GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 7, 2022

Connie Clauson
Leisure Living Mgt of Portage
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390016015
Investigation #: 2022A0581011
Fountain View Ret Vil 0f Port #2

Dear Mrs. Clauson:

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.

A six-month provisional license is recommended due to quality of care violations. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390016015
Investigation #:	2022A0581011
Complaint Receipt Date:	12/10/2021
Investigation Initiation Date:	12/10/2021
Report Due Date:	02/08/2022
Licensee Name:	Leisure Living Mgt of Portage
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Kimberly Barber
Licensee Designee:	Connie Clauson
Name of Facility:	Fountain View Ret Vil 0f Port #2
Facility Address:	7818 Kenmure Drive Portage, MI 49024
Facility Telephone #:	(269) 327-9595
Original Issuance Date:	08/01/1995
License Status:	REGULAR
Effective Date:	12/25/2020
Expiration Date:	12/24/2022
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was admitted to the ER with multiple fractures in her lower legs and abrasions and scrapes over her body. There is concern Resident A was mistreated at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/10/2021	Special Investigation Intake 2022A0581011
12/10/2021	APS Referral APS received the allegations and are investigating. A referral is unnecessary.
12/10/2021	Contact - Document Received Reviewed Incident Report submitted by Administrator from 12/09/2021 relating to Resident A's injuries.
12/10/2021	Contact - Document Sent Email to APS, Ryan McPherson
12/10/2021	Special Investigation Initiated - Telephone Interview with APS, Mr. McPherson
12/13/2021	Contact - Face to Face Unannounced on-site with APS. Interview with staff.
12/13/2021	Inspection Completed On-site Interviewed staff and reviewed documentation
12/13/2021	Contact - Document Sent Requested autopsy and investigative report from WMed for Resident A.
12/13/2021	Contact – Telephone call received Interview with direct care staff, Rachel Posthumus.
12/14/2021	Contact - Document Received Received resident documentation from Administrator, Kim Barber.
12/14/2021	Contact - Document Received

	Investigative report from WMed.
12/15/2021	Referral - Law Enforcement via Portage Police Department online complaint system. Online submission #9223.
12/15/2021	Contact - Document Received Received health care appraisal and lift/transferring information
01/12/2022	Contact - Document Sent Email to WMed.
01/19/2022	Contact - Document Sent Email to APS requesting report
01/19/2022	Inspection Completed-BCAL Sub. Non-Compliance
01/20/2022	Contact – Document Sent Email to Ms. Barber requesting lift and transfer policy
01/21/2022	Contact – Document Received Email from Ms. Barber indicating no lift and transfer policy.
01/25/2022	Contact – Document Sent Email to WMed requesting status of autopsy report.
01/27/2022	Contact – Document Sent Email to Ms. Barber requesting BFS CAP.
01/27/2022	Contact – Document Received Received additional fire drill information.
02/01/2022	Contact – Document Sent Requested resident information.
02/01/2022	Contact – Telephone call made Requested time sheets for direct care staff.
02/02/2022	Contact – Document Received Staff timesheets
02/07/2022	Exit conference with Connie Clauson.

ALLEGATION:

Resident A was admitted to the ER with multiple fractures in her lower legs and abrasions and scrapes over her body. There is concern Resident A was mistreated at the facility.

INVESTIGATION:

On 12/10/2021, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint did not provide additional information other than Resident A's fractures, abrasions, and scrapes were of unknown origins and there were concerns for Resident A's safety and well-being at the facility.

On 12/10/2021, I interviewed Ryan McPherson, Kalamazoo Adult Protective Services (APS) specialist, via telephone. He confirmed he received the allegations; therefore, no referral was necessary. Mr. McPherson stated he had observed Resident A at the hospital; however, he was unable to interview her due to her being intubated from being under mental duress upon admission to the ER, which had been indicated to him by a hospital nurse. Mr. McPherson stated he observed the wounds on Resident A's foot and toes. He stated hospital staff were unable to determine how old the leg fractures were or what caused them.

On 12/10/2021, I reviewed my email from the facility's Administrator, Kim Barber, and the facility file for any *Incident / Accident Reports* (IR) relating to Resident A. On 12/09/2021, Ms. Barber sent me via email two IRs, both dated 12/09/2021. The first IR indicated at approximately 6:30 am Resident A was transferred with the assistance of three staff into a wheelchair and evacuated from the building "per the fire department orders". The second IR indicated at approximately 9:30 am direct care staff noticed wounds and skin tears on Resident A's feet and right elbow "due to moving/transporting". The IR indicated Resident A was taken back to the facility with staff holding her feet up and utilizing a three person transfer, direct care staff got Resident A back into her bed. The IR indicated Resident A complained of pain in her left leg and when direct care staff, Annie Swier, touched her leg she determined it was "not broken severely". The IR further indicated Resident A's leg was monitored, and at 12:30 pm her left foot was observed to be bruising, which led to Resident A's family members and doctor being contacted.

On 12/13/2021, Mr. McPherson contacted me and reported Resident A had passed away at the hospital over the weekend. He indicated an autopsy report would be completed by Western Michigan University's School of Medicine, WMed.

