GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 10, 2022

Ann Meldrum
Samaritas
8131 East Jefferson Avenue
Detroit, MI 48214-2691

RE: License #: AS610015816
Investigation #: 2022A0357002
Samaritas --Mararebecah Lane

Dear Ms. Meldrum:

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 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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610015816
Investigation #:	2022A0357002
Complaint Receipt Date:	12/09/2021
Investigation Initiation Date:	12/09/2021
Report Due Date:	02/07/2022
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenue Detroit, MI 48214-2691
Licensee Telephone #:	(231) 773-6593
Administrator:	Ann Meldrum
Licensee Designee:	Ann Meldrum, Designee
Name of Facility:	Samaritas --Mararebecah Lane
Facility Address:	2760 Mararebacah Lane Muskegon, MI 49442-1577
Facility Telephone #:	(231) 777-5767
Original Issuance Date:	03/14/1994
License Status:	REGULAR
Effective Date:	08/23/2020
Expiration Date:	08/22/2022
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct Care Staff Tateyana Reynolds hurt Resident A's leg and head on 12/8/21.	No
Staff Tateyana Reynolds left Resident A wet and dirty and did not toilet her on 12/8/21.	Yes
Staff, Tateyana Reynolds did not take Resident A out of her bed on 12/8/21.	Yes
Staff Tateyana Reynolds had used the "F" word in referencing Resident A and other residents.	No

III. METHODOLOGY

12/09/2021	Special Investigation Intake 2022A0357002
12/09/2021	Contact - Telephone call received Received call from Darcey Home Manager regarding the allegations. She reported that she called Recipient Rights at HealthWest and Centralized intake.
12/09/2021	Special Investigation Initiated - Telephone APS referral
12/09/2021	APS Referral
12/09/2021	Contact – Document Received Received a Recipient Rights Complaint Form from Darcy Torrey.
12/11/2021	Contact - Document Received Email from Carne Lynn, APS, she typed her interview with Resident A and Darcy Torrey.
01/10/2022	Contact - Telephone call received From Muskegon County Adult Protective Services, Caren Lynn.
01/10/2022	Contact - Document Received Email from Muskegon County Adult Protective Services, Caren Lynn who wrote she was opening a complaint and would be going out to see the resident, tomorrow.
01/10/2022	Contact - Document Received Received an email from Caren Lynn, APS.
01/11/2022	Contact - Document Received

	Received an email from APS, Caren Lynn asking for updates and asking about Recipient Rights.
01/12/2022	Contact - Document Received Email from APS Caren Lynn. She requested contact information for Lawrence O. Spartaro, Recipient Rights at HealthWest
01/13/2022	Contact - Document Received Email received from Caren Lynn concerning any changes or updates with Resident A.
01/13/2022	Contact - Telephone call made Telephone interview with direct care staff, Tateyana Reynolds.
01/13/2022	Contact - Telephone call made With Darcy Torrey.
01/13/2022	Contact - Telephone call made Telephone interview with direct care staff, Precious Buchanan.
01/14/2022	Contact - Document Received Received and reviewed a copy of Recipient Rights Report by Lawrence O. Spartaro.
01/14/2022	Contact – Document Received From Caren Lynn, APS and a summary of her interview with direct care staff, Tateyana Reynolds.
01/27/2022	Contact -Face-to-Face with the Licensee Designee, Ann Meldrum and Home Supervisor, Darcy Torrey.
01/27/2022	Contact - Document Received Received and reviewed Resident A's, Health Care Appraisal, Treatment Plan, and her assessment plan.
02/10/2021	Conducted a telephone exit conference with LeRoy Goldsworthy, Program Manager.

ALLEGATION: Direct care staff Tateyana Reynolds hurt Resident A's leg and head on 12/8/21

INVESTIGATION: On 12/09/2021 Ms. Darcy Torrey completed a Recipient Rights Complaint and she emailed this document to me. The date on the form for the incident was 12/08/2021. Under the section of time it read: "*Unsure of time." "At 8p (Resident A) had staff call me. She stated that Tateyana Reynolds hurt (Resident A's) leg and head. She also stated that she was left wet and dirty and Tateyana*

would not get her up out of bed. She stated that Tateyana said "F" these residents and she was angry."

