STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 18, 2022

Theresa & John Posey
7550 E. Allen Rd.
Fenton, MI 48430

RE: License #: AS470312590
Investigation #: 2022A0783009
Green Acres

Dear Theresa & John Posey:

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 #:	AS470312590
Investigation #:	2022A0783009
Complaint Receipt Date:	11/09/2021
Investigation Initiation Date:	11/09/2021
Report Due Date:	01/08/2022
Licensee Name:	Theresa & John Posey
Licensee Address:	7550 E. Allen Road Fenton, MI 48430
Licensee Telephone #:	(810) 210-8167
Administrator:	Nancy Posey
Name of Facility:	Green Acres
Facility Address:	5385 Green Road Fenton, MI 48430
Facility Telephone #:	(810) 459-6232
Original Issuance Date:	03/13/2012
License Status:	REGULAR
Effective Date:	09/13/2020
Expiration Date:	09/12/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility and was found deceased on a nearby property the following day.	No
The facility was over capacity when Resident A was temporarily placed there November 6, 2021 – November 8, 2021.	No
Staff members were not trained on Resident A's behaviors, needs, and supervision requirements.	No
Resident A's medication was not administered when she was temporarily placed at the facility on November 6, 2021 – November 8, 2021.	No
Additional Findings	Yes

III. METHODOLOGY

11/09/2021	Special Investigation Intake – 2022A0783009
11/09/2021	Special Investigation Initiated – Telephone call with Complainant
11/09/2021	Contact - Document Received – *AFC Licensing Division Incident/Accident Report* for Resident A.
11/10/2021	Contact - Telephone call made to direct care staff member Jenna Ray
11/10/2021	Contact - Face to Face interviews with licensee Theresa Posey and direct care staff member Faith Martin
11/10/2021	Inspection Completed On-site
11/10/2021	Contact - Document Received – Resident Register
11/17/2021	Contact - Telephone call made to Green Acres administrator Nancy Posey
11/17/2021	Contact - Document Received – Resident A's Green Acres resident record

12/17/2021	Contact – Document Sent – Freedom of Information Act request to the Livingston County Sheriff's Department
01/06/2022	Contact - Document Received – *Reporting Officer Narrative, Case Supplemental Report, Death Report* from the Livingston County Sheriff's Department
01/06/2022	Contact - Telephone call made to Relative A1
01/07/2022	Contact - Telephone call made to direct care staff member Sueanne Talmadge
01/07/2022	Exit Conference with Nancy Posey as Theresa Posey was unavailable

ALLEGATION:

Resident A eloped from the facility and was found deceased on a nearby property the following day.

INVESTIGATION:

On November 9, 2021, I received a complaint via email that Resident A eloped from the facility at about 2:45pm on November 8, 2021. The complaint stated Resident A did not live at Green Acres rather she was there during day as the facility where she resides, Fenton Assisted Living was having the floors redone. The complaint stated facility administrator Nancy Posey reported that on November 8, 2021 at 2:45 pm Resident A was at the dining room table while direct care staff member Jenna Ray went to the bathroom and when she returned Resident A was gone. The complaint stated Ms. Ray searched the facility and the street and called Theresa and John Posey (licensees) to look for her also. The complaint stated Ms. N. Posey called the police and Relative A1 and she also came to look for Resident A. The complaint stated Ms. N. Posey reported that the police helicopters were out until 3:00 am looking for Resident A, but she was not located. The complaint stated Ms. N. Posey said that there is a search party starting on November 9, 2021 to continue to search for Resident A. The complaint stated Resident A weights about 90 pounds and police are not able to locate Resident A through thermal/infrared techniques. The written complaint stated the concern is regarding Resident A's elopement and if Resident A was properly supervised.

On November 9, 2021, I reviewed a written *AFC Licensing Division – Incident/Accident Report* for Resident A dated November 9, 2021. The written report stated, "Resident [A] eloped from facility 11/8/21 at 3:00 pm. Resident [A] found deceased 11/9/21 at 11:30." In the "action taken by staff" section of the written report it stated, "Resident [A] last seen at 3:00pm. 3:05 pm staff searched house and yard.