On 12/13/2021, Mr. McPherson and I also conducted an unannounced on-site inspection at the facility. Mr. McPherson and I interviewed the facility's Administrator, Ms. Barber. Ms. Barber's statement to me was consistent with what was reported in the IRs she provided to me on 12/09/2021. Ms. Barber's office was in the

neighboring facility, which she identified as the “Assisted Living” facility, while identifying the facility in which Resident A resided in as the “Memory Care” facility. These two facilities, both operated by the licensee, are within walking distance of one another and approximately 40 feet apart.

Ms. Barber stated the Memory Care facility’s fire alarm first went off at approximately 9:30 pm on 12/08/2021, which was addressed by the facility’s maintenance staff and the alarm was turned off; however, she indicated the fire alarm went off again at approximately 3 am on 12/09/2021 and then again at approximately 6 am. She stated direct care staff evacuated the building when the alarm went off at 6 am, which included evacuating Resident A. Ms. Barber stated the local fire department informed staff at 3 am that if the alarm went off again staff would need to evacuate the residents until the fire alarm had been serviced and deemed to be functioning properly.

Ms. Barber stated she arrived at the Assisted Living facility at approximately 7:45 am and spoke to all the residents, including Resident A, everyone seemed “fine.” Ms. Barber explained that Resident A was in the Assisted Living facility as all residents had been evacuated to this building during the fire drill. She stated she observed Resident A sitting in a wheelchair and she did not appear under distress. Ms. Barber stated she did not observe Resident A’s feet at that time but indicated Resident A did not make any complaints or report being in pain.

Ms. Barber stated at approximately 9 am Fire Pros gave approval for the residents to be transferred back to Memory Care after they had assessed the fire alarm and deemed it to be functioning properly. Ms. Barber reported while staff were moving Resident A back to her facility, they observed the top of her left foot was swollen and tender. Ms. Barber indicated staff held Resident A’s feet up while transporting her back to the Memory Care facility because there were no footrests on the wheelchair Resident A was using. Ms. Barber denied any of the staff transporting Resident A back to Memory Care dropped Resident A or her feet or did anything that could have caused Resident A’s injuries. Ms. Barber stated Resident A’s leg pain was noticed around 9:30 am when staff were transferring Resident A back into her bed.

During the on-site investigation, I interviewed direct care staff and Director of Resident Care, Jackie Johnson. She stated she arrived at the Assisted Living facility on 12/09/2021 and observed all the residents from both facilities. Ms. Johnson stated all the residents appeared “fine”, including Resident A. She stated Resident A ate breakfast and took her prescribed medication with no issues. She stated she observed Resident A’s feet that morning and they did not appear to be injured. Ms. Johnson did not have any additional information regarding how Resident A obtained her injuries.

I interviewed direct care staff and Activities Director, Annie Swier. Her statement to me was consistent with Ms. Barber’s and Ms. Johnson’s statements to me; however, Ms. Swier indicated when Resident A was at the Assisted Living facility, she

observed scrapes and blood on the top of Resident A's left foot and toes prior to Resident A being transported back to the Memory Care facility. Ms. Swier also did not have any additional information as to how Resident A obtained her injuries.

I interviewed direct care staff, Melvina Higgins. Ms. Higgins's statement to me was consistent with Ms. Barber's, Ms. Johnson's, and Ms. Swier statements to me; however, Ms. Higgins stated when staff got Resident A back into her bedroom around 9:30 am, Resident A was "mumbling" and slouching over indicating her demeanor had changed when she was transported back to Memory Care. She also indicated she observed the top of Resident A's left foot was bleeding and indicated her leg also look "twisted". Ms. Higgins also did not have additional information regarding how Resident A obtained her injuries.

On 12/13/2021, I interviewed multiple direct care staff via telephone including Ashley Penny, Jayla Kelly, and Jessica Kellogg. Ms. Penny's statement to me was consistent with the other staff I interviewed. Ms. Penny indicated she had been working the overnight or 3rd shift from 12/08/2021 to 12/09/2021 at the Assisted Living facility. She stated the fire department came to the Memory Care facility at approximately 3 am and informed direct care staff working in the facility, Ms. Kelly, and Ms. Kellogg, that if the fire alarm went off again, they would need to evacuate the residents. Ms. Penny indicated at approximately 6 am, Ms. Kelly contacted her about the facility's fire alarm going off and requested assistance with evacuating the residents to the Assisted Living facility.

Ms. Penny stated when she got to Resident A's bedroom, Resident A was able to sit up and Ms. Penny had her in a "bear hug", indicating her arms were around her, to lift Resident A out of bed. Ms. Penny indicated when she pulled Resident A up, Resident A was against her body, but then Resident A started to "slide down" despite Ms. Penny still holding onto her indicating an assisted fall. Ms. Penny stated she yelled for Ms. Kelly to assist her in transferring Resident A to a wheelchair. She stated after Ms. Kelly came into Resident A's room, they both requested the assistance of third direct care staff, Ms. Kellogg, to help transfer Resident A into her wheelchair. She stated they laid Resident A on a sheet and then they used the sheet to transfer Resident A into the wheelchair. Ms. Penny stated there were no footrests on Resident A's wheelchair. Ms. Penny indicated she could not recall who transported Resident A from Memory Care to the Assisted Living facility. Ms. Penny also indicated that after Resident A was transferred to the Assisted Living facility, Ms. Kellogg informed her and Ms. Kelly she had discovered blood near the door of the Assisted Living facility and discovered it was Resident A's toe that was bleeding. Ms. Penny indicated Ms. Kellogg told Ms. Johnson about Resident A's bleeding toe. Ms. Penny denied mistreating Resident A or causing her injuries.