On 12/09/2021, Darcy Torrey, the Home Supervisor of Samaritas --Mararebecah Lane, telephoned and reported that direct care staff, Precious Buchanan had telephoned her when she started her second shift on 12/08/2021. Ms. Buchanan reported that the first shift staff, direct care staff, Tateyana Reynolds was the only staff in the home. Ms. Torrey said that Ms. Buchanan told her that she had arrived at the home at 2:30 PM and could hear Resident A wanting something, so she checked on her first. Ms. Torrey reported that Ms. Buchanan said that Resident A was in her bed and wanted to get out of her bed, so Ms. Buchanan got her up and brought her into the living room. Resident A asked Ms. Buchanan to help her telephone, Darcy Torrey. Ms. Buchanan told Ms. Torrey that she was interpreting for Resident A by the use of her wolf board, and she said Ms. Reynolds had hurt her leg and her head. Ms. Torey reported that she went to the home to see Resident A and she did not find any injury to Resident A's leg or to her head.

On 12/11/2021, I received an email from Caren Lynn, Adult Protective Services Worker, with a summary of her interview with Resident A with the help from Ms. Torrey on 12/09/2021. Her interview reported that Resident A is 58 years old, wheelchair dependent, non-verbal and uses a communication board that was created by a speech therapist which has a number of symbols, words, colors, letters, numbers and an array of illustrations. The email further stated that; *(Resident A) communicates by being asked a series of questions and she answers by pointing to the image and that is consistent with what she wants to communicate. Darcy assisted ASW (Ms. Lynn) with the interview, it should be noted that ASW was unable to verify the entire amount of information (Resident A) communicated with the assistance of Darcy. The letter "T" referred to in this contact should be reference to the name Tateyana (staff). Darcy asked (Resident A) what happened to her? She pointed to her head. Darcy asked (Resident A) what happened to her head she pointed to the letter T. Darcy asked (Resident A) did T so something to her head and she pointed to the word yes. She (Darcy) asked if anything happened. (Resident A) pointed to the symbols let and hurt. Darcey asked (Resident A) if her leg was hurt and she pointed to the symbol yes. ASW asked (Resident A) if someone hurt her leg and she pointed to the symbol yes. ASW asked (Resident A) who hurt her and she pointed to the letter T. ASW asked (Resident A) if she was hurt anywhere else and she pointed to yes. ASW asked (Resident A) where else was she hurt and (Resident A) took her hand and mimicked being hit in her actual head and she made that action several times. ASW asked (Resident A) if anyone else had hurt her and she pointed to the symbol no. Darcy advised ASW T has been placed on administrative leave and will not be returning to the facility. It should be noted Darcy had to ask (Resident A) to calm down many times as she was pointing to several symbols while communicating which made it very difficult to follow what she was communicating."*

On 01/13/2022, I conducted a telephone interview with direct care staff, Tateyana Reynolds. She confirmed that she worked 1st shit in the home on 12/08/2021. I asked her if she had hurt Resident A's leg or head. She stated: "*That is news to me I never hurt her leg or her head. She said she never got her out of bed, and she changed her as she was taught to roll her in her bed."* Ms. Reynolds stated that Rasheeda Cheatum followed her and worked the second shift.

On 01/13/2022, I spoke with Ms. Torrey by telephone, and she confirmed that Rasheeda Cheatum did not work the second shift on 12/08/2021, but direct care staff, Precious Buchana has worked the second shift. She stated that Ms. Buchanan was working in the home on second shift and I could call and conduct an interview with her.

On 01/13/2022, I telephoned the Samaritas --Mararebach Lane home and conducted an interview with direct care staff, Precious Buchanan. She confirmed she had worked second shift after Tateyana on 12/08/2021. She stated she knew that Resident A was upset because she was making noises. She said that Resident A wanted to call Ms. Torrey immediately, so she did, and she said heard what Resident A told Ms. Torrey. She stated that Resident A communicates with her with her communication board. She said Resident A told Ms. Torrey that Ms. Reynolds had hurt her let and head. I asked Ms. Buchanan if she had looked at Resident A's leg and head and she said yes and there were no marks on her.

