 2021A0101025
08/02/2021	APS Referral
08/02/2021	Special Investigation Initiated - Telephone Megan Vanderworp, Health Care Aid #1's support coordinator/caseworker at Senior Alliance
08/10/2021	Contact - Telephone call made Parkside Estate No answer left voice mail message.
08/10/2021	Contact - Telephone call received Relative A
08/12/2021	Contact - Telephone call made No answer left voice mail message. Gregory Richards, licensee designee
08/12/2021	Contact - Telephone call received Teresa Bailey, administrator
08/13/2021	Inspection Completed On-site Gregory Richards, licensee designee
08/13/2021	Contact - Face to Face Trenton Police Department
08/17/2021	Inspection Completed-BCAL Sub. Non-Compliance

09/16/2021	Contact - Telephone call made Relative A
09/21/2021	Contact - Telephone call received Teresa Bailey, administrator Cynthia Bailey, direct care staff
09/22/2021	Contact - Telephone call made Relative B
09/23/2021	Contact - Telephone call made Sharon Sabbath, Adult Protective Services (APS) Worker
09/23/2021	Contact - Telephone call made Megan Vanderworp, Support Coordinator/Caseworker at Senior Alliance
09/23/2021	Contact - Telephone call made Health Care Aid #1
09/24/2021	Contact - Telephone call made Gregory Richards, licensee designee
09/24/2021	Comment – e-mail sent
09/24/2021	Contact- Documents received
09/28/2021	Contact - Telephone call made Gregory Richards, licensee designee
11/24/2021	Exit Conference Mr. Richards

ALLEGATION:

Licensee designee, Gregory Richards, was passed out at the facility and no other staff was present. Residents were unsupervised and not provided care.

INVESTIGATION:

On 08/10/2021, I received a phone call from Relative A. Relative A stated on 08/01/2021, he arrived at the facility at approximately 9:00 a.m. to check on Resident A. Relative A stated he knew there was going to be a staffing issue because the staff who work the morning shift, administrator, Teresa Bailey and her

mother, direct care staff, Cynthia Bailey were schedule to be off. Relative A stated he walked into the facility and found licensee designee, Gregory Richards “passed out” in a chair in the living room. Relative A stated he observed Ms. Teresa and Ms. Cynthia Bailey appeared to be scrambling to take care of the residents. Relative A stated he shook Mr. Richards’ leg several times to wake him up. Relative A asked Mr. Richards what was going on. Relative A stated Mr. Richards responded, “I work midnights and sleep during the day.” Relative A asked Mr. Richards if he was drunk or had been drinking because of his demeanor. Relative A stated Mr. Richards responded, “I was in a car accident last night.” Relative A stated he never saw Mr. Richards act in this manner. Relative A observed Mr. Richards go to the basement. Relative A called the Trenton Police Department and apprised them of his concerns.

On 08/12/2021, I attempted to contact the licensee designee, Gregory Richards, and did not get an answer. I left a voice message. Shortly thereafter I received a phone call from administrator, Teresa Bailey. Ms. Teresa stated she no longer works for Mr. Richards. Ms. Teresa stated Mr. Richards worked the midnight shift on 07/31/2021, and she started to get multiple text messages from Health Care Aid #1 that night. Ms. Teresa further stated Health Care Aid #1 lived in the basement at the group home. Health Care Aid #1 was upset because Mr. Richards messed up her medications and she thought Mr. Richards was intoxicated. Ms. Teresa stated due to Health Care Aid #1’s multiple text messages, she called the group home at 6:00 a.m. and there was no answer. Ms. Teresa stated she might have also called Health Care Aid #1. Ms. Teresa stated since the morning staff did not show up at 6:00 a.m., she and Ms. Cynthia went to the group home. Ms. Teresa stated she and Ms. Cynthia were scheduled to be off because they were supposed to attend her brother’s memorial service. Ms. Teresa stated they arrived at the group home at 7:00 a.m. Ms. Teresa stated it was apparent Mr. Richards did not take care of the residents during the midnight shift. Ms. Teresa stated Residents B, C and D were soiled laying in their beds and their bed linens were saturated with urine. Ms. Teresa stated she and Ms. Cynthia changed, fed, and gave the residents their medications. Ms. Teresa further stated the police were at the home on 08/01/2021, but they did not do a breathalyzer test on Mr. Richards.

