GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2021

Renae Clark
Community Living Support Services, LLC
PO Box 5
Albion, MI 49224

RE: License #: AS130381539
Investigation #: 2022A0783005
Linden Ave.

Dear Mrs. Clark:

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,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130381539
Investigation #:	2022A0783005
Complaint Receipt Date:	10/21/2021
Investigation Initiation Date:	10/22/2021
Report Due Date:	12/20/2021
Licensee Name:	Community Living Support Services, LLC
Licensee Address:	PO Box 5 Albion, MI 49224
Licensee Telephone #:	(517) 554-8788
Administrator:	Renae Clark
Licensee Designee:	Renae Clark
Name of Facility:	Linden Ave.
Facility Address:	504 Linden Ave. Albion, MI 49224
Facility Telephone #:	(517) 554-8788
Original Issuance Date:	04/29/2016
License Status:	REGULAR
Effective Date:	10/25/2020
Expiration Date:	10/24/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was left on the floor for 26 hours at the facility and was not assisted by multiple staff members.	Yes
Resident A was physically abused at the facility.	No

III. METHODOLOGY

10/21/2021	Special Investigation Intake – 2022A0783005
10/22/2021	Special Investigation Initiated – Telephone call with Complainant
10/22/2021	Contact - Telephone call made to assigned adult protective services (APS) investigator Jennifer Stockford, unsuccessful
10/22/2021	Contact - Document Received – Written AFC Licensing Division - Incident/Accident report for Resident A
11/01/2021	Inspection Completed On-site, unsuccessful, no one present at facility
11/08/2021	Contact - Document Received – Resident A's resident record
11/08/2021	Contact - Document Received – *Shift Summary Report* for October 13 - October 14, 2021
11/08/2021	Contact - Face to Face interviews with assistant administrator Shelby Bristow and licensee designee Renae Clark
11/08/2021	Inspection Completed On-site
12/08/2021	Contact - Document Received – Employee schedule for October 13 - October 14, 2021
12/08/2021	Contact - Telephone call made to Sparks Behavioral Services consultant Nick Christensen
12/10/2021	Contact - Telephone call made to assigned APS investigator Jennifer Stockford, unsuccessful

12/10/2021	Contact - Telephone call made to direct care staff members Amber Schroll, Tiffany Showers, and Terrica Ridley
12/11/2021	Contact - Telephone call made to direct care staff member Barb Fairchild
12/16/2021	Contact - Telephone call made to recipient rights officer Kent Rehman
12/17/2021	Contact - Telephone call received from Jennifer Stockford
12/17/2021	Contact - Telephone call made to Guardian A1
12/17/2021	Contact - Telephone call received from Jennifer Stockford
12/21/2021	Exit Conference with Renae Clark

ALLEGATION:

Resident A was left on the floor for 26 hours at the facility and was not assisted by multiple staff members.

INVESTIGATION:

On October 22, 2021, I received a complaint via email that stated Resident A has an intellectual disability along with mental health disorders. The written complaint stated Resident A fell on the bathroom floor at the facility on October 13, 2021. The written complaint stated Resident A has a Behavior Treatment Plan that states if Resident A falls, staff members are to medically assess Resident A and offer assistance getting up. The written complaint stated if Resident A does not comply, staff members are to walk away and try again in ten minutes. The written complaint stated Resident A was on the floor for 26 hours in total from October 13, 2021 – October 14, 2021. The written complaint stated no one from the facility notified Resident A's public guardian that Resident A was on the floor until 26 hours had passed and Resident A went to the hospital. The written complaint stated the licensee designee told Resident A's guardian that Resident A has a Behavior Treatment Plan that states she is supposed to be left alone for 26 hours. The written complaint stated Complainant spoke to a nurse at Oaklawn Hospital who stated due to Resident A laying on the floor for 26 hours she developed Rhabdomyolysis, which is muscle breakdown and is very painful. The written complaint stated that hospital staff members have had no behavioral issues with Resident A since she was admitted to the hospital.

On October 22, 2021, I spoke to Complainant who stated Jennifer Stockford, the assigned investigator from Adult Protective Services (APS) confirmed the allegations

made in the written complaint and told him that she had spoken with Guardian A1, who is Resident A's assigned public guardian and staff members at the hospital where Resident A was treated after being on the floor for approximately 26 hours. Complainant said Ms. Stockford told him Resident A would not be returning to the facility upon release from the hospital.

On October 22, 2021, and December 10, 2021, I telephoned assigned APS investigator Jennifer Stockford who returned my telephone call on December 17, 2021. Ms. Stockford stated her investigation resulted in the facility being substantiated for the neglect of Resident A because direct care staff members left Resident A on the floor for approximately 26 hours. Ms. Stockford said licensee designee Renae Clark informed her that staff members were following the protocol in Resident A's written *Behavior Treatment Plan* and that she informed Nick Christensen from Sparks Behavioral Services after Resident A had been on the floor for several hours, who advised staff members to continue to follow the written plan. Ms. Stockford said Mr. Christensen told her that he advised Ms. Clark to telephone him that day (October 13, 2021) if Resident A did not get up from the floor but he was not informed until the following day (October 14, 2021).