On 01/14/2022, I received an email from Ms. Lynn where she had reported her interview with Tateyana Reynolds. Her report read "*Tateyana Reynolds denied all of the allegations. She knew nothing about the resident saying that she (Tateyana) had hurt her let or her head. She denied hurting the resident on her leg or her head. She reported that the second shift staff came in for second shift, Rasheeda Cheatum."* Ms. Lynn's report stated: "*According to Darcy it was not Rasheed who was on 2nd shift, but it was Precious Buchanan. Darcy stated that Tateynana was put on suspension for a week and then she never came back to work and was a "no show no call." They terminated her.* In this same report Ms. Lynn reported she had interviewed Precious Buchan by telephone. Her report read: "*She acknowledged she had worked second shift after Tateyana. She knew that the reside, and she heard what she told Darcey. She communicates with her with her communication board. It was all the same issues that were in the complaint."*

On 01/14/2022 I received and reviewed a copy of Report of Investigative Findings by Lawrence O. Spataro, Recipient Rights Officer. The report read that Mr. Spataro conducted interviews with Resident A and Darcy Torrey, Home Supervisor on 12/09/2021. His report read: "(Resident A) uses a wolf board to speak and requires assistance with personal care and transferring to her wheelchair. (Resident A) said she did not want Tateyana Reynolds to work with her anymore. She said she was angry with Tateyana Reynolds." Mr. Spataro's report read: "*There was no evidence of injury. (Resident A) did not raise the issue during her interview."*
On 01/27/2022, I went to see Resident A and she was not home.

On 02/10/2022, I conducted a telephone exit conference with the Program Manager, LeRoy Goldsworthy and he agreed with my findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A reported that direct care staff Tateyana Reynolds hurt her leg and head. Darcy Torrey the Home Supervisor inspected Resident A's leg and head and found no injury. Tateyana Reynolds denied that she hurt Resident A's leg or head. There was no evidence of injury to Resident A and therefore no violation was found.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care Staff, Tateyana left Resident A wet and dirty and did not toilet her on 12/8/21.

Investigation: On 12/09/2021 Ms. Darcy Torrey completed a Recipient Rights Complaint, and she emailed this document to me. The date on the form for the incident was 12/08/2021. Under the section of time it read: "*Unsure of time." "At 8p (Resident A) had staff call me. (Resident A) also stated that she was left wet and dirty."*

On 12/09/2021, Darcy Torrey, the Home Supervisor of Samaritas --Mararebecah Lane, telephoned and reported that direct care staff, Precious Buchanan had telephoned her when she started her second shift on 12/08/2021, Ms. Buchanan reported that the first shift staff, direct care staff, Tateyana Reynolds was the only staff in the home. Ms. Torrey said that Ms. Buchanan told her that she had arrived at the home at 2:30 PM and she could hear Resident A wanting something, so she checked on her first. Ms. Torrey reported that Ms. Buchanan said that Resident A

was in her bed, and she wanted to get out of her bed, so Ms. Buchanan got her up and brought her out into the living room. Resident A asked Ms. Buchanan to help her telephone, Darcy Torrey. Ms. Buchanan told Ms. Torrey that she was interpreting for Resident A by the use of her wolf board, and she said Ms. Reynolds had left her wet and dirty.

On 12/11/2021, I received an email from Caren Lynn, Adult Protective Services Worker, with a summary of her interview with Resident A with the help from Ms. Torrey on 12/09/2021. *Darcy asked (Resident A) if she if she got up and (Resident A) pointed to the symbol no. (Resident A) pointed to the symbol wet and dry. Darcy asked (Resident A) if she was wet all day and she pointed to the symbol yes."*

On 01/13/2022, I conducted a telephone interview with direct care staff, Tateyana Reynolds. She confirmed that she worked 1st shit in the home on 12/08/2021. Ms. Reynolds stated that day was very hectic, and she had to unload the groceries, put them away, prepare lunch, and pass medications. I stated asked her if she was aware that Resident A was upset. She said she was not aware of Resident A being upset. I asked her If she had changed Resident A during her shift. She stated she checked her when she arrived then changed her at 8:00 AM, at noon, and before she left at 2:30PM and she was clean and dry. She stated that Resident A wears adult protection. She explained that she changes Resident A in her bed by rolling her the way she was taught. She also stated that she is pregnant and on weight restrictions and in order to get Resident A up she has to use the Hoyer lift. She said it was a typical day. She reported that if Resident A wants something she makes noises or says "Hey" and she said when she hears the noises, she goes to see what she wants or needs. She denied that she left Resident A soiled or wet.

