GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 7, 2022

Mark Walker
Premier Operating Goodrich AL, LLC
8111 S State Road
Goodrich, MI 48438

RE: License #:	AL250382795
Investigation #:	2022A0123009
	The Pines of Goodrich

Dear Mr. Walker:

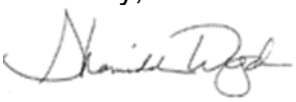
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (906) 226-4171.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250382795
Investigation #:	2022A0123009
Complaint Receipt Date:	11/18/2021
Investigation Initiation Date:	11/19/2021
Report Due Date:	01/17/2022
Licensee Name:	Premier Operating Goodrich AL, LLC
Licensee Address:	299 Park Ave - 6 Fl New York, NY 10171
Licensee Telephone #:	(419) 429-9984
Administrator:	Mark Walker
Licensee Designee:	Mark Walker
Name of Facility:	The Pines of Goodrich
Facility Address:	8111 S State Road Goodrich, MI 48438
Facility Telephone #:	(810) 636-7070
Original Issuance Date:	02/10/2017
License Status:	REGULAR
Effective Date:	08/10/2021
Expiration Date:	08/09/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility is not notifying relatives of COVID-19 quarantines.	No
Resident A's bedroom was observed on 11/17/2021 to smell strongly of urine and feces, and he had defecated on his mattress. Staff were not providing prompt and proper care to Resident A. On an unknown date, Resident B was found on the ground outside just off the back porch.	No
The facility is short staffed.	Yes
There are cigarette butts all over the back lawn along with trash.	No

III. METHODOLOGY

11/18/2021	Special Investigation Intake 2022A0123009
11/19/2021	Special Investigation Initiated - Telephone I spoke with Ruby Mogensen via phone.
11/19/2021	Contact - Telephone call made I made a call to the facility. I spoke with administrator Ruby Mogensen via phone.
11/24/2021	Inspection Completed On-site I conducted Facetime interviews with the facility.
11/24/2021	Contact - Document Received Requested documentation received via email from Ms. Mogensen.
12/10/2021	APS Referral An APS referral was completed.
12/10/2021	Contact- Document Sent I sent a letter to the Genesee County Sheriff's department requesting information.
12/13/2021	Contact- Document Received I received an email response for the Sheriff's department informing that there is no police report on file.
12/15/2021	Contact - Telephone call made

	I interviewed staff Nicole Brooks via phone.
12/20/2021	Contact- Telephone call made I left a voicemail requesting a return call from Resident A's hospice social worker.
12/20/2021	Contact- Telephone call made I spoke with Resident A's hospice nurse Robert Young via phone.
12/20/2021	Contact- Telephone call made I conducted a follow-up Facetime call with the facility. I made face to face with Resident B virtually.
12/20/2021	Contact- Telephone call made I left a voicemail for Relative 2, requesting a return call.
12/20/2021	Contact- Telephone call made I spoke with staff Emma Brown via phone.
12/21/2021	Contact- Telephone call received I spoke with Relative 2 via phone.
12/22/2021	Contact- Telephone call received I received a voicemail from Resident A's hospice case manager Sarah Dickie.
12/22/2021	Contact- Telephone call made I returned Ms. Dickie's phone call and left a voicemail message.
01/03/2022	Contact- Telephone call made I made an attempted call to Sarah Dickie, Resident A's case manager. There was no answer.
01/03/2022	Contact- Telephone call received I spoke with Sarah Dickie, Resident A's case manager via phone.
01/04/2022	Contact- Telephone call made I spoke with administrator Ruby Mogensen and requested additional documentation.
01/07/2022	Contact- Telephone call made I left a voicemail requesting a return call from licensee designee Mark Walker regarding an exit conference.
01/07/2022	Exit Conference I spoke with licensee designee Mark Walker via phone.

ALLEGATION: The facility is not notifying relatives of COVID-19 quarantines.

INVESTIGATION:
This investigation was completed virtually due to the COVID-19 pandemic.