Ms. Kelly's statement to me regarding the fire alarm issue at the Memory Care facility was consistent with other staff's statements to me. Ms. Kelly stated Ms. Penny had been in Resident A's bedroom when she called for her to help her transfer Resident A. Ms. Kelly stated when she got into Resident A's bedroom she

observed Resident A on the floor, next to a wheelchair. She stated Resident A's arms were in front of her while her legs were on the side of her, "like a mermaid". She stated they required Ms. Kellogg's assistance as well in picking Resident A up from the ground and putting her in a wheelchair. Ms. Kelly indicated Ms. Penny transferred Resident A via wheelchair to the Assisted Living facility. Ms. Kelly also indicated she saw blood at the Assisted Living facility side after the residents in the Memory Care facility were transferred and discovered Resident A's foot was bleeding. Ms. Kelly denied mistreating Resident A or observing any other staff mistreating Resident A.

Ms. Kellogg's statement to me regarding the fire alarm issues was also consistent with the other staff's statements to me. She also stated Ms. Penny had been working at the Assisted Living facility and came over to assist her and Ms. Kelly in getting the residents out of the building. Ms. Kellogg stated she was working on getting the ambulatory residents up and moving. She stated while she and Ms. Kelly were assisting another resident, Ms. Penny "hollered for assistance" and Ms. Kelly went to help. Ms. Kellogg stated all three staff assisted Resident A in transferring from the floor to her wheelchair. Ms. Kellogg also stated the wheelchair in which Resident A was put in did not have pegs or foot holds. Ms. Kellogg denied mistreating Resident A or observing any other staff mistreating her during the evacuation.

On 12/13/2021, I received WMed's investigative report, dated 12/12/2021, relating to Resident A's death. The report indicated Resident A was admitted to a local hospital with "urosepsis, encephalopathy, a recent fall, bilateral tib/ fib fractures, and possible wheelchair dragging injuries sustained at an assisted living facility on 12/09/21 during a fire evacuation." The report indicated facility staff contacted a family member of Resident A's to report Resident A may have gotten "scuffed up" during a fire evacuation and was complaining of foot pain.

Ms. Barber provided Resident A's "Assessment Report" (written assessment plan), dated 11/18/2021. According to this assessment plan, Resident A is "…bedbound. Does not walk. Transfers are done with Hoyer lift and she is [wheelchair] bound when out of bed…[*sic*]". Regarding transferring, the assessment plan stated Resident A was "Total dependence – Full performance by others during all episodes". Her assessment also indicated she required the assistance of 1 person with dressing and requires "Maximal assistance – Weight – bearing support (including lifting limbs) by 2 + helpers – OR – Weight bearing support for more than 50% or more of subtasks" with toileting. Her assessment also indicated she is "dependent on someone propelling the [wheelchair] for her."

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:	Based on my investigation, on 12/09/2021, the licensee did not provide protection and safety to Resident A during an emergency fire drill at the facility, which resulted in serious injuries to Resident A's leg and foot requiring hospitalization. During this emergency fire drill, direct care staff, Ashley Penny, attempted to lift Resident A from her bed into a wheelchair when Resident A's written assessment plan indicated she is "total dependence" on staff when being transferred and required the use of a Hoyer lift. Despite not knowing if Resident A sustained her injuries during the transfer from her bed to a wheelchair or during the evacuation to the neighboring facility, Resident A's injuries occurred during the fire drill and resulted in her being hospitalized where she passed away three days after admission. Additionally, when staff evacuated Resident A in a wheelchair to the Assisted Living facility, staff again did not provide for Resident A's safety by ensuring Resident A's wheelchair had footrests. Consequently, Resident A was propelled in a wheelchair to the neighboring facility without her feet in footrests, resulting in injuries to her feet, which required medical attention.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

The facility's licensed capacity is 20 residents. The facility is licensed to provide personal care, supervision, and protection to the aged populations and/or individuals with Alzheimer's disease. I reviewed the facility's Resident Register which indicated there were 16 residents residing at the facility from 12/01/2021 until Resident A was admitted to the hospital on 12/09/2021.

On 12/09/2021, I interviewed Bureau of Fire Services (BFS) inspector, Ken Howe, via telephone. Mr. Howe stated he had been contacted by the local fire department and Ms. Barber regarding the facility's fire alarm system malfunctioning the early morning of 12/09/2021 causing facility direct care staff to evacuate the building.