On 01/13/2022, I conducted a telephone interview with direct care staff, Precious Buchanan. She confirmed she worked 2nd shift on 12/08/2021. When I asked how it went when she started her shift, she stated that as soon as she arrived, she said, "the house smelled like BM, just like (Resident A) has just been changed." She said that Resident A has a distinct smell to her bowel movements. She stated that she checked Resident A and she was clean and dry.

On 01/14/2022, I received an email from Ms. Lynn where she had reported her interview with Tateyana Reynolds on 01/13/2022. Her report read "*Tateyana Reynolds denied all of the allegations. She denied leaving the resident soiled or wet. She reported that the resident wears protection (Depends) and she has been taught how to change her in her bed by rolling her. She stated it was a quite hectic that day. She had to put the groceries away, prepare lunch, and pass meds."*

On 01/14/2022, I received and reviewed a copy of Report of Investigative Findings by Lawrence O. Spataro, Recipient Rights Officer. The report read that Mr. Spataro conducted interview with Tateyana Reynolds and "*she said that she could not get (Resident A) out of bed because she was doing the grocery shopping, had to put*

them away, make lunch and administer medications. When asked how often she toilets (Resident A), Tateyana Reynolds said she had never toileted (Resident A). She said she checks her when she arrives at 8:00 am, and noon, and before she leaves at 2:30 pm. Tateyana Reynolds said she changed (Resident A's) brief before leaving on December 8, 2021, and she was clean and dry." Mr. Sparato's investigative findings included the statement that "there is a preponderance of evidence that Tateyana Reynolds is not providing the personal care services by (Resident A's) plan of service."

On 01/27/2022, I received and reviewed Resident A's Treatment Plan, Health Care Appraisal, and her assessment plan. Diagnoses on her Health Care Appraisal read in part: "Dysphagia, Cerebral Palsy, Major depression and anxiety." In her Treatment Plan it stated she has "*severe spastic quadriplegia*." Her assessment plan stated the need for toileting was for staff to transfer her to her toilet chair, requires full assistance with grooming, and with dressing and with personal hygiene. Her special equipment was listed as "wheelchair, hoyer, and showerchair." In Resident A's "Treatment Plan," it read: "*Toileting – wears at all times r/t occasional incontinence; can indicate need to be changed; requires full assistance for toileting needs. Services are provided by the home staff in the home setting. Monitoring of acceptance and progress with personal care services provided by DD team."*

On 01/27/2022, I interviewed Ms. Torrey and she explained that they are "short staffed" and therefore she works on shift and provides direct care to the residents. She explained that they always get Resident A up to use the toilet. She said Resident A can tell you when she must use the bathroom. She reported it is the expectation of all the staff to provide transfer support for Resident A to be able to use the restroom when she lets you know that she has to use the restroom, besides it is in her care plan and in her Treatment Plan. Ms. Torrey stated that she was with Mr. Spataro when he interviewed Resident A. She said that Tateyana Reynolds admitted to leaving Resident A in bed because she was too busy, and she had to put the groceries away and do her end of shift charting.

On 02/10/2022, I conducted a telephone exit interview with the Program Manager, Le Roy Goldsworthy and he agreed with my findings.