On 11/19/2021, I made a call to administrator Ruby Mogensen due to the facility having active COVID-19 cases. She was asked if anything has happened at the facility recently. She stated the following:

Ms. Mogensen stated that Relative 1 was upset that the facility was in lock down. Ms. Mogensen stated that the facility tests for COVID-19, and that they notified families regarding positive cases. She stated that Relative 1 showed up one day at the door when the facility had just found out that they had a COVID-19 case in the home.

On 11/24/2021, I conducted the following Facetime interviews with the facility:

I interviewed staff Allisa Dunn via Facetime. She stated that each time the facility has a positive COVID-19 case, families are notified. She stated that Relative 1 showed up on 11/10/2021 right when they were testing and was notified that they had a positive case at that time. She stated that it is not true that Relative 1 was told that they were opening on 11/17/2021, and that when Relative 1 showed up at the door on 11/17/2021, Relative 1 did not attempt to enter the facility through the front door.

I interviewed staff Nicole Berry via Facetime. She stated that she was not present during the day of the incident on 11/17/2021. She stated that she heard Relative 1 was upset. She stated that she notified families of the last Covid-19 cases. She stated that she did not call Relative 1 on that day because Relative 2 showed up the day the found out, and she was informed in person.

I interviewed staff Jennifer O'Neal via Facetime. She stated that families are notified when there are active COVID-19 cases.

On 12/20/2021, I spoke with McLaren hospice nurse Robert Young via phone. He stated that he thinks the facility were quarantining to keep Relative 1 from visiting. He stated that he is unaware if the facility had other active COVID-19 cases.

On 12/20/2021, I interviewed staff Emma Brown via phone. Staff Brown stated that families are notified timely of quarantines. She stated that the facility had a quarantine that kept going because they kept getting positive COVID-19 cases. She stated that it lasted about a month and a half.

On 12/21/2021, I spoke with Resident B's Relative 2 via phone. Relative 2 stated that he is notified of quarantines when they start, but not when they have been lifted.

On 01/03/2022, I spoke with Resident A's case manager from McLaren, Sarah Dickie. Ms. Dickie stated that that she follows COVID-19 protocols when she visited the facility, and she was never denied entry as Resident A was on hospice. She stated that she spoke with the facility regarding the family being able to visit as Resident A was declining. She stated that she believes the facility allowed visits after she made her request.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.**
ANALYSIS:	Administrator Ruby Mogensen, Staff Dunn, Staff Berry, Staff O'Neal, and Relative 2 denied the allegation and stated that families are notified of the facility's quarantines. Ms. Dickie stated that she spoke with the facility regarding family being able to visit with Resident A once he started to decline, and that she believes the facility allowed the visits after she made her request. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident A's bedroom was observed on 11/17/2021 to smell strongly of urine and feces, and he had defecated on his mattress. Resident A had been calling for help from his bathroom. Staff were not providing prompt and proper care to Resident A.**

- **On an unknown date, Resident B was found on the ground outside just off the back porch.**

INVESTIGATION: On 11/19/2021, I made a call to administrator Ruby Mogensen due to the facility having active COVID-19 cases. She was asked if anything has happened at the facility recently. She stated the following:

Staff had to call police around 5:30 pm on 11/17/2021 due to Relative 1. Relative 1 was aware the facility was on lockdown due to active COVID-19 cases. Staff had been assisting Resident A with toileting. Relative 1 showed up at the facility, a staff person answered the door. The staff person told Relative 1 that she could go to the window to visit Resident A and had also provided Relative 1 with a rundown of what has been going on with Resident A. Relative 1 saw Resident A in his wheelchair naked and barged into the facility. Staff tried telling Relative 1 that they were waiting on a response from hospice. Relative 1 was yelling in staff's face. Ms. Mogensen stated that she told staff to contact 911. Resident A was cursing at Relative 1 telling her to "get the hell out" and was screaming while staff was on the phone with Ms. Mogensen. Ms. Mogensen stated that hospice told Relative 1 that Resident A would have these accidents. Ms. Mogensen stated that the cops responded and stayed for about 20 minutes to make sure Relative 1 did not return. She stated that the Genesee County Sherriff's office responded to the call. Ms. Mogensen stated that staff wrote statements regarding the incident on 11/17/2021. She stated that Resident A has colon cancer and becomes constipated.