I reviewed the facility file for Mr. Howe's most recent BFS report, dated 10/19/2021. According to Mr. Howe's report, he issued the facility a temporary Fire Safety Certification until 01/25/2022, based on the following deficiencies being found:

- There were no records of fire extinguishers monthly inspections after 02/12/2021 available at time of inspection
- There was no record of a fire extinguisher annual inspection available at time of inspection
- There was no record of the emergency lighting system monthly 30 second tests available at time of inspection
- There was no record of the emergency lighting system annual 90 minute tests available at time of inspection
- There were no records of the kitchen hood suppression bi-annual inspections available at time of inspection
- There was no record of a fire alarm system annual inspection available at time of inspection
- There were no records of fire drills available at time of inspection

Mr. Howe requested a corrective action plan be submitted specifying how the violation was or would be corrected and how the facility would ensure the violation would not reoccur. Additionally, Mr. Howe indicated in the report all the corrections would need to be corrected, ensured they wouldn't reoccur and would not need have expected dates of compliance.

On 12/10/2021, I reviewed my email from the facility's Administrator, Kim Barber, and the facility file for any *Incident / Accident Reports* (IR) relating to Resident A. On 12/09/2021, Ms. Barber sent me via email two IRs, both dated 12/09/2021. The first IR indicated at 6:30 am, staff entered Resident A's bedroom to do an emergency transfer from her bed to a wheelchair with "3 staff assisting". The IR indicated Resident A was first lowered to the floor and then lifted to a wheelchair. The IR indicated a top sheet was placed under Resident A to assist with lifting and then transferred to the neighboring facility "per the fire department orders".

The second IR indicated at 9:30 am, after the residents of the facility had been evacuated to the neighboring facility direct care staff noticed wounds and skin tears on Resident A's feet and right elbow "due to moving/transporting". The IR indicated Resident A was taken back to the facility with staff holding her feet up and utilizing a three-person transfer, direct care staff got Resident A back into her bed.

During my on-site at the facility, I requested to review the facility's fire drills, which Ms. Barber provided. According to the facility's fire drill records, no fire drills were completed in 2021 until 10/26/2021 when there was one completed for 1st, 2nd, and 3rd shifts. Ms. Barber indicated maintenance personnel was expected to complete drills throughout the year; however, they had not completed them. I also reviewed the facility's "Evacuation Records" for fire drills, which provided more detailed information at the time of the fire drills. The Evacuation Records indicated all three

fire drills were planned. The 1st shift drill indicated four direct care staff took part in the drill, along with Ms. Barber, and it took a total of six minutes to complete (10:35 am – 10:41 am). The 2nd shift drill indicated three direct care staff took part in the drill and it took a total of five minutes to complete (4:06 pm - 4:11 pm). The 3rd shift drill indicated two direct care staff took part in the drill and it took six minutes to complete (11:05 pm – 11:11 pm).

I also requested Ms. Barber provide me with the Assisted Living facility's fire drill and Evacuation Records to review due to direct care staffing concerns. According to these records, the Assisted Living facility had also not completed any fire drills for 2021 until 10/26/2021 when there was one completed for 1st (10:30 am – 10:35 am), 2nd (4:00 pm – 4:06 pm), and 3rd (11:00 pm – 11:05 pm) shifts.

When I cross referenced the Evacuation Records between both the Memory Care and Assisted Living facilities, I discovered the same direct care staff, Latoya Howard, was involved in both 1st shift fire drills at both facilities, indicating this direct care staff was being used as a roaming or floating staff between the facilities. Additionally, I found the same direct care staff, Jasmine Muhammad, was listed on the evacuation records as being involved for both 2nd shift fire drills at both buildings and direct care staff, Tammy Ward, was also listed on both 3rd shift fire drill evacuation records indicating both of these direct care staff were working at both facilities at the same time.

I also reviewed the facility's staff schedule from 11/21/2021 through 12/25/2021, which was provided by Ms. Barber during my on-site inspection. Ms. Barber confirmed staff assigned to the Memory Care facility were indicated with an "M" and staff assigned to the Assisted Living facility were indicated with an "A". Ms. Barber indicated an asterisk located next to the M or A indicated the staff was assigned as the medication passer for that building. Upon my review of the facility's staff schedule, two staff were assigned to work at the Memory Care facility on 12/08/2021 for 3rd shift, which were Jayla Kelly and Dominique Thorne. The staff schedule also indicated there were two staff assigned to work the Assisted Living facility on 12/08/2021 for 3rd shift, which were Ashley Penny and Jessica Kellogg. Ms. Barber stated that contrary to what was indicated on the staffing schedule, Ms. Thorne hadn't worked 3rd shift on 12/08/2021 due to calling in. Ms. Barber indicated she had not updated the schedule to reflect these changes.

Upon my review of the schedule, there were 26 shifts from 11/21/2021 through 12/25/2021 where only one direct care staff was identified as being assigned to the facility. Twenty-three out of 26 of these shifts were during 3rd shift and three out of 26 of these shifts were during 1st shift. The facility's staffing schedule also indicates staff are assigned to work at both facilities as indicated by the notation "M/A".

Based on my review of the facility's Resident Register, the number of residents residing in the facility between 11/21/2021 and 12/25/2021 were the following:

- 14 residents residing in the facility from 11/21/2021 through 11/22/2021
- 15 residents residing in the facility from 11/23/2021 through 11/30/2021
- 16 residents residing in the facility from 12/01/2021 through 12/09/2021
- 15 residents residing in the facility from 12/10/2021 through 12/25/2021

Ms. Barber provided me with an updated staffing schedule on 01/19/2022 for 11/21/2021- 12/25/2021 showing additional staff were inputted for shifts throughout the month indicating the facility had more direct care staff on shift compared to the original staffing schedule I observed on 12/13/2021.