On October 22, 2021, I reviewed an *AFC Licensing Division Incident/Accident Report* for Resident A dated October 14, 2021. The written incident report was signed by licensee designee Renae Clark and completed and signed by assistant to the facility administrator, Shelby Bristow. The written incident report stated, "On 10/13/21 at approx. 10 am Admin. Assist. (AA) Shelby assisted [Resident A] into the restroom using her wheelchair. Once in the restroom [Resident A] attempted to stand up, she then said she was going to fall. AA Shelby then prompted her to sit back down into her wheelchair if she feels she was going to fall, [Resident A] then sat down in her wheelchair. [Resident A] then stood up again after about 60 seconds. [Resident A] then slowly lowered herself to the bathroom floor. AA Shelby prompted [Resident A] to get up off the floor. [Resident A] stated, "I can't, I need you to pick me up." AA Shelby informed [Resident A] that she would not be picking her up, [Resident A] needed to use her [physical therapy] skills to get herself up off the floor. At approx. 11:45 am Nick Christensen (Behaviorist through Sparks Behavioral Services) arrived at the home to further in-service and assist staff with [Resident A's] Behavior Treatment Plan (BTP). Staff in attendance were Renea Clark, administrator, Tiffany Showers, manager, Amber Schroll, manager, and Shelby Bristow, administrative assistant. At this time [Resident A] was still lying/sitting on the bathroom floor. Nick instructed staff to approach [Resident A] and say, "[Resident A], it's time to get up." If [Resident A] stated "I can't" or made little to no effort to get up off of the floor, staff were to count to 5 Mississippi silently to themselves and then walk away with no dialogue. Staff were instructed to repeat this process until she got herself up off the floor. Nick requested that each staff member listed above complete these steps while Nick watched to ensure accuracy. Amber, Shelby, and Tiffany each took a turn approaching [Resident A] and saying, "[Resident A] it's time to get up." [Resident A] would say, "I don't think I can." Staff would then walk away as instructed by Nick. Staff followed this procedure through

the second (4 p – 12 a) shift and third (11:59 a – 8:00 am) shift. It was reported to management by second and third shift that [Resident A] was calling them names and using profanity and screaming at staff to pick her up off the floor. Staff repeated the BTP process as instructed. [Resident A] then proceeded to dig and claw at her skin on her face leaving open wounds and peeling the scabs off her arms and legs. It was then reported that [Resident A] undressed herself while lying on the bathroom floor and requested staff get her clean clothes. Staff Terrica Ridley gave [Resident A] clean clothes. [Resident A] proceeded to dress herself while sitting on the bathroom floor. Upon first shift arrival at 8 am on 10/14/21 Amber (manager) contacted Nick (behaviorist) to inform him that [Resident A] was still on the bathroom floor and had made little to no effort to get up off of the floor. Nick informed Amber that this behavior was called "extinct behavior" and her behaviors would increase in severity before they began to get better. Nick instructed the staff to continue following the BTP as written. At 1 pm AA Shelby contacted Kent Rehman from recipient rights and explained the events that took place from 10 am on 10/13/21 to current. Kent informed AA Shelby that at this point in time it would be considered an inhumane environment. Kent informed AA Shelby that he would contact Nick (behaviorist) to discuss changing the BTP. Kent then instructed AA Shelby to contact EMS to have [Resident A] evaluated. If EMS felt that [Resident A] did not need to be seen at the hospital at least have EMS assist [Resident A] off the floor into a comfortable position. At approx. 1:45 pm Officer Riley as well as Officer Morgan arrived at the home. AA Shelby explained the events leading up to the current date and time. Officer Riley walked into the restroom with AA Shelby and asked [Resident A] why she was laying on the floor. [Resident A] stated, "I want to leave here." Resident A stated she wants to live with her brother. Officer Riley explained that lying on the bathroom floor would not help [Resident A] be able to live with her brother. AA Shelby held out her hand to assist [Resident A] up off the floor, [Resident A] grabbed Shelby's hand and pulled herself up into a sitting position. [Resident A] did all the work, Shelby was just used as a support. [Resident A] then said, "Officer Riley will you help me up?" AA Shelby explained. "No, Officer Riley will not help you, I'm here to help you." [Resident A] then let go of Shelby's hand and slowly laid herself back on the floor. This was repeated three other times. AA Shelby then asked [Resident A] if she would like to wait for EMS arrival. [Resident A] stated, "Yes." EMS arrived at approximately 2 pm. AA Shelby again relayed all the events leading up to the current date and time. EMS assisted [Resident A] up off the floor and into her wheelchair. [Resident A] was speaking with EMS personnel, answering questions, and speaking in full sentences. EMS personnel assisted [Resident A] into a gurney and transported her to Oaklawn hospital for further evaluation."

On November 8, 2021, I received a copy of Resident A's written *Behavior Treatment Plan* dated May 1, 2021 and completed by Nick Christensen from Sparks Behavioral Services. One of the "target behaviors" noted in the written plan was "dropping to the floor." The written plan defined "dropping to the floor" as "falling to the floor from a standing or sitting position in a controlled manner and requesting help to stand up." The written plan provided an example such as, "sliding down out of her chair or leaning on countertops to lower herself down and shouting to a staff member that

she needs assistance." The related "objective" to address the "target behavior" stated, "[Resident A] will engage in no more than two instances of dropping to the floor over six consecutive months as measured by staff recording. This goal should be met by one year from the date of this plan." The "strategy" indicated in the written plan to meet the objective stated, "In the event that [Resident A] slides out of her chair to the ground, or claims to have fallen while no one was present, staff should check for signs of bodily impact to [Resident A] (signs of injury due to a fall) and signs of impact to her surrounding environment (broken walls, dents in wall/floor). If it is determined [Resident A] fell in a controlled manner consistent with the definition in this treatment plan, staff are to provide minimal attention to [Resident A] and prompt her to return to her chair or walker and only provide assistance as necessary. When she has returned to her chair or walker, redirect her to an unrelated activity and do not discuss the incident with her further."