Went to road looked – called out. Alerted mgmt. Search party (5 people) looking." In the "corrective measures taken" section of the written report it stated, "Electronic location device advised to families upon admission. Tracking chip ordered information."

On January 6, 2022, I received a written *Reporting Officer Narrative* from the Livingston County Sheriff's Department dated November 8, 2021. The written report, Completed by Deputy Boyer indicated Resident A was reported missing from Green Acres at approximately 3:46 pm on November 8, 2021. The written report stated, "I was sent to [the facility] for a report of a resident walking away from an assisted living facility. Caller stated the subject suffers from advanced dementia and has a history of walking away from the facility. Nancy [Posey] stated she was not on site at the facility but one of her employees contacted her and informed her that one of the residents walked away. While tending to another resident at their at – risk residence [Resident A] walked away from the home. Posey advised that she immediately organized employees to go out and search and attempt to locate [Resident A]. Upon arrival I made contact with the caregiver Jenna Ray. Ray stated [Resident A] was visiting from another facility due to renovations being made at that facility. Ray was assisting another worker who was on scene and doing work in the garage and due to [Resident A's] history of walking off; she brought her outside with her. Upon completion of the work she took [Resident A] back into the home and sat her down at the dining room table with a snack while she went to check on another resident. She finished up with the other resident and returned to the dining room and [Resident A] was no longer in the dining room. Ray checked the entire residence inside and out and when she was unable to locate [Resident A], she contacted her supervisor, Nancy Posey." The written report went on to state, "I immediately searched all areas of the home including areas not normally accessible to residents and determined that [Resident A] was not inside the home. With the assistance of Sgt. Schmidt and Deputy Clayton, the area and roads near the residence were also checked with negative results. A short time later Deputy Topolski responded to the scene and attempted a K9 track with no success. A drone was deployed in the area with no success. Overnight, a Michigan State Police K9 team and Aviation unit responded to the scene and assisted in the search for [Resident A]. K9 units conducted grim searches of the area while the aviation unit conducted an aerial search of the area using thermal imagine cameras. Both searches were unsuccessful." The report stated on Tuesday November 9, 2021 "a small group of volunteers organized and began searching," and that the Deputy was advised the volunteers located Resident A and she was deceased. The report indicated the case was "closed" and the detective bureau assumed the investigation.

On January 6, 2022, I received a written *Case Supplemental Report* from the Livingston County Sheriff's office which was completed by Investigator J. Fairbanks. The written report stated, "I was directed to the location where [Resident A] was laying approximately 150 yards northwest of the [facility.] Directly north of the residence was a manicured roadway/atv trail that led from Green Road west to the location where the body was found. The terrain was muddy and under water in some

places.” The written report indicated the investigator searched the area and found clothing and shoes believed to belong to Resident A. The report stated, “a search of the body did not show any signs of trauma to [Resident A].” The report included written information regarding the investigator’s interviews with facility administrator Nancy Posey and direct care staff member Jenna Ray, who was working when Resident A eloped from the facility. According to the written report Ms. Posey said that Resident A temporarily moved into the facility on November 6, 2021 because the flooring in Resident A’s bedroom at the separately licensed facility where Resident A resided needed to be replaced. The written report indicated Ms. Posey reported that prior to November 2020 Resident A was “a flight risk,” but that Resident A fell in late 2020 and broke her hip and has not attempted to leave the facility since. The report stated Ms. Posey said the facility is equipped with door alarms except for the door leading to an elevated deck with a railing and no stairs. The report indicated Resident A had been outside and then sat at the dining room table with a snack while staff member Jenna Ray went to the restroom and when she returned, Resident A was gone. The report indicated that Ms. N. Posey received a telephone call from Ms. Ray and then notified police and organized people to look for Resident A. The report indicated Ms. Posey thought Resident A walked out the front door while Ms. Ray was in the bathroom and Ms. Ray did not hear the door alarm. According to the written report Ms. Ray told the investigator that though Resident A had just moved into the facility temporarily while the flooring in the separately licensed facility where Resident A lived, she has worked for the licensee for more than two years and was familiar with Resident A. Ms. Ray reported she did not think of Resident A as “a flight risk.” Ms. Ray reported that she left Resident A at the dining room table at approximately 3:00 pm to go to the bathroom and when she returned approximately five minutes later, Resident A was gone. The report indicated Ms. Ray estimated she spent approximately 20 minutes looking for Resident A before police were telephoned. The report stated the case status was “closed, awaiting autopsy results. Criminal charges are not being pursued due to lack of evidence.”