I spoke with Ms. Teresa again on 09/16/2021, Ms. Teresa stated when she and Ms. Cynthia arrived at the group home on 08/01/2021, she observed Mr. Richards asleep in a recliner in the living room. The front door to the facility was unlocked, so they let themselves in. Ms. Teresa stated she needed the keys and had to kick Mr. Richards in his leg to wake him up. I asked Ms. Teresa if Health Care Aid #1 was a staff or a resident? Ms. Teresa stated she did not know. Ms. Teresa further stated Mr. Richards was supposed to become Health Care Aid #1’s “guardian.”

I also spoke with Ms. Cynthia on 08/12/2021. Ms. Cynthia stated on 08/01/2021, she and Ms. Teresa changed, fed, and gave the residents their medications.

On 08/13/2021, I interviewed Mr. Richards at the group home. Mr. Richards stated this incident was a lie made up by his “mentally ill aide,” Health Care Aid #1. Mr.

Richards stated Health Care Aid #1 is “crazy and she did this at another AFC home.” Mr. Richards stated he received a written statement from Health Care Aid #1’s physician stating it was okay for her to “help out changing, feeding and bathing the residents” living in the home. Mr. Richards stated Health Care Aid #1 “was not an employee.”

Mr. Richards denied being intoxicated on 08/01/2021. Mr. Richards further stated it was Health Care Aid #1 who was drinking during the midnight shift, and she had alcohol all over the basement. Mr. Richards denied the residents had not received personal care. Mr. Richards stated Ms. Teresa and Ms. Cynthia came to work at 6:00 a.m. Mr. Richards stated the police were not at the group home. He contended this was all a lie. Mr. Richards further stated while travelling to the facility on 07/31/2021, he was in a car accident on the highway, and he took some Tylenol.

On 08/13/2021, I went to the Trenton Police Department. I obtained a copy of the police report, a narrative they had with Adult Protective Services (APS) Worker Sharon Sabbath, and written statements from Relative A, Relative B, and the administrator, Teresa Bailey.

According to the police report they were dispatched to the group home on 08/01/2021, “due to patients being unattended all night”.

> Upon arrival Officer Kleszcz “spoke with [Relative A]. [Relative A] stated he arrived at approximately 0900 hours to check on his mother due to a staffing issue at the group home. [Relative A] stated he walked inside the residence and found the owner passed out in a chair. [Relative A] stated he also found Teresa Bailey and Cynthia scrambling to take care of residents. [Relative A] stated Teresa and Cynthia were not scheduled to be there and found it odd they were scrambling to take care of the residents. [Relative A] stated he spoke with Gregory about what was going on and Gregory replied “I worked midnights I sleep during the day” [Relative A] stated he suspected Gregory had been drinking the night before while he was supposed to be taking care of residents. [Relative A] stated he checked on his mother [Resident A] and she seemed to be ok but was concerned about the other residents and called the police. [Relative A] completed a written statement.”
>
> I spoke with Parkside Estates manager Teresa. Teresa stated Gregory worked the midnight shift and she started to get multiple text messages from co-worker [Health Care Aid #1]. Teresa stated [Health Care Aid #1] was upset because Gregory messed up her medications and she thought Gregory was intoxicated. Teresa stated there is a staffing issue and she attempted to contact the morning staff, but no one answered. Teresa stated Resident B was soiled laying in her bed and not changed along with Resident C and D. Teresa stated she changed, fed and medicated all residents but it was apparent they were not taking [sic] care of during the midnight shift. Teresa completed a written statement.” …

> I spoke with the owner of Parkside Estates, Gregory. Gregory stated he was working the midnights shift with [Health Care Aid #1] who he hired to be a health care aid. Gregory stated [Health Care Aid #1] was hired to help change, feed and bathe the residents. Gregory stated that [Health Care Aid #1] was not mentally stable, and he terminated her employment on 08/01/2021. Gregory stated that during the midnights shifts he was pretty much working alone. Gregory stated he did check up on residents throughout the night and denied all allegations of neglecting patients. Gregory stated he works midnights and that is why he was sleeping when [Relative A] arrived at 0900 hours, and that he was not drinking the night prior. Gregory stated the claims of neglect were false and he has cameras set up inside the house in common areas where you can see him checking on patients. Gregory stated there is a medication book that is kept to track all medications given and everyone was up to date on receiving medications. …
>
> While investigating [Relative B] arrived on scene to also check on her mother. [Relative B] stated she received a phone call from her mother at 0750 hours, stating Gregory and [Health Care Aid #1] got into an argument last night and that she was soaked in her own urine and was not taken care of, did not receive breakfast nor medication….