On November 8, 2021, I received a copy of the facility *Shift Summary Report* for October 13, 2021 – October 14, 2021. According to the written report completed by Terrica Ridley, Ms. Ridley worked from 4 pm until 11:59 pm and Resident A refused to eat and was on the floor throughout the entire shift. According to the written report completed by Barb Fairchild who worked from 12:00 am until 8:00 am on October 14, 2021, Ms. Fairchild completed "hourly bed checks" and Resident A was on the bathroom floor during each "bed check." The additional comments section stated, "Staff prompted [Resident A] to get off the floor every 15 minutes, she refused, wanted her blanket. Monitored for safety." According to the written report completed by Amber Schroll who worked from 8:00 am until 4:00 pm on October 14, 2021, Resident A refused meals, and "laid on the floor," and went to the hospital at 2:00 pm.

On December 14, 2021, I received a written *Summary Report of Investigation* written by recipient rights officer Kent Rehman and dated December 7, 2021. The written report indicated Mr. Rehman reviewed Resident A's hospital records from Oaklawn Hospital dated October 14, 2021. According to the written report, Resident A's chief complaint at the hospital was "hurting all over." The written report indicated Resident A was diagnosed with, "decubitus ulcer at the buttocks, cellulitis of the left foot, a large abrasion on the left knee, concern for early rhabdomyolysis, and bruises of various ages all over her body." The written report indicated hospital staff were told that Resident A had been on the floor for 24 hours prior to being evaluated at the hospital and that "while the extensive duration of time spent laying on the floor could have contributed to [the diagnoses above], there is not enough evidence to determine whether these issues began prior to October 13, 2021."

On November 8, 2021, I received the employee schedule for October 13, 2021 – October 14, 2021. I noted that direct staff member and manager Amber Schroll worked from 8:00 am – 4:00 pm on October 13, 2021. Direct care staff member and manager Tiffany Showers worked from 12:00 pm until 8:00 pm on October 13, 2021. Direct care staff member Terrica Ridley worked from 4:00 pm – 11:59 pm on

October 13, 2021. Direct care staff member Barb Fairchild worked from 12:00 am to 8:00 am on October 14, 2021.

On November 2, 2021, I attempted an unannounced onsite inspection at the facility and nobody answered the door, it appeared as if nobody was there. I returned on November 8, 2021, once again to find nobody at the facility so I telephoned Ms. Clark and she and Ms. Bristow met me at the facility.

On November 8, 2021, I interviewed the assistant to the facility administrator Shelby Bristow who stated she previously worked at the facility as a direct care staff member and has completed all the required training and competencies, but now primarily completes "office" tasks. Ms. Bristow said Resident A has a behavioral history of dropping to the floor purposefully and then demanding that staff members assist her up from the floor. Ms. Bristow stated this behavior is addressed in a written *Behavior Treatment Plan*. Ms. Bristow stated she came to the facility to "check in" at approximately 10:00 am on October 13, 2021 and found Resident A sitting her wheelchair in the living room. Ms. Bristow said she assisted Resident A to the restroom and while in the restroom Resident A stood up from her wheelchair and said, "I'm going to fall." Ms. Bristow said she advised Resident A to sit down in her wheelchair and Resident A sat down, waited one to two minutes, and then stood again, and said, "I'm going to fall." Ms. Bristow said at that time Resident A "lowered herself onto the bathroom floor on her knees and then slanted onto her butt/hip area." Ms. Bristow said she verbally prompted Resident A to get up off the floor and Resident A stated that she could not get up and needed Ms. Bristow to "pick [her] up." Ms. Bristow said she followed Resident A's written *Behavior Treatment Plan* and left the room, returning every "10 – 15" minutes to verbally prompt Resident A to get up off the floor. Ms. Bristow said at approximately 11:30 am on October 13, 2021, Nick Christensen, Resident A's Behavior Treatment Plan developer came to the facility and was told that Resident A had been on the floor for at least an hour. Ms. Bristow stated licensee designee Renae Clark, as well as direct care staff members/home managers Tiffany Showers and Amber Schroll were present that morning. Ms. Bristow said Mr. Christensen modeled what staff members should do to verbally prompt Resident A to get up from the floor and then watched as Ms. Bristow, Ms. Showers, and Ms. Schroll all verbally prompted Resident A to get up from the floor. Ms. Bristow said Mr. Christensen told them to continue to verbally prompt Resident A to get up and continue to engage minimally and walk away if Resident A refused to get up. Ms. Bristow said Mr. Christensen instructed them to verbally prompt Resident A every 15 – 20 minutes but did not provide any further instructions or time frames in which to continue to verbally redirect Resident A and not physically assist her off the floor. Ms. Bristow said she left the facility after Mr. Christensen left and did not hear from any staff members nor did she inquire about Resident A for the rest of the day. Ms. Bristow said the following morning on October 14, 2021, she received a telephone call from Ms. Schroll at approximately 9:00 am and was informed that Resident A had been on the bathroom floor since approximately 10:00 am on October 13, 2021. Ms. Bristow said Ms. Schroll told her she had already contacted Mr. Christensen that morning and he advised to continue

with the *Behavior Treatment Plan* as written, and as modeled the day prior. Ms. Bristow said Ms. Schroll told her Mr. Christensen warned that the behavior would "get worse before it gets better," and staff should continue to do what they had been doing since 10:00 am the day prior. Ms. Bristow said she called the Office of Recipient Rights and spoke to recipient rights officer Kent Rehman who told her to call 911 to get assistance for Resident A. Ms. Bristow said she did, and police and emergency medical technicians (EMT) arrived and the EMTs assisted Resident A from the floor to her wheelchair and transported her to the hospital. Ms. Bristow said Resident A never returned to the facility as she was admitted to another facility after she was discharged from the hospital. Ms. Bristow stated the staff members who worked second and third shift on October 13, 2021 – October 14, 2021, never notified anyone that Resident A was on the floor during their entire shift and she found out when Ms. Schroll notified her on October 14, 2021, when Resident A had been on the bathroom floor for nearly 24 hours. Ms. Bristow said her understanding is that while Resident A was on the floor, she refused all meals but took her medication from the floor. Ms. Bristow said Resident A urinated in her clothing and on the floor and eventually requested a change of clothing and changed while on the bathroom floor. Ms. Bristow said it was not uncommon for Resident A to spend as long as four to five hours on the floor, but she had never stayed on the floor this long in the past.