Ms. Mogensen stated that Resident B fell out of her wheelchair back in the summertime in the dining room. She denied that Resident B fell off the porch outside. Resident B is on hospice.

On 11/24/2021, I conducted the following Facetime interviews with the facility:

Ms. Mogensen stated again that Resident B did not fall outside in the backyard, but in the dining room, and hospice was called regarding the incident.

I interviewed staff Allisa Dunn via Facetime. Staff Dun stated that Relative 1 showed up at the facility about 10 minutes before dinner time. She stated that she explained to Relative 1 that the facility was in lock down due to active COVID-19 cases. She stated that she spoke with Relative 1 about Resident A and his odd behaviors he had that day. Relative 1 provided snacks for Resident A at the door. Staff Dunn stated that Resident A had been laying on his side and digging in his rectum. She stated that she had got Resident A to the bathroom, pulled his sheets off the bed, and told Relative 1 that she would come back to his room with sheets and other supplies. She stated that in a matter of five minutes, Resident A had gotten back into his wheelchair. She stated that she asked staff Emma Brown for assistance with Resident A's bedding. Relative 1 came into the facility and came down the hallway as Staff Brown was getting the linen. She stated that they headed into Resident A's room, and Relative 1 was yelling that Resident A was naked, and that staff were neglecting him. She stated that she tried to explain to

Relative 1 that Resident A had been having small bowel movements all day, after Relative 1 complained about the smell. She stated that she tried to explain that they were waiting for hospice to respond regarding his constipation. She stated that she asked staff Christina Gamble to call Ms. Mogensen. She stated that it was difficult trying to get Relative 1 to understand, and that Relative 1 had Resident A in an agitative state. She stated that Staff Brown was in the bathroom with Resident A and it took about 30 minutes to get Resident A situated. She stated that they tried to explain that Resident A had an accident, and they were changing his sheets. She stated that the clean sheets were still by his bed, and the situation had literally just happened. Staff Dunn stated that she spoke with the police when they arrived. She stated that she understands, but Relative 1 was not listening. She stated that she had to ask Relative 1 multiple times to put on a mask, and that Relative 1 did not seem to care that there were active COVID-19 cases in the building. Staff Dunn stated that she was not wearing gloves and did not hand Resident A any fruit while wearing dirty gloves. She stated that Resident A had an apple sitting on the window bay. She stated that Resident A was in the bathroom yelling for help while Staff Brown was already in the bathroom assisting him. Staff Dunn stated that when hospice arrived, Resident A's situation made more sense. She stated that the hospice worker had her write down what staff needed to do, and hospice also ordered morphine PRN for Resident A for pain. She stated that hospice showed up around an hour after the incident with Relative 1. She stated that Resident A's normal hospice nurse came out the next day and left orders for Miralax, morphine, prune juice, apple juice, and a soap enema.

Regarding Resident B, Staff Dunn stated that she has no knowledge of Resident B falling off the porch, and that no residents have ever fallen in the back yard.

On 11/24/2021, I received requested documentation via email. I received a copy of Staff Dunn's written statement regarding what happened on 11/17/2021. It states the following:

"Family member came to the door wanting to see resident. I explained to her that we wont open up until Friday. I had also mentioned residents odd behavior he had all morning. She handed me 2 oranges, an apple, and a snack size M&M for her dad. I walk to residents room to get him up in his chair because I had laid him in bed about an hour prior. So he could talk to her through the window while she filled the bird feeders. I noticed resident had brief down and laid up on his right side digging fecal out of his behind (odd behavior). So I put resident on the toilet strip him the clothing he had on and pulled the fitted sheet from his bedding. I told resident to pull cord when ready to get up (he is normally a cord puller) I went to get fitted sheet and a chuck for his bed. Laid it on the nurses station to answer a call light after getting dinner started (took 5 minutes top). Employee from next door came over to notify us that a family member was screaming at her to tell her someone to check on her dad as he was naked in wheelchair. I then told my coworker Emma to take the sheets I pulled into residents room and to help him get dressed. Family member came running into building with no mask on demanding me to make her family members bed as I was trying to serve dinner as it was now ten minutes after 5:00 pm. Coworker was already on her way to his