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:	According to Resident A's Treatment Plan, Resident A can indicate her need to be changed and she requires full assistance for her toileting needs. Her assessment plan stated

	her need for toileting was for staff to transfer her to her toilet chair. Mr. Spataro's report read that Resident A reported that Tateyana Reynolds left her wet and dirty. Tateyana Reynolds reportedly told Mr. Spataro that she was too busy on 12/08/2021, to toilet her and she has never toileted Resident A. She said she changes Resident A's brief. Ms. Reynolds acknowledged to this consultant that she changes Resident A in her bed as she has been taught by rolling her. She denied that she had left Resident A wet and soiled. Resident A's assessment plan and her Treatment Plan define that Resident A requires total assistance with toileting. She can indicate her need to use the restroom and has a toilet chair that staff can transfer her too. Ms. Reynolds acknowledged that she has never toileted Resident A. Therefore, she failed to provide the personal care specified in Resident A's assessment plan and her Treatment Plan for Resident A to be lifted out of bed and toileted. There is clear evidence that the rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct Care Staff Tateyana Reynolds did not take Resident A out of her bed on 12/08/2021.

INVESTIGATION: On 12/09/2021 Ms. Darcy Torrey completed a Recipient Rights Complaint, and she emailed this document to me. The date on the form for the incident was 12/08/2021. Under the section of time, it read: "*Unsure of time." "At 8p (Resident A) had staff call me. She stated that Tateyana Reynolds would not get her up out of bed.*

On 12/09/2021, Darcy Torrey, the Home Supervisor of Samaritas --Mararebecah Lane, telephoned and reported that direct care staff, Precious Buchanan had telephoned her when she started her second shift on 12/08/2021, Ms. Buchanan reported that the first shift staff, direct care staff, Tateyana Reynolds was the only staff in the home. Ms. Torrey said that Ms. Buchanan told her that she had arrived at the home at 2:30 PM and she could hear Resident A wanting something, so she checked on her first. Ms. Torrey reported that Ms. Buchanan said that Resident A was in her bed, and she wanted to get out of her bed, so Ms. Buchanan got her up and brought her out into the living room. Resident A asked Ms. Buchanan to help her telephone, Darcy Torrey. Ms. Buchanan told Ms. Torrey that she was interpreting for Resident A by the use of her wolf board, and she said Ms. Reynolds would not get

Resident A, out of her bed all shift. Ms. Buchanan stated that when she arrived too her second shift, and she found Resident A in her bed.

On 12/11/2021, I received an email from Caren Lynn, Adult Protective Services Worker, with a summary of her interview with Resident A with the help from Ms. Torrey on 12/09/2021. Her interview reported that Resident A is not-verbal and "*she uses a communication board that was created by a speech therapist which has a number of symbols, words, colors, letters, numbers and an array of illustrations. (Resident A) communicates by being asked a series of questions and she answers by pointing to the image and that is consistent with what she wants to communicate. Darcy assisted ASW (Ms. Lynn) with the interview, it should be noted that ASW was unable to verify the entire amount of information (Resident A) communicated with the assistance of Darcy. The letter "T" referred to in this contact should be reference to the name Tateyana (staff). Darcy asked (Resident A) if something else happened and she pointed to the symbol day and up. She asked (Resident A) if she got up and she pointed to the symbol no."*

On 01/13/202, I telephoned Ms. Torrey. She stated that she was with Mr. Spataro when he interviewed Tateyana Reynolds. Ms. Torrey stated that Ms. Reynolds admitted to leaving the resident in her bed because she was too busy, and she had to put the groceries away and do her end of shift charting. Ms. Torrey also stated that Ms. Reynolds admitted to Mr. Spataro that she had left Resident A in bed, not only this time but two times before. Ms. Torrey stated that she did not have the exact dates except for 12/07/2021 and 12/08/2021, but she said Ms. Reynolds admitted she left Resident A in her bed the entire shift.

On 01/13/2022, I conducted a telephone interview with Tateyana Reynolds. She stated it was quite a hectic day and she had to put the groceries away, fix lunch, pass residents medications, and complete her charting at the end of her shift. Ms. Reynolds stated that she asked Resident A if she wanted to get up and get dressed but she declined and said she wanted to stay in bed and watch television. She stated she was pregnant and was on weight restrictions and would had needed to use the Hoyer lift to get Resident A out of her bed. She stated she did not get Resident out of bed on 12/08/2021 because Resident A refused to get out of bed. She said she has never gotten Resident A out of her bed.