On January 6, 2021, I received a written *Death Report* from the Livingston County Sheriff’s Office for Resident A dated November 9, 2021. The written report stated Resident A’s estimated time of death was November 9, 2021 at 11:44 am. The report status was “closed.”

On November 17, 2021, I spoke to facility administrator Nancy Posey who said Resident A had a “spitting disorder” which damaged the flooring in Resident A’s bedroom at Fenton Assisted Living and the flooring needed to be replaced. Ms. N. Posey said she spoke to Relative A1 and explained that Resident A would be temporarily relocated to Green Acres (a separately licensed facility with the same licensee) while the flooring in Resident A’s bedroom at Fenton Assisted Living was replaced and Relative A1 agreed. Ms. N. Posey said Resident A temporarily relocated to Green Acres on November 6, 2021 and the plan was for Resident A to stay the weekend. Ms. N. Posey said she sent a text message to Relative A1 regarding the temporary move, but nothing further was provided. Ms. N. Posey said

on Monday November 8, 2021, Resident A was “enjoying” her time at Green Acres and the flooring in her bedroom at Fenton Assisted Living was not completed so Resident A stayed at Green Acres. Ms. N. Posey said staff member Jenna Ray was “working 1:1” with Resident A to redirect her from spitting and Resident A responded positively. Ms. N. Posey said Resident A was first admitted into one of the licensee’s separately licensed facilities in 2015 after Resident A had “wandered away” from home, was hospitalized and was being placed from the hospital. Ms. N. Posey said Resident A attempted to elope from that facility several times after admission, but never made it off the facility property before being redirected by a staff member. Ms. N. Posey said Resident A has not attempted to elope in more than a year. Ms. N. Posey said in September 2020 Resident A fell and broke her hip and has had limited mobility since, which rendered her incapable of elopement. Ms. N. Posey said since being admitted to Fenton Assisted Living in September 2020 Resident A has not attempted to elope from the facility. Ms. N. Posey said on Monday November 8, 2021 at approximately 3:00 pm she received a telephone call from direct care staff member Jenna Ray who told her she “could not find” Resident A. Ms. N. Posey said Ms. Ray told her she looked throughout the facility and the yard and could not locate Resident A so Ms. N. Posey telephoned police to alert them that Resident A could not be located at the facility. Ms. N. Posey said Ms. Ray told her that Resident A eloped while Ms. Ray was using the facility restroom for five minutes and Ms. Ray notified Ms. N. Posey immediately, who notified police.

On November 10, 2021, I spoke to direct care staff member Jenna Ray who stated she was working alone at Green Acres at 3:00 pm on November 8, 2021 when Resident A eloped from the facility. Ms. Ray said Resident A came to the facility temporarily on November 6, 2021 because the flooring in her bedroom was being replaced at one of the licensee’s separately licensed facilities where Resident A lived. Ms. Ray said she has worked for the licensee for approximately two and a half years, has worked at the other facility, and was familiar with Resident A. Ms. Ray said Resident A “hasn’t been a flight risk in at least two years,” and stated Resident A had limited mobility and required stand – by assistance from a staff member for ambulation. Ms. Ray said on November 6, 2021 Resident A came to the facility and spent the night and returned to the facility where she lived the following morning. Ms. Ray said Resident A returned to Green Acres during the evening on November 7, 2021 and spent a second night. Ms. Ray said during the day on Sunday November 7, 2021 Relative A1 came to the facility and took Resident A on a brief outing and then brought her back to the facility. Ms. Ray said she was scheduled to work a 24-hour shift from November 7, 2021 – November 8, 2021 and she was still working on November 8, 2021 at approximately 2:30 pm she and Resident A went outside through the garage door and stayed outside for approximately 20 – 25 minutes and then retuned inside. Ms. Ray said while they were outside and during her time at the facility in the days prior Resident A showed no indication she was going to elope from the facility. Ms. Ray said at approximately 3:00 pm she directed Resident A to sit at the dining room table where she gave her a snack and then went to use the bathroom. Ms. Ray said when she returned to the dining room approximately five minutes later Resident A was gone. Ms. Ray said another resident told her Resident