On November 8, 2021, I interviewed licensee designee Ranae Clark who said Resident A "placed herself on the floor" regularly and that she did so on October 13, 2021, because Nick Christensen, who is a consultant for Sparks Behavioral Services and the person who wrote Resident A's Behavior Treatment Plan, was coming to reassess Resident A that day. Ms. Clark said Resident A was previously evaluated by a physical therapist and the refusal to get off the floor was strictly behavioral. Ms. Clark said she was present on October 13, 2021, when Mr. Christensen came to the facility, assessed Resident A, and advised staff members to continue to follow her written *Behavior Treatment Plan* which prohibits physically assisting Resident A off the floor. Ms. Clark said she specifically asked Mr. Christensen how long staff members should continue to follow the plan by leaving Resident A on the bathroom floor and he advised they needed to continue to follow the written *Behavior Treatment Plan*. Ms. Clark said Mr. Christensen modeled for Ms. Bristow, Ms. Showers, and Ms. Schroll how to verbally prompt Resident A and told them they may "extend a hand" toward Resident A but they were not to physically assist her from the floor. Ms. Clark stated Mr. Christensen advised that if Resident A urinated and refused to get up staff members should "clean up around" Resident A. Ms. Clark stated when she left on October 13, 2021, Resident A was on the bathroom floor. Ms. Clark said she did not hear from any staff members, nor did she inquire about Resident A for the rest of the day. Ms. Clark said the following morning on October 14, 2021, she received a telephone call from Ms. Schroll at approximately 9:00 am and was informed that Resident A had been on the bathroom floor since approximately 10:00 am on October 13, 2021. Ms. Clark said staff members believed Resident A could physically get off the floor because she changed her clothing independently on the bathroom floor when given clothing by a staff member.

Ms. Clark said she asked Ms. Bristow to go to the home and “assess” Resident A which she did and then Ms. Bristow telephoned recipient rights officer Kent Rehman who mentioned leaving Resident A on the bathroom floor was “inhumane.” Ms. Clark said Resident A was transported to the hospital by EMS and would not be returning to the facility. Ms. Clark said she advised Resident A’s public guardian that Resident A cannot live at the facility if she “refuses to walk” and Guardian A1. Ms. Clark said Guardian A1 did not have any concerns regarding Resident A’s treatment at the facility.

On December 10, 2021, I spoke to direct care staff member and facility manager Amber Schroll who said she worked from 8:00 am to 4:00 pm on October 13, 2021 and October 14, 2021. Ms. Schroll said it was common for Resident A to “drop” or “lower herself” to the floor and that there were specific steps staff were to follow per Resident A’s written *Behavior Treatment Plan.* Ms. Schroll said at approximately 10:00 am Resident A engaged in the falling behavior and was on the bathroom floor. Ms. Schroll said she followed Resident A’s written behavior plan and went into the bathroom every 15 minutes and encouraged Resident A to stand up, told Resident A that she was strong and could lift herself up. Ms. Schroll said staff members cannot physically lift Resident A from the floor and also stated doing so would be contrary to Resident A’s *Behavior Treatment Plan*. Ms. Schroll said after approximately two hours and after staff members Shelby Bristow and Tiffany Showers also failed at verbally prompting Resident A to get up from the bathroom floor, she telephoned Nick Christensen who wrote Resident A’s *Behavior Treatment Plan* and he came to the facility. Ms. Schroll said Mr. Christensen modeled how staff members should handle the falling behavior and watched as staff members practiced the skills. Ms. Schroll said Mr. Christensen advised that staff members should continue to follow Resident A’s written *Behavior Treatment Plan* and told them to start verbally prompting Resident A to get up every five minutes, which was done. Ms. Schroll said during her shift on October 13, 2021, when she prompted Resident A to get up Resident A would stand herself up, and then slide back to the floor again. Ms. Schroll said Resident A urinated on herself and on the floor which staff members cleaned “as best they could” with Resident A on the floor. Ms. Schroll said Resident A changed her clothing independently and took her medication from the bathroom floor but refused meals. Ms. Schroll said at one point Resident A became “wedged” between the toilet and the sink so Ms. Schroll “pulled [Resident A] forward,” and Resident A kicked Ms. Schroll and told her she did not want help. Ms. Schroll said when her shift ended at 4:00 pm on October 13, 2021, Resident A was still on the bathroom floor where she had been for six hours. Ms. Schroll denied that she notified anyone because Mr. Christensen had already advised them to continue to follow the behavior treatment plan. Ms. Schroll said when she arrived at 8:00 am on October 14, 2021, Resident A was still on the bathroom floor, where she had been for approximately 22 hours. Ms. Schroll said at that time she telephoned Mr. Christensen who told her to telephone the Office of Recipient Rights and inquire about how to handle the situation. Ms. Schroll said she did that and was advised to notify Resident A’s physician, for whom she left a voicemail. Ms. Schroll said after another hour passed and she did not hear from Resident A’s physician she

telephoned 911 for assistance. Ms. Schroll said Resident A's written *Behavior Treatment Plan* did not specify any time frame for which to continue the intervention with Resident A on the floor and Mr. Christensen told her the behavior would get worse before getting better, so she did not inquire about further assistance for Resident A until she had been on the floor for approximately 22 hours.