Furthermore, according to Relative B's written statement, dated 08/01/2021, "This morning at 7:50 a.m. I received a call from my mom who stated another intense argument broke out between Greg and [Health Care Aid #1] and she was soaked, and no one had taken care of her. She was drenched in urine and her sheets were soaked. I spoke with Teresa who assured me she was going to take care of her and change her clothes and bed." …

On 08/17/2021, I conducted a second onsite investigation. Mr. Richards stated this is all a lie that Health Care Aid #1 made up. I informed Mr. Richards that the police were at the facility on 08/01/2021 and that I have a copy of the police report. Mr. Richards did not respond to learning that the police had been at the facility. Mr. Richards stated Health Care Aid #1 lived in the basement of the home and her estranged husband (Husband #1) was paying him for her to stay in the basement. Mr. Richards stated he did not have contact information for Health Care Aid #1 and Husband #1. On 09/23/2021, I was able to get telephone numbers for Health Care Aid #1 and Husband #1 from Health Care Aid #1's support coordinator/caseworker at Senior Alliance, Megan Vanderworp.

I asked Mr. Richards for the video footage from the cameras in the common areas of the home which he told the police he had. Mr. Richards stated there was no video footage. Furthermore Mr. Richards did not have medication logs for Residents A and B.

On 09/23/2021, I interviewed Health Care Aid #1. Health Care Aid #1 stated Mr. Richards worked the midnight shift, and he had been drinking all night. Health Care

Aid #1 stated Mr. Richards was hiding bottles outside in the backyard. Health Care Aid #1 stated she asked Mr. Richards for her evening medications, and he responded, “I don’t give a fuck about your medication.” Health Care Aid #1 stated there was a verbal altercation between her and Mr. Richards. Health Care Aid #1 stated when she woke up, Ms. Teresa and Ms. Cynthia were changing the residents and Mr. Richards was passed out in a chair in the living room. Health Care Aid #1 left the home when Husband #1 arrived to pick her up.

APPLICABLE RULE	
R 400.14305	**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:	Pursuant to Public Act 218 "Personal care" means personal assistance provided by a licensee or an agent or employee of a licensee to a resident who requires assistance with dressing, personal hygiene, grooming, maintenance of a medication schedule as directed and supervised by the resident's physician, or the development of those personal and social skills required to live in the least restrictive environment. Mr. Richards failed to attend to the residents' personal needs at all times. On 08/12/2021, I spoke with Ms. Teresa. Ms. Teresa stated she and Ms. Cynthia arrived at the group home at 7:00 a.m. on 08/01/2021. Ms. Teresa stated it was apparent Mr. Richards did not take care of the residents during the midnight shift. Ms. Teresa stated Residents B, C and D were soiled laying in their beds and their bed linens were saturated with urine**.** Ms. Teresa stated she and Ms. Cynthia changed, fed, and gave the residents their medications. On 08/12/2021, I spoke with Ms. Cynthia. Ms. Cynthia stated on 08/01/2021 at 7:00 a.m. she and Ms. Teresa changed, fed, and gave the residents their medications. According to Relative B's written statement, dated 08/01/2021, "This morning at 7:50 a.m. I received a call from my mom who stated another intense argument broke out between Greg and [Health Care Aid #1] and she was soaked, and no one had taken care of her. She was drenched in urine and her sheets were soaked. I spoke with Teresa who assured me she was going to take care of her and change her clothes and bed." … Based upon interviews with Ms. Teresa, Ms. Cynthia, my review of the Trenton Police/report and Relative B's written statements, the residents were not provided personal care during the midnight shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Licensee Designee, Gregory Richards did not administer a resident's medication.

INVESTIGATION: On 08/13/2021, I interviewed Mr. Richards at the home group. Mr. Richards stated Health Care Aid #1 was an "aide" who "helped out with

changing, feeding and bathing the residents."

On 08/13/2021, I reviewed the Trenton Police Department Police Report. According to the police report, Ms. Teresa stated to Officer Kleszez "Gregory worked the midnight shift and she started to get multiple text message from co-worker [Health Care Aid #1]." The police report also stated Officer Kleszez "spoke with the owner of Parkside Estates, Gregory. Gregory stated he was working the midnight shift with [Health Care Aid #1] who he hired to be a health care aid. Gregory stated [Health Care Aid #1] was hired to help change, feed and bathe the residents."