A went down the hallway and she searched the entire inside of the facility but could not locate Resident A. Ms. Ray said she went outside and looked for Resident A for approximately 15 minutes, could not locate her and returned inside and telephoned facility administrator Nancy Posey to inform her that Resident A could not be located. Ms. Ray said Ms. Posey telephoned police and the licensees as well as other employees to come search for Resident A. Ms. Ray said she left the facility the following morning at 9:00 am and Resident A had not been located. Ms. Ray said the facility exterior doors are equipped with alarms and she did not hear any alarm while she was in the bathroom.

On November 10, 2021, I interviewed licensee Theresa Posey who stated Resident A lived at Fenton Assisted Living where she had “a spitting behavior” that caused damage to the flooring in her bedroom and it needed to be replaced so Resident A went to Green Acres for respite care during the night until the flooring project was completed. Ms. T. Posey said Resident A was to stay at Green Acres the evenings of November 6 and 7, 2021 but the flooring project was still not completed by November 8, 2021 so Resident A remained at Green Acres that afternoon when she eloped. Ms. T. Posey said Resident A had “never” attempted to elope prior to November 8, 2021 and that Resident A “could barely walk” and she required assistance from a staff member to ambulate. Ms. T. Posey said at approximately 3:00 pm on November 8, 2021 direct care staff member Jenna Ray telephoned Green Acres facility administrator Nancy Posey and reported that she could not locate Resident A inside the facility, nor outside on the property. Ms. T. Posey said police were immediately notified and a group of approximately 30 people organized and began looking for Resident A. Ms. T. Posey said police officers used canine units, thermal imagining, and helicopters but ultimately Resident A was found deceased on a neighboring property the following morning.

On November 10, 2021, I spoke to direct care staff member Faith Martin who said she was working when Resident A arrived at the facility during the evening of November 6, 2021. Ms. Martin said Resident A was calm and cooperative and did not show any indication she would elope from the facility while she worked with her until 7:00 am on Sunday November 7, 2021. Ms. Martin said direct care staff member Jenna Ray relieved her at 7:00 am on Sunday November 7, 2021. Ms. Martin said she is familiar with Ms. Ray and had no concerns regarding Ms. Ray’s ability to supervise residents.

On January 7, 2022, I spoke to direct care staff member Sueanne Talmadge who said she worked at the facility on Saturday November 6, 2021 and observed Resident A. Ms. Talmadge said she has worked for the licensee since 2012 and was familiar with Resident A who moved into one of the licensee’s facilities in 2015. Ms. Talmadge said when Resident A lived at the other facility shorty after admission Resident A “talked about going home,” and regularly went to the facility exterior door and opened the door. Ms. Talmadge said Resident A has not displayed any exit seeking or wandering behavior in at least two years. Ms. Talmadge said on Saturday November 6, 2021 she observed that Resident A appeared “content,” and was in the

common area conversing with other residents and watching TV. Ms. Talmadge described Resident A as “happy and smiling,” and denied that Resident A displayed any of her previous exit seeking behavior. Ms. Talmadge said she is familiar with direct care staff member Jenna Ray and observed her supervising and interacting appropriately with Residents on November 6, 2021.