On December 10, 2021, I interviewed direct care staff member and home manager Tiffany Showers who said she worked from 12:00 pm until 8:00 pm on October 13, 2021 and October 14, 2021. Ms. Showers said when she arrived at the facility on October 13, 2021, Resident A was on the bathroom floor. Ms. Showers said Resident A had a frequent behavior of "dropping" to the floor and that a consultant from Sparks Behavioral Services, Nick Christensen wrote a *Behavior Treatment Plan* for Resident A and provided consultation on implementing the written plan. Ms. Showers said on October 13, 2021, when she arrived at the facility Mr. Christensen was at the facility modeling how to verbally prompt Resident A to get up from the bathroom floor. Ms. Showers said Mr. Christensen informed her that she was offering "too much dialogue" when prompting Resident, A to get off the floor. Ms. Showers said she was advised to instruct Resident A to get up, and if she did not then walk away for five minutes, come back, and verbally prompt Resident A again. Ms. Showers said every time staff members prompted Resident A to get up, Resident A attempted to get up and then "would drop back down." Ms. Showers said the only direction she received from anyone was to continue to follow Resident A's written behavior plan and that no specific time frame was ever discussed regarding how long it was acceptable for Resident A to stay on the floor. Ms. Showers stated while Resident A was on the floor, she refused all meals. Ms. Showers stated Resident A urinated in her clothing and staff members were directed by Mr. Christensen to clean up the area around Resident A but continue to follow her *Behavior Treatment Plan*. Ms. Showers said Resident A was on the floor throughout her entire shift and acknowledged she was concerned for Resident A's safety and wellbeing when she left at 8:00 pm but did not call 911 on behalf of Resident A because she was following Resident A's written *Behavior Treatment Plan*, which she was instructed to do. Ms. Showers denied that she reported to Ms. Clark nor anyone else that Resident A had been on the floor for approximately ten hours when she left at 8:00 pm on October 13, 2021. Ms. Showers said she returned to the facility at 10:00 am on October 14, 2021, and Resident A was still on the floor, where she had been for 24 hours straight. Ms. Showers stated at that time she determined "something needed to be done," so she advised Ms. Schroll to telephone Ms. Clark who instructed them to telephone Ms. Bristow. Ms. Showers said shortly after that she left the home to manage an emergency with another resident. Ms. Showers said later returned to the facility and went to the emergency room with Resident A at approximately 2:00 pm and Resident A was admitted to the hospital.

On December 10, 2021, I spoke to direct care staff member Terrica Ridley who stated she worked from 4:00 pm to 11:59 pm on October 13, 2021. Ms. Ridley said it is common for Resident A to drop to the floor for short periods of time but had never known Resident A to stay on the floor for hours. Ms. Ridley said when she arrived for

her shift at the facility at 4:00 pm on October 13, 2021, Resident A was on the bathroom floor. Ms. Ridley said she was told to verbally prompt Resident A to get up from the floor independently, and that she was not to physically assist Resident A. Ms. Ridley said she went into the bathroom and verbally prompted Resident A to get up from the floor every five to ten minutes throughout her shift. Ms. Ridley said Resident A "tried to get up a couple of times but she was weak and couldn't get up." Ms. Ridley stated, "I would have helped [Resident A] but I was told not to." Ms. Ridley said she "kept trying" to verbally prompt Resident A to come to dinner and she observed that Resident A "was trying but her hands were slipping from anything she grabbed." Ms. Ridley said she "didn't really know if [Resident A] could get up" independently but she did not assist her nor call for medical attention because she was told by Ms. Showers and Ms. Schroll that Resident A was exhibiting behavior addressed in a written *Behavior Treatment Plan* which needed to be followed. Ms. Ridley said, "I tried for hours, and I wanted to help [Resident A] but I didn't want to go through that," meaning she believed she needed to follow Resident A's written behavior plan. Ms. Ridley said she had seen Resident A get up from the floor independently in the past, but it appeared as if Resident A was physically struggling to get up during her shift on October 13, 2021. Ms. Ridley said Resident A refused meals, took her medication from the floor, and urinated on herself and the floor around her which staff members attempted to clean around Resident A. Ms. Ridley said Resident A had never urinated on herself or the floor in the past, so she found that unusual. Ms. Ridley said Resident A requested a change of clothing and independently changed her clothing while on the bathroom floor.

On December 11, 2021, I spoke to direct care staff member Barb Fairchild who stated she worked from 12:00 am until 8:00 am on October 14, 2021. Ms. Fairchild said it was common for Resident A to drop or lower herself to the floor for which Resident A had a written *Behavior Treatment Plan* that instructed staff members to verbally prompt Resident A to get up from the floor but not physically assist her. Ms. Fairchild said when she arrived on October 14, 2021, Resident A was on the bathroom floor, and she was told by Ms. Ridley that Resident A had been on the bathroom floor "all day; since first shift." Ms. Fairchild said she "kept [verbally] prompting" Resident A to get up from the floor but Resident A told her she "could not get up," and requested that Ms. Fairchild physically assist her by "picking her up and carrying her." Ms. Fairchild said she informed Resident A that she could not physically pick her up and carry her. Ms. Fairchild said she offered her own body as a stabilizing force for Resident A to use to help her get up from the floor, but Resident A could not get up. Ms. Fairchild said she did not telephone 911 for assistance for Resident A because Resident A told her she was not hurt and because she was following Resident A's written *Behavior Treatment Plan*. Ms. Fairchild said Resident A had "scrapes on the side of her face," but she did not see any further injuries, though Resident A refused to let Ms. Fairchild physically examine her. Ms. Fairchild said Resident A remained on the floor throughout her entire shift and she was concerned so she sent a text message to Ms. Showers and Ms. Schroll and neither manager responded to her. Ms. Fairchild said Resident A refused all meals and anything to drink while she was on the bathroom floor but took

her scheduled medication. Ms. Fairchild said Resident A urinated on herself and on the floor and Ms. Fairchild "cleaned around" Resident A and "tried to wipe her up" but could not due to the written *Behavior Treatment Plan*.