On 09/23/2021, I spoke with Megan Vanderworp, Health Care Aid #1's support. Ms. Vanderworp stated Health Care Aid #1 was a resident of the Parkside Estate AFC Home. Ms. Vanderworp gave me Health Care Aid #1 and Husband #1's phone numbers.

On 09/23/2021, I interviewed Health Care Aid #1. Health Care Aid #1 stated on 08/01/2021, Mr. Richards worked the midnight shift, and he had been drinking all night. Health Care Aid #1 stated she asked Mr. Richards for her evening medications, and he responded, "I don't give a fuck about your medications." Health Care Aid #1 stated during her interview with Mr. Richards she told him she was a Certified Nursing Assistant (CNA). Mr. Richards told her he was going to help her get her CNA certification reinstated. Mr. Richards informed Health Care Aid #1 she could have the apartment in the basement and work in the group home. Mr. Richards told Health Care Aid #1 that he must become her representative payee. Health Care Aid #1 stated she agreed, however, they never officially made him the representative payee. Health Care Aid #1 stated her duties were preparing meals, doing laundry, feeding, toileting, and bathing the other residents and be there when staff do not show up for work. Health Care Aid #1 stated she did not pass medications. Health Care Aid #1 stated she resided in the home for a couple of weeks and Mr. Richards never paid her for working in the home.

Health Care Aid #1 further stated Husband #1 gave Mr. Richards a $1000 for her to live in the basement and obtain training. Health Care Aid #1 stated Mr. Richards would not return any of the unused proportion of the money Husband #1 paid for her to live in the home. Health Care Aid #1 stated she nor Husband #1 obtained any written documentation regarding her employment or occupancy in the home.

On 09/24/2021, I spoke to Mr. Richards by phone, regarding Health Care Aid #1 not receiving her medications. Mr. Richards stated, "[Health Care Aid #1] was not a resident, and she was not an employee." He stated she was an aide, and her duties were to assist staff. Mr. Richards further stated the reason he was passing Health Care Aid #1 medications was because Husband #1 asked him to. Mr. Richards stated on 07/31/2021, there was no need for him to pass Health Care Aid #1's medications. Mr. Richards stated he worked from 10:00 p.m. until 6:00 a.m. and Health Care Aid #1 was not scheduled to receive her medications. Mr. Richards stated Health Care Aid #1 wanted additional medication which was not given.

On 09/28/2021, I reviewed Health Care Aid #1 medication log for July 2021. The initials of the staff person who administered Health Care Aid #1's medication on 07/31/2021, at 8:00p.m. was not legible, therefore, I called Mr. Richards. Mr. Richards stated he passed Health Care Aid #1's medications at 8:00 p.m. on 07/31/2021.

On 09/28/2021, I spoke with Health Care Aid #1 again. Health Care Aid #1 stated she never received her medication on 07/31/2021 at 8:00 p.m. Health Care Aid #1 also stated she does not administer her own medications because she will abuse them. Furthermore, Health Care Aid #1 stated she is currently in a licensed facility, and she completed all required admission forms.

On 09/28/2021, I interviewed Husband #1. Husband #1 stated Mr. Richards told Health Care Aid #1 she could work in the home because she had a CNA certification. He stated Health Care Aid #1 was doing the laundry and changing the residents. Husband #1 stated Health Care Aid #1 had to change the residents because Mr. Richards would not change them.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon the preponderance of evidence, it is concluded that Health Care Aid #1 was not a resident. Therefore, Mr. Richards was not required to administer Health Care Aid #1's medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: On 08/13/2021, I interviewed Mr. Richards at the group home. Mr. Richards stated he received a written statement from Health Care Aid #1's physician stating it was okay for her to "help out changing, feeding and bathing the residents" living in the home.

On 08/13/2021, I reviewed Health Care Aid #1's employee record. Her file contained the following documents, a driver license, Medicare Health Insurance Card, Michigan Workforce Background Application submitted on 07/22/2021, ICHAT Criminal History Check submitted on 07/22/2021, fingerprint request form,

verification of her CNA certification and a letter from her mental health provider. The letter reads:

> This letter of support is written at the request of and permission of the above-named individual.
>
> Health Care Aid #1 has been receiving care from us via our service agreement with Neighborhood Services Organization (NSO) where she also receives Case Management and Therapy Services. We have had regular interaction with her 3-4 times a week, for the past 6 months.
>
> She has been adherent with her medication and while doing so and with other supports she is able to remain stable. She does receive SSD and we believe requires additional subsidy to afford reasonable housing….