On January 6, 2022, I spoke to Relative A1 who said Resident A has been placed in several of the licensee’s separately licensed facilities since she was first admitted in 2015. Relative A1 said Resident A had not displayed any exit seeking or wandering behavior that he was aware of in approximately two years. Relative A1 said in September 2020 Resident A fell and broke her hip and has had limited mobility since that time which in part is why the exit seeking behavior decreased. Relative A1 said he visited with Resident A at Green Acres and took her for an outing on November 7, 2021. Relative A1 said Resident A appeared “in good spirits,” and the two of them went to a restaurant for lunch. Relative A1 said he noted that Resident A was having difficulty with mobility and needed assistance to walk. Relative A1 said he noted that the front door to the facility as well as the garage door were open when he came to the facility on November 7, 2021. Relative A1 said on November 8, 2021 he received a telephone call from facility administrator Nancy Posey who told him Resident A was “missing.” Relative A1 said he inquired about how long Resident A had been missing how it happened and was told that she had been gone for approximately 30-35 minutes and police had been contacted. Relative A1 said he was given multiple “stories” about how Resident A eloped and was never clear about what happened and how. Relative A1 said he assumed Resident A could not have wandered far from the facility due to her limited mobility. Relative A1 said police searched for Resident A with infrared lights and helicopters but could not locate Resident A. Relative A1 said he was out of the state at the time and Theresa Posey regularly called him with updates during the search. Relative A1 said he was notified by Ms. T. Posey on Tuesday, November 9, 2021 that Resident A was found deceased on a nearby property. Relative A1 said an autopsy was performed and the results have not been determined as of the date of the interview. Relative A1 said he believes Resident A’s cause of death was exposure to the outdoor elements.

On November 17, 2021, I received Resident A’s resident record from Green Acres where Resident A was placed on November 6, 2021. The record contained a written *Resident Assessment Plan* signed by Nancy Posey and not dated. The written assessment plan did not indicate that Resident A had exit seeking or wandering behavior. The written plan specifically addressed the following:

- Ambulation – Resident A was indicated to require stand-by assistance with ambulation
- Weight bearing – Resident A was indicated to bear weight
- Position – Resident A was indicated to self – position
- Mental status – Resident A was indicated to be “confused” and had a “poor memory.”
- Emotional – Resident A was indicated to be “friendly,” and “expresses according to situation”

- Bladder – Resident A was indicated to require assistance in the bathroom
- Bowels – Resident A was indicated to have “regular” bowels
- Adult incontinence briefs – Resident A was indicated to use them
- Eating habits – Resident A was indicated to have a “spitting” behavior where she spit food
- Vision - Resident A was indicated to have “good” vision
- Sleep pattern – Resident A was indicated to “sleep at night”
- Hearing - Resident A was indicated to have “good” hearing
- Oral hygiene – Resident A required assistance
- Grooming - Resident A required assistance
- Hygiene – Resident A was indicated to prefer a shower
- Diet – Resident A required a soft – mechanical diet and “will chew and spit out”
- Allergies – not assessed
- Special Needs – The assessment stated Resident A “spits and will eat it”
- Comments - The assessment stated “watch closely for spitting – que and give spit cup. Soft foods she will lick the spit.”

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on statements from Ms. N. Posey, Ms. Ray, Ms. T. Posey, Ms. Martin, Ms. Talmadge, and Relative A1 along with the written information provided by the Livingston County Sheriff's Department and written documentation maintained at the facility it can be determined that Resident A had not displayed any exit seeking or wandering behavior in approximately two years, since she broke her hip and had limited mobility. Interviews with staff members who interacted with Resident A and written documentation maintained at the facility from November 6, 2021 when Resident A was admitted temporarily until November 8, 2021 when she eloped indicated that Resident A did not display any unusual or alerting behavior prior to eloping from the facility. Ms. Ray consistently reported that Resident A was left unattended for five minutes while she used the restroom, which is not an extensive amount of time. Once Ms. Ray discovered Resident A was not at the dining room table, she took immediate and appropriate steps to attempt to locate Resident A including searching for her and promptly notifying Ms. N. Posey that she could not locate Resident A. The licensee took all appropriate steps after Resident A was discovered missing including notifying Relative A1, the local police authority, and making a reasonable attempt to locate Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was over capacity when Resident A was temporarily placed there November 6, 2021 – November 8, 2021.

