GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 27, 2021

Fahim Uddin
Regency Assisted Living LLC
30700 Telegraph Road Suit
Bingham Farms, MI 48025

RE: License #: AL290408542
Investigation #: 2022A1029007
Regency Assisted Living

Dear Mr. Uddin,

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov
(989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL290408542
Investigation #:	2022A1029007
Complaint Receipt Date:	11/01/2021
Investigation Initiation Date:	11/02/2021
Report Due Date:	12/31/2021
Licensee Name:	Regency Assisted Living LLC
Licensee Address:	30700 Telegraph Road Suit Bingham Farms, MI 48025
Licensee Telephone #:	(313) 549-7708
Administrator:	Stephanie Seifert
Licensee Designee:	Stephanie Seifert
Name of Facility:	Regency Assisted Living
Facility Address:	211 West Wallace St Ashley, MI 48806
Facility Telephone #:	(989) 847-2188
Original Issuance Date:	08/01/2021
License Status:	TEMPORARY
Effective Date:	08/01/2021
Expiration Date:	01/31/2022
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her prescribed medication, Clozapine 200 mg, between October 28, 2021 and October 31, 2021.	Yes
Resident A missed her scheduled appointment for her blood draw on October 21, 2021, because there was not a direct care staff member scheduled to transport her.	Yes
The direct care staff members are allowing the residents to bring alcohol into the facility and have parties in their bedrooms.	No
The direct care staff members at Regency Assisted Living have not received proper training.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/01/2021	Special Investigation Intake 2022A1029007
11/01/2021	Contact - Document Sent - Email to the complainant
11/02/2021	Special Investigation Initiated – Telephone to Jennifer Harper LCCMHA Case Manager
11/08/2021	Contact - Face to Face at Regency AL with direct care staff member Theresa Tessman, maintenance, Howard Wherry, direct care staff member Amy Onstott
11/08/2021	Contact - Telephone call made to Guardian A1, recording with wrong number
12/07/2021	Contact - Face to Face with Residents A, B, C, E, Jason Edel, direct care staff members Theresa Tessman, Corey Copeman, and Jason Edel
12/15/2021	Contact - Document Sent - Email to Bridget Vermeesch
12/15/2021	Contact - Document Sent to Elizabeth Simon, CMH
12/16/2021	Contact - Document Sent Email to Mikael McKendrick and Michele Carey requesting documents - Assessment Plans and training documentation.
12/16/2021	Contact - Telephone call made to Guardian A1, invalid number.

12/16/2021	Contact - Document Sent - Email to complainant
12/16/2021	Contact - Telephone call made to Regency Assisted Living. Interviewed Jeannie Woodworth Dietary, Resident F, and Resident D
12/16/2021	Contact - Telephone call made to Angela Sultana, RN at Livingston CMH
12/17/2021	Contact - Telephone call made from Karen Bresette, Central Michigan CMH.
12/20/2021	Contact – Telephone call received from direct care staff members, Taylor Oswald, and Amy Onstott.
12/20/2021	Exit conference with Fahim Uddin

ALLEGATION:

Resident A did not receive her prescribed medication, Clozapine 200 mg, between October 28, 2021 and October 31, 2021.

INVESTIGATION:

On November 1, 2021, a referral was received via a rejected adult protective services referral alleging that Resident A did not receive her prescribed medication, Clozapine 200 mg, between October 28, 2021 and October 31, 2021.

On November 2, 2021, I interviewed Resident A's case manager from Community Mental Health (CMH), Jennifer Harper. Ms. Harper stated Guardian A1 reported Resident A did not receive her Clozapine 200 mg for four days and Ms. Harper stated she realized this because Resident A had already been symptomatic during her visit. Ms. Harper stated Resident A was observed to be irritable, paranoid, and delusional.

On November 8, 2021, I interviewed direct care staff member Theresa Tessman outside of Regency Assisted Living. Due to several of the direct care staff member and residents contracting coronavirus, I did not enter the facility. Ms. Tessman made copies of Resident A's medication administration record (MAR) which I reviewed. According to the MAR, Resident A did not receive her prescribed medication, Clozapine 200 mg, between October 28, 2021 and October 31, 2021. Ms. Tessman stated the medication was not delivered from the pharmacy as a result of Resident A missing her blood draw appointment necessary for this medication.