room. He had made it to his bed back in same position he was in when I had gotten him out of bed. I tried to explain she couldn't be in here especially with no mask on as my coworker was taking him back to the bathroom she is screaming telling us how it smells and that she wasn't leaving until her dads bed was made. I explained it smells because resident has been trying to pass a BM all day. I then told employee from next door after she brought over sandwiches for the soup I had on the stove to call Ruby and to get her on the phone. I then told the family we will have to call 911 if you won't leave the building. Family member continues to scream, employee had to close bathroom door because her father was becoming agitated while Emma was trying to get him dressed. Bed was made while family member took pictures…then left."

A written statement regarding the incident on 11/17/2021, authored by staff Christina Gamble states the following:

"I went next door during dinner time to drop off their dinner which was grilled cheese. I seen someone walk by, an asked Allissa who was that? She said who? I said there looks like an older lady, she said it must be [Resident A's] daughter. She asked me to walk with her, so I said okay. When we walked into the resident's room his daughter, was complaining about the bed not being made, how her dad was sitting in a "poopy brief" and how the room smelled bad. Emma was in there with bed sheets and was explaining to [Relative 1] how he had an accident. And they were in the middle of cooking dinner. While in the room she was talking about how they were neglecting her father. I told her to get out many times until I told her I was going to call ruby, she said she was going to call the cop 3 different times. So, I ended up calling ruby, put her on speaker. Ruby was on the phone explaining to her that we have active covid cases still and we have to follow state guidelines, and that she needed to leave the building before she calls the cops on her. She was still in the resident's room, yelling, and telling Emma and I that she was not going to leave until her dad was well taken care of and be(d) was made. Emma kept explaining to her that she needed to leave, her dad had an accident. Finally, ruby told me to call the cops. So, I did. While I was still on the phone with ruby, I did not hear her ask for my name, so instead she takes a photo of me without permission. I asked her why she took a photo of me, her response was "you would not give me your name." I ended up calling the police on her, I explained to 911 dispatch everything. Cops showed up, Allissa went outside to talk to him, I called ruby she ended up having a conversation with the police officer."

I interviewed staff Nicole Berry via Facetime. She stated that she saw and spoke with Relative 1 before everything happened. She stated that she knows Relative 1 was upset that the bedding was not on Resident A's bed. She stated that she does not know details of what occurred. Regarding Resident B, she stated that she has no knowledge of Resident B falling outside. She stated that Resident B fell in the dining room about a month or so ago.

I interviewed staff Jennifer O'Neal via Facetime. She stated that Resident B fell in the dining room about a month ago, and that no one has fallen in the backyard.

On 11/24/2021, I received requested documentation via email. I received an incident report. The incident report dated for 11/17/2021 authored by staff Allisa Dunn states the following:

"Notified family there were not allowed in building until Friday due to active Covid quarantine. Family proceeded to come in thru back door without a mask. Asked to leave multiple times. Family used profanity towards staff demanding more care to resident when doing what we had already been doing during her unauthorized visit." Called ED then called 911."

On 12/10/2021, I sent an email to the Genesee County Sheriff's Department requesting a copy of a police report for this facility regarding the incident on 11/17/2021. On 12/13/2021, I was informed via email that there was no record on file for the incident.

On 12/15/2021, I interviewed staff Nicole Brooks via phone. She stated that she saw and spoke with Relative 2 before everything happened on 11/17/2021. She stated that she knows Relative 1 was upset that Resident A's bedding was not on the bed. She stated that she doesn't know the details of what happened.