INVESTIGATION:

On November 9, 2021, I received a complaint via email that cited concern that the facility was over capacity when Resident A was brought there during the day for respite on November 6, 2021 – November 8, 2021.

On November 10, 2021, I completed a review of Bureau Information Tracking System (BITS) and determined the facility is licensed to care for up to six residents.

On November 10, 2021, I completed an unannounced onsite inspection at the facility and determined there appeared to be five residents in total admitted to the facility at that time. On November 10, 2021 I reviewed the written resident register and noted that there were five residents in total admitted to the facility at that time. Resident B was admitted on June 1, 2017, Resident C was admitted on July 24, 2016, Resident

D was admitted on October 28, 2016, Resident E was admitted to the facility on May 30, 2018 and Resident F was admitted on September 28, 2018.

On November 10, 2021, I spoke to licensee Theresa Posey who said there were five full – time residents admitted to the facility and when Resident A was placed there as a respite placement the facility was at capacity with six residents in total.

On November 17, 2021, I spoke to facility administrator Nancy Posey who said there were five full – time residents admitted to the facility and when Resident A was placed there as a respite placement the facility was at capacity with six residents in total.

On various dates during the course of this investigation I spoke with direct care staff members Jenna Ray, Faith Martin, and Sueanne Talmadge who all confirmed there were five residents in total admitted to the facility prior to November 6, 2021 when Resident A was placed at the facility temporarily making the total count six residents.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.
ANALYSIS:	Based on my observations at the unannounced onsite inspection as well as written documentation at the facility and interviews with Ms. T. Posey, Ms. N. Posey, Ms. Ray, Ms. Martin, and Ms. Talmadge it can be determined that the facility was not over capacity when Resident A was temporarily placed there from November 6, 2021 – November 8, 2021. Rather, the facility had six residents in total which is full capacity when Resident A was placed there.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff members were not trained on Resident A's behaviors, needs, and supervision requirements.

INVESTIGATION:

On November 9, 2021, I received a complaint via email that cited concern regarding staff training on Resident A's behaviors, needs, and supervision requirements.

On November 10, 2021, I completed an unannounced onsite investigation and requested Resident A's resident record which included a written assessment plan that evaluated and documented information about Resident A's behaviors and needs in 18 areas (referenced earlier in this report).

On November 10, 2021, I interviewed licensee Theresa Posey who stated Resident A has lived at several of the licensee's separately licensed facilities and was first admitted in 2015. Ms. T. Posey said facility staff members are trained to work at all the facilities and to care for all residents in each home so that each shift at each facility is sufficiently covered. Ms. T. Posey stated the staff members at Green Acres were already familiar with Resident A and her behaviors, needs, and supervision requirements before she came there for respite care because they had worked with her at other facilities. Ms. T. Posey stated Resident A's needs, behaviors, and supervision requirements were similar to the other residents who live at Green Acres.

On November 17, 2021, I spoke to Green Acres administrator Nancy Posey who said she completed a written Resident Assessment Plan for Resident A that provided detailed information about Resident A's behaviors and needs and discussed the written plan with staff members who would be caring for Resident A during her temporary respite stay at the facility. Ms. Posey said staff members are trained to work at all the homes owned by the licensee and the direct care staff members at Green Acres were familiar with Resident A because they worked with her at Fenton Assisted Living. Ms. N. Posey stated Resident A's needs, behaviors, and supervision requirements were similar to the other residents who live at Green Acres.

On November 10, 2021, I interviewed direct care staff member Faith Martin who said she was trained on how Resident A ate, when/how she slept, when/how she took medication, what her ambulation needs were, what her mental and emotional status were, and what her personal care needs were prior to working with Resident A at Green Acres on November 6, 2021. Ms. Martin said she was comfortable caring for Resident A.