On December 7, 2021, I interviewed Resident A at Regency Assisted Living. Resident A stated all of her medications are given as prescribed by the facility but she knows that she missed her Clozapine sometime in October 2021. Resident A stated she did not

know the date but remembered that it was near Halloween 2021. She stated she missed the medication because she was not taken to her blood draw appointment first which is a required part of taking this medication. Resident A stated she did not remember experiencing any side effects or needing to go to the hospital because of the missed medication.

On December 7, 2021, I interviewed Resident B, Resident C, and Resident E at Regency Assisted Living. On December 16, 2021, I interviewed Resident D and Resident F on the telephone. All residents interviewed stated they received their medications as prescribed. None of them were aware of any time they missed their medications or did not receive them on time.

On December 7, 2021, I interviewed direct care staff member, Jason Edel. Mr. Edel stated that when Resident A moved in, she was prescribed Clozaril 25 mg which later changed to Clozaril 200 mg. Please note that Clozapine and Clozaril are the same drug with Clozaril being the brand name version of the medication. He stated she did not receive her medication for October 28, 2021, through October 31, 2021, because he thought the script was missing and she could not get the medication sent on time. Mr. Edel stated two weeks after she missed the medication, he found an envelope in the office with the missing prescriptions in them.

On December 16, 2021, I interviewed Angela Sultana, RN from Livingston Community Mental Health. RN Sultana stated Resident A had missed her Clozapine dose from October 28, 2021, through October 31, 2021. RN Sultana stated Resident A must have a lab drawn before the pharmacy will dispense the next month worth of medication so it is requested Resident A's lab work is done two days before the medication is due to be refilled so the pharmacy is able to fill the medication. Since Resident A was not taken to have her lab work completed timely according to RN Sultana, the medication was not dispensed. RN Sultana stated Resident A's lab work was also late the week of November 8, 2021 and according to their records, she would have been out of medication on November 8, 2021.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	According to Resident A's medication administration record (MAR) Resident A did not receive her prescribed medication, Clozapine 200 mg, between October 28, 2021, through October 31, 2021, as prescribed. Livingston County Community Mental Health Recipient Rights officer, Ms. Simon was able to confirm that Resident A did not receive her medication as prescribed. Mr. Edel stated the medication was missed because the prescriptions were missing and then stated he found the scripts two weeks later in an envelope in the office.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A missed her scheduled appointment for her blood draw on October 21, 2021, because there was not a direct care staff member scheduled to transport her.

INVESTIGATION:

On November 1, 2021, a referral was received via a rejected adult protective services referral alleging Resident A missed her scheduled appointment for her blood draw on October 26, 2021, because there was not a direct care staff member scheduled to transport her. Further clarification was received from RN Sultana that this appointment was scheduled for October 21, 2021. RN Sultana stated Resident A's blood draw is scheduled to take place once every seven days and then Resident A's Clozapine is delivered to the facility after the results are received.

On November 1, 2021, Complainant emailed and stated she was told by Guardian A1 Resident A missed her blood draw appointment for the prescribed medication Clozaril/Clozapine resulting in Resident A missing her prescribed medications.

On November 2, 2021, I interviewed Resident A's case manager from Livingston Community Mental Health (CMH), Jennifer Harper. Ms. Harper stated Guardian A1 initially told her Resident A missed her lab appointment. Ms. Harper stated she received verification of the missed labs from RN Angela Sultana that Resident A did not show for her lab work until October 30, 2021. The labs are required to make sure that her medication levels are in a healthy range in order for the pharmacy to refill the prescription for the following week. Ms. Harper stated Guardian A1 signed a copy of the *Resident Care Agreement* and in that agreement, there was documentation the AFC facility direct care staff members will provide transportation for medical appointments.

On November 8, 2021, I interviewed direct care staff member, Theresa Tessman outside at Regency Assisted Living. I was unable to enter because several residents and direct care staff members had contracted coronavirus. Ms. Tessman made

photocopies of the lab test order and the medication administration record for Resident A which I reviewed. Ms. Tessman stated blood draw labs are completed weekly on Mondays at Carson or Gratiot Hospital labs but due to direct care staffing issues at the AFC facility Resident A missed her lab appointment on October 21, 2021. Ms. Tessman stated there was supposed to be a blood draw that morning (on November 8, 2021) again for Resident A and Resident F however they both missed these appointments due to the low direct care staffing numbers available to transport for blood draws. Ms. Tessman stated Resident A and Resident F are scheduled every Monday to have blood draws. Ms. Tessman stated Resident A missed her blood draw appointment during the week of October 18, 2021 and again on November 8, 2021, due to the AFC facility not having any direct care staff available to transport the residents for their blood draws. Resident A's lab test order was reviewed from Livingston County CMH which is a standing order beginning October 7, 2021, for blood draw for CBC with differential/platelet and Clozapine, serum level which was ordered by Dr. Manzar Rajput and is necessary to assure the refill of Clozapine medication.