On 02/01/2022, I requested to review staff timesheets from 11/21/2021 through 12/25/2021, which Ms. Barber provided on 02/02/2022. It should be noted the timesheets did not indicate the specific buildings direct care staff were working in. Instead, the timesheets provided the total number of direct care staff working between the two buildings.

I reviewed direct care staff timesheets from 12/01/2021 through 12/08/2021 when the facility had 16 residents and determined the following:

Date	Shift	Total number of staff working for *both* buildings
12/01/2021	1st shift	5
	2nd shift	4
	3rd shift	2
12/02/2021	1st shift	4
	2nd shift	4
	3rd shift	4
12/03/2021	1st shift	4
	2nd shift	3 NOTE: timesheets indicated only two staff were working for both buildings between 4:30 pm and 6:50 pm
	3rd shift	3
12/04/2021	1st shift	2
	2nd shift	3 NOTE: timesheets indicated only two staff were working for both buildings after 8 pm until the morning of 12/05/2021

	3rd shift	2
12/05/2021	1st shift	3
	2nd shift	3
	3rd shift	4
12/06/2021	1st shift	4
	2nd shift	4
	3rd shift	3
12/07/2021	1st shift	4
	2nd shift	3
	3rd shift	3
12/08/2021	1st shift	6
	2nd shift	3
	3rd shift	3

Based on my review of direct care staff timesheets for the week of 12/01/2021 through 12/08/2021, there were 13 shifts where the facility only had two or three staff working between the Memory Care and Assisted Living facilities, which indicates one direct care staff was assigned to work at each facility, at a minimum, and at times, there was an additional third direct care that would float or roam between the two facilities.

In my interviews with Ms. Swier and Ms. Higgins, they both confirmed it took three direct care staff to get Resident A from her wheelchair into her bed after transporting her back to the Memory Care facility on 12/09/2021. Both Ms. Swier and Ms. Higgins reported they assisted Resident A with getting her into bed along with direct care staff, Dajainique Smith. Both Ms. Swier and Ms. Higgins stated they did not observe a Hoyer lift in Resident A's bedroom on 12/09/2021.

Ms. Penny indicated during the overnight on 12/08/2021, Ms. Kellogg and Ms. Kelly, were both working at the Memory Care facility; despite Ms. Kellogg being assigned to work at the Assisted Living facility. Ms. Penny indicated two to three staff are scheduled for 3rd shift between both the facilities. She indicated when three direct care staff are working among the buildings, then one direct care staff will go back and forth between the two buildings, indicating this direct care staff is a floater or roaming staff. She indicated if either building needs assistance, then staff call or text the floating or roaming staff.

Ms. Penny confirmed on 12/09/2021 at approximately 6 am she went to the Memory Care facility to help evacuate residents to the Assisted Living facility, including Resident A. Ms. Penny stated it took approximately "8-10 minutes" to evacuate the residents in the facility.

Ms. Penny stated she had gone into Resident A's bedroom to transfer her into a wheelchair; however, when she attempted to pick Resident A by herself and while holding her in a "bear hug", Resident A began "sliding" towards the floor, indicating an assisted fall. Ms. Penny stated she yelled for Ms. Kellogg and Ms. Kelly to assist

her. She stated it took all three direct care staff to transfer Resident A from the floor to a wheelchair to evacuate her from the facility.

Ms. Penny stated she's worked at both facilities for approximately one month and had not participated in a fire drill before. She indicated she had not received training on emergency situations or fire drills.

Ms. Kelly confirmed she was assigned to work at the Memory Care facility during 3rd shift on 12/08/2021. She confirmed Ms. Kellogg worked with her in the Memory Care facility while Ms. Penny was working by herself in the Assisted Living facility. She also confirmed when the fire alarm went off around 5 am or 6 am she contacted Ms. Penny and requested her assistance in evacuating the residents in the Memory Care facility.

Ms. Kelly's statement relating to Resident A was consistent with Ms. Penny's statement to me. Ms. Kelly also indicated Resident A is a two person assist if a Hoyer lift is not available. Ms. Kelly also indicated Resident B is a two person assist and required both her and Ms. Kellogg's assistance in transferring her into a wheelchair during the evacuation.

Ms. Kellogg's statement to me was consistent with Ms. Penny's and Ms. Kelly's statement to me. Ms. Kellogg indicated when she and Ms. Kelly started evacuating residents, she focused on getting the ambulatory residents "up and moving" and Ms. Penny assisted Resident A.

Ms. Kellogg stated there were four residents in the facility who required two person assists in transferring, which were Resident A, Resident B, Resident C and Resident D. She indicated Resident E requires a wheelchair for mobility and there are times when she requires assistance from staff in transferring and other times when she can ambulate into the wheelchair by herself.

Ms. Kellogg stated she had worked at the facility for approximately 2 years. She stated she participated in fire drill, but not during the overnight shift. Ms. Kellogg also indicated the facility utilizes floating or roaming staff that go between the two facilities.