On 12/20/2021, I interviewed staff Emma Brown via phone. She stated that on 11/17/2021, Relative 1 came to visit. Staff Brown stated that she and Staff Dunn told Relative 1 that they were in quarantine. Staff opened Resident A's blinds so Relative 1 could do a window visit with Resident A. She stated that they saw that Resident A made a mess, so they stripped the bed and got him to the toilet. She stated that when they went to take the soiled bedding out of the room, they came back to the room, and Resident A had another accident. Resident A had gotten off the toilet and made his way back to bed. He only had a shirt on. Relative 1 came in, after she had just told Resident A she would be back with sheets. She stated that she got distracted with dinner, and not even five minutes later she grabbed the sheets, and Relative 1 came down the hall yelling asking when they will get the sheets on Resident A's bed and clean his room. She stated that Relative 1 was asked three times to leave. Staff Brown stated that she took Resident A to the bathroom to change him, and was in the bathroom with him, with the door shut trying to keep Resident A calm. She stated that all the yelling from Relative 1 got Resident A riled up. She stated that Resident A was yelling "stop it!" and grunting trying to poop while saying "help me" in Spanish. Staff Brown stated that she had put dinner on the counter for Staff Dunn to get it served. She stated that she was going to the laundry room to get the sheets, but Relative 1 got to the laundry room before she did. Staff Brown stated that she had just started working in this facility was just getting to know Resident A. She stated that Relative 1 was yelling that they were not doing their job, that she should not have to change Resident A's sheets, and that she was going to call the police. Staff Brown stated that nothing was wrong with Resident A's room at the time other than his unmade bed. Staff Brown stated that she never saw trash or food on the floor, and that Resident A was good at picking things up. She stated that she had Resident A's bed wiped down and had walked out of Resident A's room about three minutes before Relative 1 walked down the hallway with sheets.

She stated that she was in Resident A's room for about an hour and a half trying to get Resident A to calm down. She stated that Resident A declined after this incident.

Staff Brown denied the allegations regarding Resident B. She stated that she has no knowledge of Resident B falling outside. She stated that staff keep an eye on Resident B, and that Resident B sits on the patio in the summer with staff.

On 12/20/2021, I spoke with McLaren Hospice nurse Robert Young via phone. Mr. Young stated that Resident A's room always smelled like feces and urine. He stated that he had to clean Resident A's room several times as the floor would be covered with trash or food. He stated that Resident A's wheelchair would have fecal stains, and that that he witnessed dirty briefs on the floor. Nurse Young stated that he saw Resident A every day until he passed away, and two to three times per week prior. He stated that Relative 1's concerns regarding Resident A's care were valid, but he was not present during the incident on 11/17/2021. He stated that Resident A would have soiled sheets but not on a regular basis, and that when he witnessed this, he would inform staff. He stated that Resident A was combative (mostly verbal) and difficult, and you couldn't talk Resident A into getting cleaned up.

On 12/20/2021, I conducted a follow-up Facetime call with administrator Ruby Mogensen. I saw Resident B during this call. She appeared clean and appropriately dressed. She was observed in her recliner chair and had been sleeping. She was unable to be interviewed due to lack of verbal skills. Ms. Mogensen stated that Resident A's room would be dirty at times due to Resident A's behaviors of flinging items and throwing food. She stated that there was an issue with Nurse Young, where she had to contact his supervisor. She denied that the nurse cleaned Resident A's room.

On 12/21/2021, I spoke with Resident B's Relative 2 via phone. Relative 2 denied having any concerns regarding Resident B's personal care. Relative 2 stated that Resident B is mobile in her wheelchair, and when she fell, staff responded immediately to her. He stated that the incident happened in the parking lot several months ago. He stated that Resident B is 102 years old and does not have good balance. He stated that she had slipped out of her wheelchair. He stated he thinks the sidewalk may have been higher than the parking lot. Resident B was bruised but had no broken bones. He stated that he has never seen staff have an improper attitude, and that staff are friendly especially toward Resident B.

On 01/03/2022, I spoke with Resident A's case manager from McLaren, Sarah Dickie. She stated that she did have concerns regarding Resident A's care. She stated that she spoke with Relative 1 a couple of days after the alleged incident on 11/17/2021, and that she is not surprised staff responded to Relative 1 the way that they did. She stated that there were several times Resident A's room smelled of bowel and urine. She stated that she witnessed staff not being very engaged with the residents. She stated that during a visit in November 2021, she observed Resident A to have feces that was up his back, and he was naked under his blanket. She stated that she informed staff of this and then left the facility. She stated that she cannot confirm whether staff cleaned him

up. She stated that it was not like this every time, but she witnessed similar situations more than once. She stated that she had observed Resident A's room to be trashed several times, and sometimes it would be tidy.