Furthermore, according to the police report Mr. Richards stated to Officer Kleszez "he was working the midnights shift with Health Care Aid #1 who he hired to be a health care aid."

On 08/13/2021, I reviewed Relative B's written statement "On 07/31/2021, … I addressed with Greg the new person who resides in the basement, and he stated her name is [Health Care Aid #1] and she is an employee here and she is here to help the staff with changing diapers and caring for the residents. He assured me she would not be dispensing medications" …

On 09/22/2021, I spoke with Relative B. Relative B stated she was in the process of finding a new placement for Resident B prior to this incident. She was looking for a new placement because Resident B was afraid of Health Care Aid #1, who lived in the basement. Relative B stated she works for the Social Security Administration and often deals with individuals who are mentally unstable. Relative B stated it was apparent that Health Care Aid #1 was not "lucid", her thoughts were unclear, and she would break down crying over minor things. Relative B stated she went to Mr. Richards to find out if Health Care Aid #1 was a resident or an employee. Relative B stated Mr. Richards told her that he spoke with "Health Care Aid #1's psychiatrist and her psychiatrist stated it would be okay for her to change, feed and bathe the residents**.** Relative B stated Mr. Richards assured her that Health Care Aid #1 would not be administering medications.

On 09/25/2021, I received and reviewed Health Care Aid #1 's medication log. Health Care Aid #1 is prescribed several psychotropic medications, which are used to treat mental health disorders.

On 09/28/2021, I spoke with Health Care Aid #1. Health Care Aid #1 stated she does not administer her own medications because she will abuse them. Health Care Aid #1 also stated she is currently in a licensed facility, and she completed all

required admission forms.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.

ANALYSIS:	On 08/13/2021, Mr. Richards stated he received a written statement from Health Care Aid #1's physician stating it was okay for her to "help out changing, feeding and bathing the residents" living in the home. The letter in Health Care Aid #1's employee file is a letter from Health Care Aid #1's mental health provider and it did not indicate it was okay for her to "help out changing, feeding and bathing the residents" living in the home. Health Care Aid #1 has been receiving care via a service agreement with Neighborhood Services Organization (NSO) where she also receives Case Management and Therapy Services. On 09/22/2021, I spoke with Relative B. Relative B stated she was in the process of finding a new placement for Resident B prior to this incident, because Resident B was afraid of Health Care Aid #1, who lived in the basement. Relative B stated it was apparent that Health Care Aid #1 was not "lucid", her thoughts were unclear. On 09/25/2021, I received and reviewed Health Care Aid #1's medication log. Health Care Aid #1 is prescribed several psychotropic medications, which are used to treat mental health disorders. On 09/28/2021, I spoke with Health Care Aid #1. Health Care Aid #1 stated she does not administer her own medications because she will abuse them. Health Care Aid #1 stated she is currently in a licensed facility. Health Care Aid #1 is a vulnerable adult and is in need of adult foster care. Therefore, it is concluded Health Care Aid #1 was an employee and she was not suitable to assure the welfare of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/13/2021, I reviewed Health Care Aid #1's employee record. Health Care Aid #1's employee record did not contain verification of direct care training.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.
ANALYSIS:	Health Care Aid #1 ’s employee record did not contain verification of direct care training. Mr. Richards failed to obtain verification of direct care training for Health Care Aid #1. Health Care Aid #1 was performing assigned tasks; changing, feeding, and bathing the residents, however, she was not trained.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/13/2021, I reviewed Health Care Aid #1 employee record. A physician statement was not in Health Care Aid #1 employee record.

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.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.

ANALYSIS:	A physician statement was not in Health Care Aid #1's employee record. Mr. Richards failed to obtain a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of Health Care Aid #1.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/13/2021, I reviewed Health Care Aid #1's employee record. Health Care Aid #1's employee record did not contain a TB test result.

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.**
	(4) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	Health Care Aid #1's employee record did not contain a TB test result. Mr. Richards failed to obtain written evidence that Health Care Aid #1 had been tested for communicable tuberculosis.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/13/2021, I reviewed Health Care Aid #1's employee record. Health Care Aid #1's employee record did not contain verification of receipt of the policies and procedures.