On December 8, 2021, I spoke to Nick Christensen who is a consultant for Sparks Behavioral Services and the developer of Resident A's written *Behavior Treatment Plan.* Mr. Christensen said Resident A's written plan addresses "purposeful falls," as Resident A has a history of "throwing herself to the floor." Mr. Christensen said if Resident A drops to the floor staff members are to "neutrally" approach Resident A and verbally prompt her to stand up. Mr. Christensen stated if Resident A "is trying to get up," staff members should physically assist Resident A as needed, being mindful of Resident A's attention seeking behavior. Mr. Christensen said if staff members verbally prompt Resident A and she does not at least attempt to get up, staff members are to walk away and return one minute later and repeat the process. Mr. Christensen stated staff members have been instructed that they should not "use" the *Behavior Treatment Plan* if they "sense [Resident A] is at risk of harm." Mr. Christensen said he was at the facility on October 13, 2021 and observed Resident A on the bathroom floor. Mr. Christensen said he modeled for staff members the proper steps and monitored them as they prompted Resident A to get up and offered feedback. Mr. Christensen said he was at the facility from approximately 12:00 pm until 1:30 pm on October 13, 2021 and understood that Resident A had been on the floor for 30 – 45 minutes prior to his arrival. Mr. Christensen said when he left, he advised Ms. Bristow to telephone him "in a few hours" if Resident A was not off the floor and nobody ever called until the following day. Mr. Christensen said on October 14, 2021, when he was notified, he advised the staff member that "26 hours on the floor is way beyond the point of a safety concern," and the Office of Recipient Rights should be notified. Mr. Christensen denied that there were specific time frames documented in Resident A's written *Behavior Treatment Plan* concerning how long she should be left on the floor before seeking medical attention on October 13, 2021 but stated such parameters have been added since.

On December 16, 2021, I spoke to Office of Recipient Rights officer Kent Rehman who stated his investigation revealed that four staff members at the facility violated Resident A's right to receive mental health services suited to her condition when they neglected to offer nor acquire assistance for Resident A to get up from the facility bathroom floor for approximately 28 hours. Mr. Rehman said he received a telephone call from Shelby Bristow who informed him that Resident A had been on the bathroom floor for approximately 23 hours and he advised Ms. Bristow to telephone 911 for assistance for Resident A.

On December 17, 2021, I spoke to Guardian A1 who is Resident A's public guardian. Guardian A1 confirmed that Resident A had a *Behavior Treatment Plan* with instructions for staff members to follow when Resident A purposefully falls to the floor. Guardian A1 said on October 14, 2021, she was notified via email that Resident A was hospitalized after being on the floor in the bathroom at the facility "by choice," for at least 26 hours. Guardian A1 said she was never contacted during

the 26–hour period that Resident A was on the floor at the facility, or she would have instructed a staff member to contact EMS for assistance and evaluation. Guardian A1 said Ms. Clark told her staff members did not assist Resident A from the bathroom floor per the instructions in her written *Behavior Treatment Plan*, which she does not believe justified leaving Resident A soaked in urine on the bathroom floor for 26 hours. Guardian A1 said she spoke to Mr. Christensen, and he told her that he spoke to at least one staff member at the facility who was instructed to telephone him “in a few hours,” and that he never received a telephone call notifying him that Resident A was still on the bathroom floor until October 14, 2021. Guardian A1 said the only reason a staff member called for EMS to assist and evaluate Resident A was due to being instructed to do so by recipient rights officer Kent Rehman. Guardian A1 stated she chose to admit Resident A into another facility due to Resident A being left on the bathroom floor for 26 hours.

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:	Based on statements from Ms. Stockford, Ms. Bristow, Ms. Clark, Ms. Schroll, Ms. Showers, Ms. Ridley, Ms. Fairchild, Mr. Christensen, Ms. Dunmire, and Mr. Rehman as well as written documentation at the facility including Resident A's written *Behavior Treatment Plan* and a written *AFC Licensing Division Incident/Accident Report* related to the allegations in this investigation it can be determined that Resident A's safety and protection needs were not met when she laid on the bathroom floor for 26 hours straight from October 13, 2021 until October 14, 2021. My investigation revealed that Resident A had a written *Behavior Treatment Plan* that addressed Resident A's tendency to "drop" to the floor purposefully, which indicated staff members should provide "minimal attention" to Resident A if she dropped to the floor, however, it further stated staff members should "provide assistance as necessary." Staff members Terrica Ridley and Barb Fairchild both indicated that Resident A appeared physically incapable of getting up from the floor during their shifts but nevertheless neither sought treatment nor assistance for Resident A. Resident A was reportedly soiled in urine as she laid on the floor for 26 hours straight and four different staff members as well as the licensee designee and her assistant neglected to attend to Resident A's protection and safety needs. Further, even after being notified that Resident A had been on the bathroom floor for at that time 23 hours licensee designee Renae Clark did not make the decision to seek assistance for Resident A, nor did she go to the facility to evaluate Resident A, rather she asked her assistant Ms. Bristow to go to the facility and assess Resident A. Finally, licensee designee Renae Clark nor any staff member that worked during the 26 hours that Resident A was on the bathroom floor ever made the decision to seek assistance for Resident A until they were directed to do so by Kent Rehman from the Office of Recipient Rights.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was physically abused at the facility.