On 01/04/2022, I received a copy of an incident report dated for 11/25/2021 regarding Resident A. The incident report states staff Allisa Dunn was doing rounds and walked into Resident A's room to find him unresponsive. Hospice, family, and management were notified. A face to face was not conducted with Resident A due to him passing away during the course of this investigation.

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:	Regarding the incident that occurred on 11/17/2021, Staff Dunn and Staff Brown were interviewed and reported that they were in the middle of assisting Resident A with toileting and changing his bedding when Relative 1 came into the facility causing a disruption. Staff Dunn reported that Relative 1's behavior resulted in staff contacting 911. Staff Brown reported that they got Resident A cleaned up and his bedding changed. She stated that she spent about an hour and a half with Resident A after the incident to calm him down. An attempt was made to obtain a police report from the Genesee County Sheriff's department regarding the incident that occurred on 11/17/2021. There was no record on file. Staff Mogensen, Staff Dunn, Staff Berry, Staff O'Neil, and Staff Brown denied the allegations regarding Resident B. Nurse Robert Young and case manager Sarah Dickie reported concerns regarding Resident A's care, but neither were present in the facility during the incident on 11/17/2021. Relative 2 denied having any personal care concerns regarding Resident B. Relative 2 stated that staff responds immediately to issues and notified him timely. I observed Resident B via Facetime on 12/20/2021. She was clean and appropriately dressed. No issues were noted. Resident A was not interviewed due to passing away on hospice on

	11/25/2021. There is no preponderance of evidence to substantiate a rule violation in regarding to staff not treating residents with dignity and attending to their personal needs. Staff interviews and written statements appear to be consistent regarding the incident on 11/17/2021 which states that they were in the middle of assisting Resident A at the time of the incident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility is short staffed.

INVESTIGATION: On 11/24/2021, I conducted the following Facetime interviews with the facility:

I spoke the administrator, Ruby Mogensen. Ms. Mogensen denied that the facility is severely short staffed, and that some staff work double shifts. She stated that she had to adjust the staff schedule for two weeks due to the active COVID-19 cases.

I interviewed staff Allisa Dunn via Facetime. She stated that during a COVID-19 outbreak, they were a bit short staffed, and staff picked up extra hours. She stated that two staff work per shift, and there have never been less than that.

I interviewed staff Nicole Berry via Facetime. She stated that the facility is within regulation and denied that they are short staffed. She stated that there are two staff that work per shift, and never less than that.

I interviewed staff Jennifer O'Neal via Facetime. She stated that two staff work per shift, no less. She stated that there are about 14 residents in the facility.

On 11/24/2021, I received a copy of the facility's *Resident Register* and Fire drill records from January 2021 through October 2021. At the time of receipt, the Resident Register reflected that there are 14 residents in the home. Fire drill record evacuation times varied between four minutes and 37 seconds and six minutes and 28 seconds. Documentation indicates that there were at least two staff participating for half of the drills conducted (in January, February, April, July, and October), and three staff for the other half of drills conducted (March, May, June, August, and September).

On 12/21/2021, I spoke with Resident B's Relative 2 via phone. He stated that his only concern is rapid turnover. He denied knowing anything about short staffing, only high turnover.

On 01/04/2022, I spoke with administrator Ruby Mogensen via phone. She stated that there is one resident in the facility who is a two-person assist, and one of them is a one-person assist if staff uses a Hoyer lift. She stated that there are four residents who are

independently mobile, and the rest of the residents are a one-person assist. She stated that all the residents have dementia. The facility is staffed minimally with two staff per shift. She stated that the facility has both a cook and a chef, and that the cook has been working at the facility for about two to three months. She stated that on 11/17/2021, the cook was out with COVID-19, so staff had to assist with meals that day.