I reviewed the staff schedule from October 24, 2021, to November 13, 2021 and there were three direct care staff members scheduled for day shift 7:00 a.m.- 3:00 p.m. shift. I noted that on November 8, 2021, one direct care staff member called in sick which resulted in two direct care staff member working. Ms. Tessman stated if one of the two direct care staff member transported Resident A to her blood draw, then it would have only left one direct care staff member working in the facility. According to Ms. Tessman the AFC facility had been struggling with call-ins due to COVID-19.

On December 7, 2021, I interviewed Resident A. She stated she missed a blood draw appointment because there were not enough direct care staff members working. Resident A stated she usually goes for a blood draw once per week on Monday. Resident A did not remember missing any other blood draws since the end of October. Resident A stated there was no set direct care staff member that takes her to these appointments rather it varies depending on who is working.

On December 7, 2021, I interviewed direct care staff member, Jason Edel at Regency Assisted Living. Mr. Edel stated that Resident A missed her lab appointment on October 26, 2021. He said that due to the COVID-19 pandemic and its association with the AFC facility's struggle with staffing, there were missed appointments however he did not recall any additional dates. He stated that since that time, Resident A has gone each week and has not missed any appointments since then.

On December 16, 2021, I spoke with dietary aide, Jeannie Woodsworth. Resident A has been transported to her blood draw appointments the last few Mondays. She stated that Ms. Onstott took her on December 13, 2021. Typically, according to Ms. Woodsworth, Mr. Edel will make complete the schedule with one additional person to provide the transportation. Ms. Woodsworth stated, If one person calls in, then it is more difficult and the appointments will need to be rescheduled.

On December 16, 2021, I interviewed RN Angela Sultana from Community Mental Health. RN Sultana stated Resident A had a blood draw appointment she attended on October 14, 2021 and then it was missed until October 30, 2021. The missed blood draw appointment was for October 21, 2021.

According to RN Sultana, Resident A had a medication review on October 29, 2021 and RN Sultana spoke with direct care staff member Sue Moore who stated there was not enough direct care staff members, vehicles, or time to get Resident A to the lab draw appointments. RN Sultana stated she reminded direct care staff member Sue Moore about the missed blood draw appointment and Resident A was brought for her lab work on October 30, 2021, resulting in Resident A missing her medications for four days. RN Sultana checked the lab draw for the week of November 8, 2021, since Ms. Tessman stated that Resident A missed her appointment on November 8, 2021. RN Sultana was able to verify Resident A was brought on November 9, 2021, for her blood draw.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	The licensee did not ensure that Regency Assisted Living had adequate direct care staff members on duty to ensure the services specified in the resident's *Resident Care Agreement* and *Assessment Plan for AFC Residents* were provided. Resident A's lab test order was reviewed from Livingston County Community Mental Health, which was a standing order beginning October 7, 2021, for blood draw for CBC with differential / platelet and Clozapine, serum level which was ordered by Dr. Manzar Rajput. Resident A missed her scheduled appointment for her blood draw on October 26, 2021 and again on November 8, 2021, because there was not a direct care staff member available to transport her. Ms. Tessman and Mr. Edel both confirmed that Resident A missed the appointment due to staffing issues and COVID-19 at the facility. As a result, Resident A missed her medication Clozapine 200 mg for four days.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The direct care staff members are allowing the residents to bring alcohol into the facility and have parties in their bedrooms.

INVESTIGATION:

On November 1, 2021, a referral was received via a rejected adult protective services referral alleging the direct care staff members are allowing the residents to bring alcohol into the facility and have parties in their bedrooms.

On November 2, 2021, I interviewed Resident A's case manager from Livingston Community Mental Health, Jennifer Harper. Ms. Harper stated that she heard from various direct care staff members and Resident C that alcohol is brought into the facility. She stated she is worried about medication interactions with Resident C because he is prescribed psychiatric medications that may be a concern with drinking alcohol however she did not have any verification from a physician stating he could not have alcohol with his medications.