Neither Ms. Penny, Ms. Kelly, nor Ms. Kellogg recalled a Hoyer lift being in Resident A's bedroom at the time of the evacuation on 12/08/2021.

I requested to review resident documentation for all 16 residents, which included documents titled "Assessment Report" (written assessment plan), "Resident Evaluation", *Assessment Plans for AFC Residents*, and *Health Care Appraisals*.

Resident documentation I reviewed for the sixteen residents indicated the following:

- Five residents required the use of a wheelchair to ambulate. Two out of five of these residents utilized a wheelchair and walker to ambulate. Three residents utilized a walker to ambulate, one resident utilized a cane to ambulate, and one resident utilized both a cane and walker to ambulate. One out of the five residents required staff to propel their wheelchair.

- One resident required the use of a Hoyer lift in transferring.

- Twelve residents had a Dementia or Alzheimer's diagnosis.

- Five residents had a history of wandering or exit seeking behaviors.

- Eight residents required the assistance from staff in completing Activities of Daily Living (ADL) such as bathing, grooming, and dressing while one resident required prompting and cues for ADLs. One resident required "Total Dependence" with ADLs.

- Two residents received hospice services.

- Eight residents were incontinent and required assistance from staff with toileting.

- Four residents had a history of falling within 30 days of their assessments.

- Eight residents had memory issues.

- Five residents had behavioral issues.

Throughout the investigation, Ms. Barber indicated she was hiring additional staff for the facility. On 12/22/2021, she reported hiring seven new direct care staff; however, on 01/19/2022, she indicated two out of these seven new hires had not come to fruition. She also indicated Ms. Penny and Ms. Kelly were not currently working at the facility. Ms. Barber also stated she had not provided Mr. Howe with a corrective action plan related to his BFS report but indicated she would contact him.

Additionally, as of the date of this report, Resident A's autopsy report had not been completed; however, I reviewed WMed's Investigative Report, dated 12/12/2021. According to this report, Resident A was admitted to a local Emergency Room on 12/09/2021 "…with urosepsis, encephalopathy, a recent fall, bilateral tib/ fib fractures, and possible wheelchair dragging injuries sustained at an assisted living facility on 12/09/21 during a fire evacuation."

Upon review of the facility's file, this is a repeat finding for Adult Foster Care Licensing Rule 400.15206(2). According to Special Investigation Report 2018A0462020, dated 04/30/2018, based on a review of every resident's written assessment plan, it was determined 10 out of 13 residents residing at the facility had

impaired mobility and required the use of a wheelchair and/or walker to ambulate. According to the facility's administrator at the time, Janet White, five of the 10 residents required the assistance of direct care staff to push them in their wheelchairs to ambulate. The investigation indicated half of the facility's resident population at the time required at least two direct care staff to assist them with mobility transfers with the use of the facility's Hoyer lift and almost half of the resident population at the time were unable to communicate their needs, were resistant to care, had fall preventions indicated in their assessment plans and were receiving hospice services. Additionally, the investigation determined more than half of the resident population at the time required total assistance with dressing, bathing, grooming and toileting.

The investigation determined documentation on the facility's fire drill evacuation record, dated 12/29/2017, indicated two employees evacuated the residents at 5:57 am and it took over a minute to start the drill and the total time for evacuation was five minutes. Documentation on the facility's fire drill evacuation record, dated 01/10/2018, indicated two direct care staff evacuated the residents at 5:01 am with an evacuation time of 14 minutes.

The investigation further indicated the Administrator, Ms. White, indicated staff who were scheduled to work in a neighboring AFC home were to report to the facility to assist with resident evacuation during fire drills, which confirmed that more than two employees were needed to safely evacuate the residents in a timely manner. The investigation determined that based on the total care needs of the facility's population, and a review of the facility's recent fire drill evacuation records, it had been established the facility's staffing ratio was not sufficient.

The facility's corrective action plan (CAP), dated 06/04/2018, indicated direct care staff would be in-serviced as to the importance of fire drills and evacuation procedures. The procedures would be reviewed to ensure staff are aware of the importance in responding to a drill as if it were a real fire. The CAP indicated a fire drill would be held with all staff present to demonstrate proper procedures and the training would be placed in the employee files. Additionally, the CAP indicated the facility would have the appropriate staff to resident ratio dependent upon levels of care needs of all residents.

This is also a multiple repeat finding for Adult Foster Care Licensing Rule 400.15303(2). According to Special Investigation Report 2018A0462020, dated 04/30/2018, per the facility's written policy, two to three direct care staff are to assist a resident with mobility transfers when the resident requires the use of the facility's Hoyer lift to transfer. The investigation determined a resident's assessment plan indicated two direct care staff were to provide the resident with assistance with mobility transfers with the use of the facility's Hoyer lift; however, on 02/19/2018, a direct care staff attempted to transfer the resident out of bed with the use of the facility's Hoyer lift without requesting the assistance of another direct care staff. Subsequently, the resident fell and obtained an injury to her head.