On 01/13/2021 I conducted a telephone interview with direct care staff, Precious Buchanan. She stated that when she arrived at 2:30 PM on 12/08/2021 she found Resident A in her bed. She said she got her out of bed and called Ms. Torrey upon Resident A's request and she helped explain what Resident A was saying on her communication board. She stated that Resident A told Ms. Torrey that Tatyana Reynolds never got her out of bed that day even though she asked her to get her out of bed.

On 01/14/2021, I received an email from Ms. Lynn, and she indicated she had interviewed Tatyana Reynolds on 01/13/2022. She said Ms. Reynolds "*said she*

asked (Resident A) if she wanted to get up and get dressed but the resident declined. Tateyana said she often does this because she likes to stay in bed and watch TV. She said she was not aware of the resident having any concerns. She said the resident can make noise or say hey and then she would know that she wanted to get up…She said she did not refuse to get the resident up. She said the resident will get up for dinner but not for lunch."

On 01/14/2022 I received and reviewed a copy of Mr. Spataro's investigative findings. His report read that Resident A communicated to him that Tateyana Reynolds would not get her out of bed. His report read further that Tateyana Reynolds said "*she was not available to get (Resident A) out of bed, because she was doing paperwork on 12/07/2021. She said (Resident A) seemed distressed. Tateyana Reynolds said on December 8, 2021, (Resident A) wanted to get out of bed around noon. She said (Resident A) normally stays in bed. Tateyanan Reynolds said she could not get (Resident A) out of bed, because she was doing the grocery shopping, had to put them away, make lunch and administer medications."* Mr. Spataro's report stated that Resident A had requested to get out of bed on 12/07/2021 an on 12/08/2021 but Ms. Reynolds refused to get her up. Mr. Spataro's investigative report included the statement that "there is a preponderance of evidence that Tateyana Reynolds is not providing the personal care services required by (Resident A's) plan of service."

On 02/09/2022, I received an email from Caren Lynn, APS, Muskegon County and she stated that she substantiated against Tateyana Reynolds for neglect.

On 02/10/2022 I conducted a telephone exit conference with the Program Manager, LeRoy Goldsworthy and he agreed with my findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	Resident A reported that Tateyana Reynolds did not get her out of bed on 12/08/2021. Ms. Torrey stated that she heard Ms. Reynolds tell Mr. Spataro that she did not get Resident A, out of bed on 12/07/2021 or on 12/08/2021.

	Ms. Caren Lynn, APS worker reported that Ms. Torrey asked Resident A if she got up and she pointed to the word no. Tateyana Reynolds stated that she offered to get Resident A up, but she declined. She acknowledged that she did not get Resident A, out of bed on 12/08/2021. Ms. Reynolds stated that she has never gotten Resident A, out of her bed. Precious Buchanan stated that she found Resident A in bed when she arrived at 2:30 PM. on 12/08/2021 There is a preponderance of evidence that Tateyana Reynolds did not get Resident A out of bed on 12/08/2021. Therefore, Tateyana Reynolds confined Resident A to her bed and restricted her movement by not getting her out of bed when she requested, and a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct Care Staff Tatyena Reynolds used the "F" word in referencing Resident A and other residents.

INVESTIGATION: On 12/09/2021 Ms. Darcy Torrey completed a Recipient Rights Complaint, and she emailed this document to me. The date on the form for the incident was 12/08/2021. Under the section of time, it read: "*Unsure of time." "At 8p (Resident A) had staff call me. She stated that Tateyana said "F" "the residents" and she was angry."*

On 01/13/2022, I conducted a telephone interview with Tateyana Reynolds. I asked if she used the "F" word in referencing Resident A and other residents. She said she does not use that word and therefore she did not say that word at all.

On 02/10/2022, I conducted a telephone exit conference with the Program Manager, LeRoy Goldsworthy.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse.

	(iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats.
ANALYSIS:	Tateyana Reynolds denied using the F work in reference to residents. There is no evidence that Tateyana Reynolds used the “F “word in referencing the residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend the Licensee provide an acceptable plan of correction and the license remain the unchanged.

Arlene B. Smith 02/10/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 02/10/2022

Jerry Hendrick Date
Area Manager