On November 8, 2021, I interviewed direct care staff member, Theresa Tessman outside at Regency Assisted Living. I was unable to enter the home at this time because several residents and direct care staff member had contracted coronavirus. She stated she was under the assumption residents could not drink alcohol in the facility but they were seeking clarification from Livingston Community Mental Health regarding this issue. Ms. Tessman stated the residents go to the store in town and buy alcohol and bring it back into their rooms. She stated she was not sure if the residents were drinking beer or liquor, but she thinks it is liquor. Ms. Tessman stated the residents who drink the most are Resident D and Resident F because they are roommates and tend to drink together. Ms. Tessman stated Resident B and Resident E will go into their individual rooms and drink alone. Ms. Tessman denied that any parties are happening at the AFC facility or that the residents are loud when they are drinking. There have not been any fights or disruption to anyone's living situation due to them drinking. Howard Wherry, who is in charge for maintenance of the building, was also present during this visit outside and he stated he was under the assumption that no alcohol was allowed on the premises.

On December 7, 2021, an on-site investigation was completed at Regency Assisted Living. Ms. Tessman explained the residents are still drinking in their bedrooms. She stated Resident C may be intoxicated during this inspection because he came back with a six pack of beer at 8:30 a.m. Resident F was no longer in the home and has been at the hospital for the last three weeks. Ms. Tessman stated the residents that are drinking in the home are Resident B, C, and E.

On December 7, 2021, I interviewed Resident A at Regency Assisted Living. Resident A stated she has not observed alcohol brought to the facility by the other residents. She

stated she is unaware of any of the other residents' drinking in their bedrooms and stated that she does not drink.

On December 7, 2021, I interviewed Resident B at Regency Assisted Living. He stated there is a party store in town that he will walk to and buy pop and coffee because he feels better when he takes a walk. During the interview, he had money in his hand and said he was heading out to the store when he was done talking. Resident B stated he did not buy alcohol at the store and said he did not know if other residents bought it. He said that he has never observed anyone under the influence. After this statement, he shook his head and stated he was not willing to share anything further.

On December 7, 2021, I interviewed Resident C at Regency Assisted Living. He stated he goes for a walk and likes they have a store so close. When he goes for his walks, he stated he buys beer, candy, and cigarettes. He stated he also bought beer on occasion that he drinks in his room. Resident C stated he did not believe any resident ever got "too drunk" except for one "old man" that used to live there. During the interview, he was looking down and slurring his words. Resident C stated he last had alcohol "this morning" (December 7, 2021) but then lifted his head and state that he "drinks responsibly" and he only had one beer.

On December 7, 2021, I interviewed Resident E at Regency Assisted Living. Resident E stated he has had two cases of beer in the last six years and has not observed other residents to be under the influence but has observed them to drink one beer here and there. The last time he said that he observed Resident F drinking was while they watched the movie Top Gun in his room.

On December 7, 2021, I interviewed direct care staff member, Corey Copeman at Regency Assisted Living. He stated that he is familiar with the residents drinking and because of their medications, he strongly advises against it. He said that he does not believe residents are buying the alcohol and has never observed anyone falling down or fighting. The direct care staff members that are working keep an eye on their drinking and would advise the residents if appeared the residents were drinking too much.

On December 16, 2021, I interviewed Resident F. He said there is a store in town he likes to visit. Resident F stated when he was in his apartment, he was drinking 4-5 beers per day and when he moved here his case manager, Dennis Byers from Community Mental Health, agreed that he can have two beers per day. Sometimes he buys a lot of beer but Resident F stated he was getting "written up." He purchases the beer with his own money. He stated that he has not been drinking it lately because he does not like it and said now, he prefers Bloody Mary drinks and margaritas. Resident F stated it is in his treatment plan that he is able to do this. He denied knowing if there is any conflict with the medications that he is prescribed and using alcohol. He typically drinks alone and cannot afford to buy the margaritas anymore because they are more expensive. He prefers to smoke cigarettes. He was informed that smoking in the facility is a fire hazard and he said the "State is paranoid." He stated the direct care staff member will sometimes hear them and advise them not to drink. He said one time he

was walking to the store and Mr. Edel followed him all the way to the store advising him not to drink.