INVESTIGATION:

On October 22, 2021, I received a complaint via email that stated Resident A was observed with bruises all over body and different stages of healing. The written complaint stated Resident A had bruises between her inner thigh, which is odd, according to the nurse that treated Resident A at the hospital on October 14, 2021.

On October 22, 2021, I spoke with Complainant who verified the allegation in the written complaint and stated there was no further information to provide.

On October 22, 2021, and December 10, 2021, I telephoned assigned APS investigator Jennifer Stockford who returned my telephone call on December 17, 2021. Ms. Stockford stated her investigation revealed that Resident A was observed with bruises at various stages of healing located "all over" her body that could have been caused by Resident A's history of self – harm and "dropping" to the floor. Ms. Stockford said while the facility staff members had the behaviors documented in writing, hospital staff members did not observe the behaviors when Resident A was in the hospital. Ms. Stockford said nevertheless, her investigation did not substantiate that Resident A was physically abused at the facility.

On November 8, 2021, I interviewed the assistant to the facility administrator Shelby Bristow who said Resident A has a behavioral history of dropping to the floor purposefully which causes her to have frequent bruising on her arms and legs. Ms. Bristow said Resident A typically engages in the "dropping" to the floor behavior multiple times daily. Ms. Bristow said Resident A engaged in self – injury when she was laying on the floor from October 13, 2021 – October 14, 2021. Ms. Bristow said it was reported to her that Resident A was "banging" her arms and legs into the wall, continually "wedging" herself between the toilet and the bathtub, scratching herself, and "picking at" cuts with scabs. Ms. Bristow stated the only new injuries noted on October 13, 2021 – October 14, 2021 were swelling in Resident A's left wrist and scrapes on her face, which were documented in writing on a written *AFC Licensing Division – Incident/Accident Report* and *Body Pain Indicator Chart* for Resident A. Ms. Bristow denied having any knowledge or reason to believe that any staff member purposefully nor neglectfully injured Resident A. Ms. Bristow denied that she did anything to cause bruising on Resident A. Ms. Bristow said Resident A caused any bruising on her body most likely from "dropping" to the floor multiple times daily and that when she saw Resident A on October 13, 2021 and October 14, 2021 the only new injury she noted was a scratch on Resident A's face, however Resident A refused any staff member to thoroughly assess her for injury.

On November 8, 2021, I interviewed licensee designee Ranae Clark who said Resident A "placed herself on the floor" multiple times daily which caused frequent

bruising on various parts of Resident A's body. Ms. Clark said staff members document all bruising and skin abnormalities in writing for each resident and she was not aware of any new injuries on October 14, 2021. Ms. Clark denied any knowledge of or reason to believe that any staff member harmed Resident A or caused her to have bruising all over her body. Ms. Clark denied seeing any new injuries on Resident A when she observed her on October 13, 2021. Ms. Clark denied that she did anything to cause bruising on Resident A.

On December 10, 2021, I spoke to direct care staff member and facility manager Amber Schroll who said she worked from 8:00 am to 4:00 pm on October 13, 2021, and October 14, 2021. Ms. Schroll said it was common for Resident A to "drop" or "lower herself" to the floor several times daily, which often caused bruising on Resident A's body. Ms. Schroll said staff members document any bruising or skin breakdown on a written *Body Pain Indicator Chart* and a written incident report. Ms. Schroll said she completed both written documents when she observed swelling in Resident A's left wrist on October 13, 2021. Ms. Schroll said from October 13 – 14, 2021 Resident A was on the bathroom floor where she "would start to get up and then drop back down," "wedged" herself between things in the bathroom and engaged in self – injury including scratching herself and "banging" her arms into the bathroom sink and walls. Ms. Schroll said the only new injuries she observed the last time she saw Resident A on October 14, 2021, were scratches on her face, but said Resident A refused to let any staff member physically evaluate her for injury. Ms. Schroll denied any knowledge or reason to believe that any staff member purposefully or neglectfully caused bruising to Resident A. Ms. Schroll denied that she did anything that could have caused bruising to Resident A.

On December 10, 2021, I interviewed direct care staff member and home manager Tiffany Showers who said she worked from 12:00 pm until 8:00 pm on October 13, 2021 and October 14, 2021. Ms. Showers said Resident A had a frequent behavior of "dropping" to the floor which caused her to become bruised at times. Ms. Showers said Resident A was on the floor from October 13, 2021 – October 14, 2021. Ms. Showers stated during that time frame Resident A was repeatedly prompted to get up, and each time staff members prompted Resident A to get up, Resident A attempted to get up and then "would drop back down." Ms. Showers said she did not note any specific injuries to Resident A except for a scratch on her face but also stated Resident A would not allow staff members to physically evaluate her. Ms. Showers said all bruising and other skin breakdown or injuries are documenting in writing and available in Resident A's written resident record. Ms. Showers denied any knowledge or any reason to believe that Resident A was harmed by any staff member at the facility. Ms. Showers denied that she did anything to cause bruising on Resident A's body.