The facility's corrective action plan (CAP), dated 06/04/2018, indicated Resident Care Managers would review all resident care plans with direct care staff to ensure proper supervision, protection and personal care is provided according to each individual care plan. The CAP also indicated all staff would sign the resident care plan log form acknowledging they read, understood, and agreed to follow each resident's care plan. The CAP further indicated all Resident Care Managers would ensure resident's requiring two person assists for mobility transfers would be assisted by two direct care staff and all residents prescribed with the use of the facility's Hoyer lift for mobility transfers would be assisted by two staff members together.

Additionally, according to Special Investigation Report 2020A0466035, dated 09/18/2020, the facility was found in violation of Adult Foster Care Licensing Rule 400.15303(2) when a resident eloped from the facility on 07/22/2020 and direct care staff were unable to locate her until three hours later. The resident's written assessment plan documented the resident wandered, had exit seeking behaviors and had bouts of confusion. The investigation determined the Administrator and direct care staff were aware of the resident's tendency to wander and exit seek; however, no additional measures were taken to ensure the resident's protection and safety. Subsequently, the resident wasn't provided with the supervision, protection and personal care as defined in the act and as specified in her written assessment plan.

The facility's CAP, dated 09/28/2020, indicated the facility's direct care staff had taken part in an additional elopement drill and in-serviced on how to deal with residents with exit seeking behaviors. Additionally, the CAP indicated the training addressed the most likely times of the day and circumstances wandering may occur and stressed all basic needs must be met. The CAP indicated that going forward, any resident admitted to the facility with a known history of exit seeking behavior would undergo 30-minute checks for their initial 24 hours of residence.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.

ANALYSIS:	Based on my review of the facility's direct care staff timesheets and the neighboring facility's (Assisted Living) timesheets, only two direct care staff were working between both facilities on 12/03/2021 from approximately 4:30 pm until 6:50 pm when there were 16 residents residing in the facility during waking hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	The facility is licensed to provide Adult Foster Care services to the aged population and/or individuals with Alzheimer's disease. Based on my review of every resident's written assessment plan, it was determined nine out of 16 residents residing at the facility from 12/01/2021 through 12/09/2021 required the use of a wheelchair, walker and/or cane to ambulate. According to Resident A's assessment plan and based on interviews with direct care, Ms. Penny, Ms. Kelly, Ms. Kellogg, Ms. Higgins, and Ms. Swier, Resident A required the assistance of at least two direct care staff with mobility transferring. Additionally, twelve out of the 16 residents had a diagnosis of Dementia and/or Alzheimer's, five had a history of wandering or exit seeking, at least half of the residents required assistance from staff in completing Activities of Daily Living such as grooming, bathing, dressing and toileting. Documentation on the facility's fire drill evacuation records for both the Memory Care facility and the neighboring Assisted Living facility, dated 10/26/2021, indicated staff were being utilized from both facilities to complete the fire drills. A licensee shall have sufficient direct care staff on duty in the facility, at all times, and shall not rely on other employees who are working in a different facility (Assisted Living facility) to assist with evacuation drills; however, on 12/09/2021, during an unplanned fire drill direct care staff, Ms. Penny, came from the Assisted Living facility to assist two direct care staff, Ms. Kellogg, and Ms. Kelly, in evacuating the facility's residents. Subsequently, Resident A sustained significant injuries to her legs and feet during the fire drill and required immediate medical attention, despite having three direct care staff transferring her from her bed into a wheelchair. Additionally, my review of the facility's staffing schedules and direct care staff timesheets indicated the facility is frequently staffed with two to three direct care staff during the 2nd and 3rd shifts between both the Memory Care and Assisted Living facilities indicating direct care staff are floating or roaming between the two buildings to provide direct care services to residents. Based upon the total care needs of the facility's population, a review of the facility's 2021 fire drill evacuation records, staffing schedules and direct care staff timesheets, direct care staff interviews, and the injuries sustained by Resident A during the 12/09/2021 fire drill, there is substantial evidence indicating

	there is not a sufficient number of direct care staff members working to meet the needs of the residents admitted to the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR 2018A0462020, DATED 04/30/2018, CAP DATED 06/04/2018]**

APPLICABLE RULE	
R 400.15303	**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:	Documentation on Resident A's written assessment plan indicated Resident A required the use of a Hoyer lift in transferring and "maximal assistance", which was indicated as weight bearing support (including lifting limbs) by "2 + helpers- or - weight bearing support for more than 50% or more of subtasks". On 12/09/2021, Resident A was not provided with the personal care she required when during a fire drill direct care staff, Ms. Penny, attempted to lift and transfer Resident A out of her bed by herself before requesting the assistance of two additional staff. After being transferred to a wheelchair, Resident A was evacuated from the facility. Though I am unable to determine if Resident A sustained her injuries while direct care staff were transferring her out of bed into her wheelchair or during the evacuation from the Memory Care facility to the Assisted Living facility; Resident A nonetheless sustained significant injuries to her legs and feet, requiring immediate medical attention. Additionally, my interviews with direct care staff also indicated there was no Hoyer lift available for staff's use at the time of the fire drill evacuation. Additionally, interviews with direct care staff indicated Resident A was at least a two person assist in transferring; however, staff interviews and the facility's Incident Report indicated Resident A required three direct care staff to assist her in transferring on 12/09/2021.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR 2018A0462020, DATED 04/30/2018, CAP DATED 06/04/2018]** **[SEE SIR 2020A0466035, DATED 09/18/2020, CAP DATED 09/28/2020]**

APPLICABLE RULE	
R 400.15318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.