On November 10, 2021, I spoke to direct care staff member Jenna Ray who said she has worked for the licensee for more than a year and has worked at several of the licensed facilities. Ms. Ray said she was familiar with Resident A because she worked at Fenton Assisted Living and cared for Resident A. Ms. Ray said she first cared for Resident A at Green Acres on November 7, 2021 and that prior to caring for Resident A she was provided verbal and written instructions from Ms. N. Posey on how to care for Resident A. Ms. she was trained on how Resident A ate, when/how she slept, when/how she took medication, what her ambulation needs were, what her mental and emotional status were, and what her personal care needs were prior to working with Resident A at Green Acres on November 7, 2021. Ms. Ray said she was already familiar with Resident A's safety and supervision needs

from caring for her at Fenton Assisted Living and was comfortable caring for Resident A.

On January 7, 2022, I spoke to direct care staff member Sueanne Talmadge who said she has worked for the licensee since 2012 and has worked at all the separately licensed facilities. Ms. Talmadge said she was familiar with Resident A because she worked at Fenton Assisted Living and cared for Resident A. Ms. Talmadge said there were written instructions from Ms. N. Posey on how to care for Resident A including how Resident A ate, when/how she slept, when/how she took medication, what her ambulation needs were, what her mental and emotional status were, and what her personal care needs were. Ms. Talmadge said she was already familiar with Resident A's safety and supervision needs from caring for her at Fenton Assisted Living and was comfortable caring for Resident A.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**
ANALYSIS:	Based on statements from Ms. T. Posey, Ms. N. Posey, Ms. Ray, Ms. Martin, and Ms. Talmadge along with the written information at the facility concerning Resident A, staff members were adequately trained and prepared to manage Resident A's personal care, protection, and supervision needs while she temporarily stayed at the facility for respite care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medication was not administered when she was temporarily placed at the facility on November 6, 2021 – November 8, 2021.

INVESTIGATION:

On November 9, 2021, I received a complaint via email that stated concerns for whether or not and how Resident A's medication was administered while she was at Green Acres for respite care November 6 – 8, 2021.

On November 10, 2021, I interviewed licensee Theresa Posey who said Resident A was only prescribed a vitamin and PRN (as needed) medications which were sent with her to Green Acres during her respite stay from November 6, 2021 – November 8, 2021. Ms. T. Posey said Resident A's medication administration records (MAR) were sent to Green Acres so staff members could document staff members' medication administration to Resident A.

On November 17, 2021, I spoke to Green Acres facility administrator Nancy Posey who said Resident A was prescribed a vitamin and PRN medication which was sent with her and administered by staff members at Green Acres when Resident A went there for respite care from November 6 – 8, 2021. Ms. Posey said staff members documented the medication administration on Resident A's written medication administration record.

On November 10, 2021, I completed an unannounced onsite investigation and reviewed Resident A's written MARs for November 2021. I noted that Resident A's only scheduled medication was a vitamin to be taken at 8:00 am daily. I noted that the medication was documented as administered according to the MAR on November 6, 2021 – November 8, 2021.

On November 10, 2021, I interviewed direct care staff member Faith Martin who said she worked at the facility on Saturday November 6, 2021 and noted that Resident A's medication and MAR were at the facility so staff members could administer Resident A's scheduled and/or PRN medication.

On November 10, 2021, I spoke to direct care staff member Jenna Ray who said she worked at the facility on Sunday November 7, 2021 – Monday November 8, 2021 and noted that Resident A's medication and MAR were at the facility so staff members could administer Resident A's scheduled and PRN medication.

On January 7, 2022, I spoke to direct care staff member Sueanne Talmadge who said she worked at the facility on Saturday November 6, 2021 and observed Resident A's medication and MAR at the facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on statements from Ms. T. Posey, Ms. N. Posey, Ms. Martin, Ms. Ray, and Ms. Talmadge as well as Resident A's written medication administration records it can be concluded that Resident A's prescribed scheduled and as – needed (PRN) medication was available at the facility for staff members to administer, which they did according to the written medication administration record.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On November 10, 2021, and January 6, 2022 I spoke to direct care staff member Jenna Ray who said she was working alone on November 8, 2021 when she took Resident A and went outside, leaving the remaining five residents completely without supervision as there was no staff member inside the home with five residents. Ms. Ray said it was "nap time" for Residents B, C, D, E, and F and all of them were asleep when she went outside except for Resident C who was in the dining room. Ms. Ray said Residents E and F were sleeping in the living room and Resident B and Resident D were in their beds sleeping when she went outside with Resident A for up to 25 minutes.