On December 10, 2021, I spoke to direct care staff member Terrica Ridley who stated she worked from 4:00 pm to 11:59 pm on October 13, 2021. Ms. Ridley said it was common for Resident A to drop to the floor for short periods of time repeatedly throughout the day. Ms. Ridley stated at times Resident A sustains bruises from

“dropping” to the floor repeatedly. Ms. Ridley said Resident A was on the floor during her entire shift on October 13, 2021, and that while she was on the floor she continuously got up and then dropped back down. Ms. Ridley said Resident A “wedged” herself between the bathtub and the toilet, and that Resident A was scratching herself, “picking at” scabs, and hitting her arms on the sink and the walls. Ms. Ridley denied that she saw any new or unexplained bruising on Resident A on October 13, 2021, but stated Resident A refused to let Ms. Ridley evaluate her for injury. Ms. Ridley denied any knowledge of or reason to believe that any staff member purposefully or neglectfully injured Resident A. Ms. Ridley denied that she did anything to cause bruising to Resident A.

On December 11, 2021, I spoke to direct care staff member Barb Fairchild who stated she worked from 12:00 am until 8:00 am on October 14, 2021. Ms. Fairchild said it was common for Resident A to drop or lower herself to the floor which could cause bruising to Resident A at times. Ms. Fairchild said Resident A was on the floor during her entire shift on October 14, 2021. Ms. Fairchild stated the only injury she noted to Resident A was scrapes on her face, which she documented in writing in Resident A’s resident record. Ms. Fairchild said she did not see any further injury and Resident A told her she was not hurt. Ms. Fairchild explained that although she did not note any further injury, Resident A refused to be fully physically evaluated. Ms. Fairchild denied any knowledge of or reason to believe that any staff member harmed Resident A and denied that she did anything to cause bruising to Resident A.

On December 8, 2021, I spoke to Nick Christensen who is a consultant for Sparks Behavioral Services and the developer of Resident A’s written *Behavior Treatment Plan.* Mr. Christensen said Resident A’s written plan addresses “purposeful falls,” as Resident A has a history of “throwing herself to the floor.” Mr. Christensen said it is not uncommon for Resident A to sustain minor cuts or bruising during the behavior episodes. Mr. Christensen said staff members reported to him on October 14, 2021, that Resident A had been on the floor for nearly 24 hours straight and that during that time she engaged in self – injurious behavior including “banging” her arms into the walls and sink, scratching herself, and reopening old wounds that had started to heal. Mr. Christensen stated he had no reason to suspect that Resident A was injured due to the purposeful or neglectful act of a staff member at the facility.

On December 17, 2021, I spoke to Guardian A1 who is Resident A’s public guardian. Guardian A1 confirmed that Resident A had a behavior that involved dropping to the floor multiple times daily, which at times did cause minor injuries such as cuts or bruises. Guardian A1 stated a staff member at Oaklawn Hospital told her that Resident A had bruises at various stages of healing all over her body when she was treated there on October 14, 2021. Guardian A1 said while she has no reason to suspect that any staff member physically abused Resident A, causing bruising, staff members neglected to assist Resident A when she was on the floor from October - October 14, 2021, and that neglect could have caused the injuries.

On November 8, 2021, I reviewed Resident A's *Behavior Support Plan Data Tracking Form* for October 2021. According to the written document Resident A "dropped" to the floor 47 times in total from October 1, 2021 – October 12, 2021.

On November 8, 2021, I reviewed all written *AFC Licensing Division – Incident/Accident Reports* for Resident A since she was admitted to the facility in July 2021. The incident reports indicated Resident A "dropped" to the floor and was injured on August 1, 2021, August 2, 2021, August 10, 2021, September 11, 2021, October 1, 2021, and October 3, 2021. A written incident report dated October 6, 2021, noted swelling near Resident A's right eye. A written incident report dated October 13, 2021, noted swelling in Resident A's left wrist. A written incident report dated October 14, 2021, documented two "scrapes" on Resident A's face.

On November 8, 2021, I reviewed all written *Body Pain Indicator Charts* since she was admitted to the facility in July 2021. The written forms documented the following:

- August 2, 2021 – "yellow and purple black eye on left side"
- August 10, 2021 – "bruising on left lower side" and "bruising on lower left side by buttocks"
- October 1, 2021 – bruise near left pelvic area and "dime size scrape" on left elbow
- October 3. 2021 – "scrape near forehead," "lip is busted," "bruising on left hand," "open sore" on left knee, and "bruising" on right "inner thigh"
- October 6, 2021 – "under her left eye looks a little puffy and dark"
- October 14, 2021 – "small scrape on [right] side of cheek," and "large scrape on [right] side of cheek"

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:	Based on statements from Ms. Stockford, Ms. Bristow, Ms. Clark, Ms. Schroll, Ms. Showers, Ms. Ridley, Ms. Fairchild, Mr. Christensen, and Guardian A1 along with written documentation in Resident A's resident record it can be determined that Resident A has a documented history of "dropping" to the floor for which she had a written *Behavior Treatment Plan*. Statements also indicated Resident A engaged in self – harm behaviors on October 13 – October 14, 2021, including banging her arms and legs on the wall, wedging herself between the toilet and the bathtub, scratching herself, and reopening wounds that had started to heal. Verbal statements also indicated on October 13, 2021 – October 14, 2021, Resident A got up and dropped to the floor repeatedly. The written documentation at the facility documented a pattern on Resident A being bruised and injured from falling to the floor purposefully. Multiple staff members denied seeing any new or unexplained injuries on Resident A on October 13 – 14, 2021 and no staff member confirmed any knowledge of Resident A being purposefully harmed at the facility. While it can be concluded that Resident A was observed with bruises in multiple stages of healing, there is lack of evidence to prove that the bruising was caused by Resident A being physically abused at the facility by any staff member.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

12/21/21

Leslie Herrguth Date
Licensing Consultant

Approved By:

12/22/2021

Dawn N. Timm Date
Area Manager