APPLICABLE RULE	
R 400. 14207	**Required personnel policies.**
	(2) The written policies and procedures identified in subrule (1) of this rule shall be given to employees and volunteers at the time of appointment. A verification of receipt of the policies and procedures shall be maintained in the personnel records.
ANALYSIS:	Health Care Aid #1's employee record did not contain verification of receipt of the policies and procedures. Mr. Richards failed to obtain verification of receipt of the policies and procedures for Health Care Aid #1 and maintain it in her employee record.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/13/2021, I reviewed Health Care Aid #1's employee record. Health Care Aid #1's employee record did not contain verification of receipt of a job description.

APPLICABLE RULE	
R 400. 14207	**Required personnel policies.**
	A licensee shall have a written job description for each position. The job description shall define the tasks, duties, and responsibilities of the position. Each employee and volunteer who is under the direction of the licensee shall receive a copy of his or her job description. Verification of receipt of a job description shall be maintained in the individual's personnel record.

ANALYSIS:	Health Care Aid #1's employee record did not contain a job description. Mr. Richards failed to obtain a written job description defining the tasks, duties, and responsibilities of Health Care Aid #1, and did not maintain verification of receipt of a job description in her employee record.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/13/2021, I reviewed Health Care Aid #1's employee record. Health Care Aid #1's employee record did not contain her telephone number, her social security number, verification of reference checks or her beginning and ending date of employment.

APPLICABLE RULE	
R 400. 14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: (a) Name, address, telephone number, and social security number. (f) Verification of reference checks. (g) Beginning and ending dates of employment.
ANALYSIS:	Mr. Richards failed to maintain Health Care Aid #1's employee record to contain telephone number, social security number, verification of reference checks, or beginning and ending dates of employment.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 10/23/2021, I reviewed the resident register. Resident C was not listed on the resident register. According to the police report, Ms. Teresa told Officer Kleszez "[Resident C] was soiled laying in her bed and not changed." The police report also states "[Relative C] was contacted and notified of the situation by Parkside Estate staff. Officer Kleszez spoke with [Relative C] via TX who advised me she removed her mother from the group home and that she would be turning in paperwork at a later date to be added to this case…."

On 08/13/2021, I conducted an onsite investigation, there were three residents in the

home Residents D, F, and G. On 08/17/2021, I conducted a second onsite investigation. I asked Mr. Richards for Resident G's resident record. Mr. Richards stated Resident G was admitted to the home last Friday, which was 08/13/2021. Resident G's admission date on the resident register is 06/13/2021.

APPLICABLE RULE	
R 400. 14209	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: e. A resident register.
ANALYSIS:	On 10/23/2021, I reviewed the resident register. Resident C was not listed on the resident register. According to the police report, Ms. Teresa told Officer Kleszez "[Resident C] was soiled laying in her bed and not changed." The police report also states "[Relative C] was contacted and notified of the situation by Parkside Estate staff. [Officer Kleszez spoke with [Relative C] via TX who advised me she removed her mother from the group home and that she would be turning in paperwork at a later date to be added to this case…." On 08/13/2021, I conducted an onsite investigation, there were three residents in the home Residents D, F, and G. On 08/17/2021, I conducted a second onsite investigation. I asked Mr. Richards for Resident G's resident record. Mr. Richards stated Resident G was admitted to the home last Friday, which was 08/13/2021. Resident G's admission date on the resident register is 06/13/2021. Resident C was not listed on the resident register and Resident G's date of admission was not correct on the resident register.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 08/17/2021, I conducted an onsite investigation. I requested Resident A and B's August medications logs. Mr. Richards stated he did not have them.

APPLICABLE RULE	
R 400. 14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information:
ANALYSIS:	On 08/17/2021, I conducted an onsite investigation. I requested Resident A and B's August medications logs. Mr. Richards stated he did not have them. Mr. Richards failed to maintain August medication logs for Residents A and B.
CONCLUSION:	**VIOLATION ESTABLISHED**

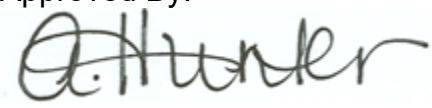
On 11/24/2021, I conducted an exit conference with Mr. Richards. Mr. Richards did not agree with the cited violations and wanted to know how to dispute the findings.

IV. RECOMMENDATION

Upon submission of an acceptable corrective action plan, it is recommended the status of the license remains unchanged.

11/24/2021
Edith Richardson — Date
Licensing Consultant

Approved By:



11/29/2021
Ardra Hunter — Date
Area Manager