On 01/04/2022, Ms. Mogensen provided copies of the staff schedules for October 17,2021 through December 4, 2021. Per the staff schedules there was one staff person assigned to work third shifts between 11/1/2021 through 11/13/2021. There appears to be two staff who worked for each day during first and second shifts. I inquired about the schedule, and Ms. Mogensen reported that the highlighted names in the schedule work until 2:00 am and the first shift staff reported for work at 2:00 am. Which would put two staff on shift minimally each shift.

APPLICABLE RULE	
R 400.15206	
	(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:	Administrator Ruby Mogensen, Staff Dunn, Staff O'Neil, and Staff Berry were interviewed and reported that there are two direct care staff who work on each shift. Relative 2 stated that his concern is rapid staff turnover. On 01/04/2022, Ms. Mogensen reported that there are two residents in the facility who require a two-person assist, one of the residents can be a one-person assist with a Hoyer lift, there are four residents who are independently mobile, the rest of the residents are a one-person assist, and all the residents have dementia. She reported that on 11/17/2022, they were short staffed, due to the cook being out sick, therefore direct care staff had to assist with meals. I reviewed a copy of the staff schedules between October 17, 2021, and December 4, 2021. According to the staff schedules, there are two staff assigned to work each shift. Two staff would not be sufficient to provide the care and supervision of the current residents. There is a preponderance of evidence to substantiate insufficient staffing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There are cigarette butts all over the back lawn along with trash.

INVESTIGATION: On 11/24/2021, I conducted the following Facetime interviews with the facility:

I spoke with Ms. Mogensen. She stated that the back yard is fine, and there are no cigarette butts littered in the yard. She stated that there is a spot for smoking by the shed. She showed me the backyard via Facetime. The back porch of the home appeared to be fenced all around. The sidewalk leading from the back porch to the side of the facility where the parking area is, has a sloped yard situated to the left of the sidewalk that appeared hilly. There was no trash observed in the backyard, nor cigarette butts.

I interviewed staff Allisa Dunn via Facetime. She denied that cigarette butts and trash are littered in the backyard.

I interviewed staff Nicole Berry via Facetime. She stated that other than raccoons taking garbage from the dumpster, there is no garbage litter in the yard.

I interviewed staff Jennifer O'Neal via Facetime. She denied that trash and cigarette butts are littered in the backyard. She stated that raccoons do get into the dumpster, but the dumpster is fenced in.

I spoke with Ms. Mogensen again via Facetime. She stated that there are liners in the garbage cans, and every shift the garbage is taken out. If not, staff receive a write up. She stated that there have been no recent write ups.

On 12/15/2021, I interviewed staff Nicole Brooks via phone. Staff Brooks denied that there is litter or trash in the yard. She stated that that the facility has guys who take care of the yard.

On 12/20/2021, I interviewed staff Emma Brown via phone. Staff Brown denied that there are cigarette butts or trash in the back yard.

On 12/20/2021, I spoke with McLaren Hospice nurse Robert Young via phone. He denied seeing cigarette butts or trash outside of the facility.

On 12/21/2021, I spoke with Resident B's Relative 2 via phone. He denied seeing any litter around the building.

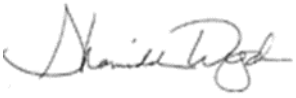
On 01/03/2022, I spoke with Resident A's case manager from McLaren, Sarah Dickie. She stated that staff smoke at the entrance doors, but she did not take mental note of any trash outside the facility or what staff do with the cigarette butts.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.
ANALYSIS:	On 11/24/2021, I observed the backyard via Facetime. There was no trash or cigarette butts observed in the yard. Relative 2, Staff Brown, Staff Mogensen, Staff O'Neal, Staff Brooks, Staff Berry, and Staff Dunn denied the allegations. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 01/07/2022, I conducted an exit conference with licensee designee Mark Walker via phone. I informed him of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of this AFC large group home (capacity 20).



01/07/2022

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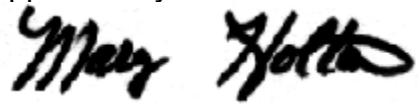
Shamidah Wyden Date
Licensing Consultant

Approved By:



01/07/2022

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Mary E Holton Date
Area Manager