On December 16, 2021, I interviewed Resident D. He stated that he does not drink and he does not buy alcohol from the store. He stated that he knew that some of the guys would buy drinks but he was not sure who did this. He felt that the staff monitor this well and make sure that it does not get out of hand. He stated that he does smoke cigarettes. He said he smokes outside and denied smoking in the facility.

The resident's *Assessment Plans for AFC Residents* were not reviewed at the time of the onsite investigation. Mr. Edel was unable to locate this form for any of the residents at the time of the onsite investigation and Mr. Edel was given my card to send them via email, however, they were not received.

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:	Although the residents are bringing alcohol from the party store into the facility, there is no indication that the direct care staff members are not attending to the residents' protection and safety. Through interviews with the direct care staff members, Ms. Tessman, Mr. Edel, and Mr. Chapman they are monitoring the alcohol use from the residents to ensure they are not at risk. The direct care staff members have not described the drinking as bothersome to the other residents or putting resident safety at risk. While reviewing the resident records during the onsite investigation, the facility did not have any resident *Assessment Plan for AFC Residents* available to review to determine if there was anything stating the residents could not use alcohol. None of the direct care staff members or case managers interviewed were aware of any restrictions prohibiting alcohol use by the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The direct care staff members at Regency Assisted Living have not received proper training.

INVESTIGATION:

On November 1, 2021, a referral was received via a rejected adult protective services referral alleging the direct care staff members at Regency Assisted Living have not received proper training.

On November 2, 2021, I interviewed Resident A's case manager from Livingston Community Mental Health (CMH), Jennifer Harper. Ms. Harper stated the direct care staff members received training from Community Mental Health for behavioral support related to the treatment plans. She stated due to COVID-19 the case managers are not in the home as often. She stated there are frequent phone calls to the facility and oversight several times per week. Ms. Harper stated few direct care staff members are trained in medication administration at this facility. She has not had concerns regarding direct care staff members not knowing how to handle any behavioral concerns related to the treatment plans.

On November 8, 2021, I interviewed direct care staff member Theresa Tessman outside at Regency Assisted Living. Ms. Tessman stated that she has received training through Saginaw County and Livingston County Community Mental Health. Former administrator for Regency Assisted Living, Ms. Rodriguez could pull all of the trainings from their employee records but she was not available at the time of the onsite investigation. Ms. Tessman explained the direct care staff members also complete trainings on the service plans from Community Mental Health for each resident and direct care staff members sign a sheet documenting each direct care staff member read the resident's service plan. There is also a crisis intervention training regarding aggression and behaviors the residents can experience and she believes this training was completed by Isabella County Community Mental Health. To her knowledge, none of the newer staff have been trained in the required licensing trainings.

On November 8, 2021, I interviewed direct care staff member Amy Onstott outside at Regency Assisted Living. She has worked at Regency Assisted Living since August 2021. Ms. Onstott stated has completed prevention and containment of communicable diseases and medication administration. She was informed when former administrator, Ms. Rodriguez was still there that they were on a waiting list for trainings. Ms. Onstott stated she feels comfortable working in the facility because she worked as a Certified Nurses Aide for over twenty years and although working in adult foster care is different, she is able to call for assistance when she needs help.

On December 7, 2021, I interviewed Resident A, Resident B, Resident C, and Resident E at Regency Assisted Living. On December 16, 2021, I interviewed Resident D and Resident F on the telephone. All residents interviewed thought the direct care staff

members were trained to handle the situations that may arise in the facility. None of them were able to recall a situation that the staff did not handle appropriately. Resident A stated she believed the residents are trained through Community Mental Health.

On December 7, 2021, I interviewed direct care staff member, Corey Copeman at Regency Assisted Living. He stated he completed training to pass medications. When he started employment, he completed his training through Saginaw County CMH. He stated he completed all the licensing trainings when he first started and he has been employed there for two years. He said that the current direct care staff members are not completely trained but everyone that passes medications has completed training. They currently have ten direct care staff members that rotate and schedule three direct care staff members for first and second shift with two direct care staff members on third shift. Mr. Copeman stated there are five newer staff that have all started since September 2021: Melissa Fuller, Angela Blankenmaker, James Blankenmaker, Amy Onstott, and Taylor Oswald. He was unable to show the training records for the employees because he did not have access to the administrative office. Some of the newer employees have started to reach out to different Community Mental Health offices to set up their own training. There is always someone that has finished their training working as a lead direct care staff member with someone who is newer. He stated the schedules are primarily done by Jason Edel who makes sure there is a more experienced direct care staff member on each shift.