On November 17, 2021, and January 6, 2022 I spoke to facility administrator Nancy Posey who confirmed Jenna Ray worked alone at the facility on November 8, 2021. Ms. Posey stated she thought Ms. Ray took all the residents outside that day.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on two different conversations with Jenna Ray and with Nancy Posey I concluded that Ms. Ray was working alone when she took Resident A outside and left the remaining five residents inside with no staff member to supervise nor assist them on November 8, 2021. There was not sufficient care staff on duty when the only staff member scheduled to work left the residents alone inside the facility while she went outside for an extended period of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On November 10, 2021, I interviewed licensee Theresa Posey who said prior to temporarily moving Resident from Fenton Assisted Living to Green Acres for respite care from November 6 – November 8, 2021 no written approval was obtained from Resident A's designated representative. Ms. T. Posey said facility administrator Nancy Posey had a verbal conversation with Relative A1 concerning the temporary move and he agreed.

On November 17, 2021, I spoke to Green Acres administrator Nancy Posey who said she sent a text message via telephone to Relative A1 to get authorization to temporarily move Resident A from Fenton Assisted Living to Green Acres and Relative A1 agreed. Ms. N. Posey said the text message was the only written approval received.

On January 6, 2022, I spoke to Relative A1 who said he did not provide written nor verbal approval for Resident A to temporarily move from Fenton Assisted Living to Green Acres. Relative A1 said he was in route to Fenton Assisted Living to visit Resident A on November 7, 2021 when he received a telephone call from Nancy Posey explaining that Resident A had been temporarily moved to another facility so the flooring in her bedroom could be replaced. Relative A1 said Ms. N. Posey then sent him a text message with the address to Green Acres and he went there to pick up Resident A. Relative A1 said Ms. N. Posey acknowledged that she should have asked him prior to moving Resident A from one facility to another.

On November 10, 2021, I reviewed Resident A's written resident record at Fenton Assisted Living and at Green Acres and I did not locate a written authorization to relocate Resident A from Relative A1, who is Resident A's authorized representative.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(6) A licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible agency.
ANALYSIS:	Based on interviews with Ms. T. Posey, Ms. N. Posey, and Relative A1 along with a review of Resident A's resident records it can be determined that the licensee changed the residency of Resident A from Fenton Assisted Living to Green Acres and did not obtain written approval from Relative A1.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On various dates I interviewed licensee Theresa Posey, administrator Nancy Posey, and direct care staff members Jenna Ray, Faith Martin, and Sueanne Talmadge who all confirmed Resident A was temporarily placed at the facility from November 6, 2021 – November 8, 2021 when she eloped.

On November 10, 2021, I completed an unannounced onsite inspection at Green Acres and requested Resident A's resident record. On November 17, 2021 I was provided with a copy of Resident A's resident record from Green Acres which contained a one-page written *Resident Assessment Plan* for Resident A that had an attachment that detailed Resident A's psycho-social history. Also included in the record was the *AFC Resident and Identification Information Sheet* for Resident A and her medication administration records. There was no further information in the record at Green Acres for Resident A.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:

	(a) Identifying information, including, at a minimum, all of the following: **(viii) Funeral provisions and preferences.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**
ANALYSIS:	Based on statements from the licensee, administrator, three direct care staff members and my observations at the unannounced onsite inspection, Resident A did not have a complete written resident record with all the documents listed above at Green Acres despite being temporarily placed there on November 6, 2021, for respite care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan and pending the outcome of the autopsy that was completed on Resident A I recommend no change in the status of the license. Should additional information become available through the written autopsy report, an addendum to this report will be completed.

01/07/2022

Leslie Herrguth　　　　　　Date
Licensing Consultant

Approved By:

01/18/2022

Dawn N. Timm　　　　　　Date
Area Manager