On December 7, 2021, I interviewed direct care staff member, Jason Edel. Mr. Edel stated he has worked at Regency Assisted Living for the last thirteen years and expressed his concern for the residents due to the lack of training with the newer employees that have been hired since September 2021 and turnover with direct care staff members. He stated the new employees have not been trained completely. He stated the newer employees are always working alongside a lead experienced direct care staff member if they are not completely trained. Most of their classes have been through Saginaw CMH and they have done online classes due to COVID-19. There are no classes scheduled for December because of the holidays and the class offerings are filled through January 2022. Before Ms. Rodriguez left, she mentioned there were trainings available through Livingston County CMH for Resident Rights and Personal care / supervision / protection needs of residents in home. He did not have keys to the administrative office because they were kept with Ms. Wadsworth who works in dietary and she was not there working during the onsite investigation. Mr. Edel stated he found a training log in the office about what trainings were missing but when he went back to see if he could find some available trainings, he was unable to find the training log again.

On December 15, 2021, an email was sent to Mikael McKendrick and Michele Carey requesting documents to verify the training documentation of various employees. A response was requested by December 17, 2021, at noon. As of December 20, 2021, this documentation has not been received.

On December 16, 2021, I spoke with dietary aide, Jeannie Woodsworth. She was unsure who had not completed trainings but stated the newer direct care staff members were not fully trained yet. She had keys to the administrative office and has not observed any documentation regarding trainings in the office. She was not aware of anyone scheduled to complete their training in the near future.

On December 20, 2021, I interviewed direct care staff member, Taylor Oswald. She stated that she has gone through reporting requirements, personal care, residents' rights, communicable diseases through Livington CMH but was told she needed additional training through Saginaw CMH. She completed First Aid but has not completed a cardiopulmonary resuscitation (CPR) yet. There have not been arrangements made to complete CPR or safety and fire prevention.

APPLICABLE RULE	
R 400.15204	**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:	During the onsite investigation on December 7, 2021, the employee records were unavailable. Mr. Eden stated that dietary aide, Ms. Woodsworth had the key for the administrative office and she was not present at the time of the inspection. Consequently, the employee records could not be reviewed by this consultant. Mr. Edel stated that the newer staff had not completed all their training at this time but usually work with an experienced fully trained direct care staff member. The newer direct care staff member includes Melissa Fuller, Angela Blankenmaker, James Blankenmaker, Amy Onstott, and Taylor Oswald. Ms. Onstott and Ms. Oswald both confirmed they have not completed the required training for direct care staff members.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on December 7, 2021, the *Assessment Plans for AFC Residents* were not located in any of the resident records that were reviewed. When asked to locate them, Mr. Edel stated those documents may have been in the administrative office but he did not have a key to this office. Ms. Woodworth had a key to the administrative office but she was not there. Mr. Edel was given my business card so he could email each resident's *Assessment Plans for AFC Residents* but those have not been received as of December 20, 2021.

On December 15, 2021, an email was sent to Mikael McKendrick and Michele Carey requesting *Assessment Plans for AFC Residents*. A response was requested by December 17, 2021, at noon. As of December 20, 2021, there has been no documentation received.

On December 16, 2021, I interviewed Ms. Woodworth who stated that she works in the kitchen but has worked at Regency Assisted Living for seventeen years. She stated that she does have a key to the office but there was no indication that the *Assessment Plans for AFC Residents* was completed for Resident A or Resident G since they both moved in within the last few months and she does not believe they were completed.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	There is no indication the form, *Assessment Plan for AFC Residents,* had been completed for all residents in the home. Ms. Woodworth stated the *Assessment Plans for AFC Residents* was not done for Resident A because she was one of the newer residents that moved into the home. During the onsite investigation, the *Assessment Plans for AFC Residents* were not available for review as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with property owner Fahim Uddin on 12/20/2021 as the currently named licensee designee/administrator no longer is employed by the licensee and a new one is being sought.

IV. RECOMMENDATION

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

_ __________12/20/2021________________________________
Jennifer Browning Date
Licensing Consultant

Approved By:

12/27/2021
____
Dawn N. Timm Date
Area Manager