ANALYSIS:	The frequency of practicing emergency and evacuation procedures referenced in this subrule is one practice during daytime hours, one during evening hours, and one during sleeping hours, *each quarter*. A minimum of 3 practices must be completed every 3 months. Administrator Ms. Barber provided fire drill records and evacuation records which indicated only three fire drills were completed for the entire year of 2021, which took place on October 26, 2021, for 1st, 2nd, and 3rd shifts. Additionally, the Bureau of Fire Services also found in October 2021 that the facility had not been completing fire drills, as required, and requested a corrective action plan addressing this violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I interviewed direct care staff, Rachel Posthumus, Ashley Penny, Jayla Kelly, and Jessica Kellogg regarding the training they received for safety and fire prevention.

Ms. Posthumus and Ms. Penny indicated they had been working at the facility for approximately one to one and a half months and denied receiving any training relating to safety and fire prevention. Ms. Posthumus indicated she had shadowed another direct care staff upon hire; however, she stated she did not sign any documentation indicating she had been trained in specific areas, including safety and fire prevention. Neither Ms. Penny nor Ms. Posthumus indicated they had participated in any type of fire drill making them familiar with what to do in the event of an emergency or actual fire.

Ms. Kelly and Ms. Kellogg both indicated they had participated in practice fire drills; however, they indicated the practice fire drill had been conducted when all the residents were all awake and residents were in the facility's "common area". Neither direct care staff indicated they had completed a practice fire drill at night.

Ms. Barber indicated an Employee Orientation Checklist is completed with every direct care staff, which indicates safety and fire prevention is addressed, as well as the facility's fire alarm response and evacuation procedures. Ms. Barber indicated an orientation was scheduled for new staff on 01/27/2022. Ms. Barber indicated four new direct care staff had been hired and provided signed copies of documents indicating they had read, received training, and understood safety and fire prevention at the facility.

Ms. Barber was unable to provide confirmation Ms. Penny, Ms. Kellogg, or Ms. Kelly had received training and were competent in safety and fire prevention.

Ms. Barber provided documentation indicating practice fire drills had been conducted at the facility on 10/26/2021 for all shifts. The documentation indicated Ms. Kelly participated in the 2nd shift fire drill at 4:06 pm; however, none of these drills indicated Ms. Penny or Ms. Kellogg participated.

Ms. Barber also provided documentation indicating a “Mandatory In-Service” regarding fire drills procedures occurred on 07/22/2021. According to the sign in sheet Ms. Kellogg attended this in-service. Ms. Barber indicated the in-service addressed the facility’s fire alarm response procedure and evacuation plan; however, the documentation indicated the procedure and evacuation plan were for a different facility based on the incorrect facility name and address.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(f) Safety and fire prevention.**
ANALYSIS:	There is no indication the licensee has a training methodology assuring direct care staff, particularly the direct care staff working 3rd shift on 12/08/2021, were competent in the area of safety and fire prevention appropriate to the needs of the current resident population identified in the facility's program statement and admission policy, which is the aged and Alzheimer’s population. The training provided to staff should minimally address knowledge of basic emergencies, including medical and weather emergencies and other disasters; knowledge of responsibilities during emergency situations; knowledge of the facility's emergency plan; knowledge of what to do to assist residents with special needs, knowledge of how to prevent and respond to common types of home fires and knowledge of the proper operation of fire extinguishers. Subsequently, there is indication staff are being hired and allowed to work without being properly trained or deemed competent first. No documentation was available confirming Ms. Penny, Ms. Kellogg, or Ms. Kelly had been trained and deemed competent in fire safety training.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(4) A licensee shall ensure that residents, all employees, volunteers under the direction of the licensee, and members of the household are familiar with emergency and evacuation procedures.
ANALYSIS:	Based on my interviews with direct care staff and the results of the 12/08/2021 emergency fire drill, direct care staff were not familiar with fire drills or evacuating residents in the event of an emergency. Consequently, Resident A sustained serious injuries to her leg and feet.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my on-site inspection, I requested to review the facility's staffing schedule. Ms. Barber indicated the schedule was not updated to reflect staffing changes as there days and shifts where staff were indicated as working when in fact they called off or did not show. Additionally, Ms. Barber indicated there were times when she came in to cover shifts, but this was also not indicated on the schedule.

Ms. Barber provided me with an updated staffing schedule on 01/19/2022 for 11/21/2021- 12/25/2021 where additional staff were inputted for shifts throughout the month indicating the facility had more direct care staff on shift compared to the original staffing schedule I observed on 12/13/2021.

Despite Ms. Barber providing me with an updated staffing schedule, both schedules provided to me did not reflect the actual staff working during specific shifts based on my investigation, which included interviews with direct care staff and Ms. Barber and my review of staff's timesheets. For example, I did not observe the correct direct care staff listed as working on the schedule for 3rd shift on 12/08/2021 for either schedule. The original staffing schedule indicated Ms. Kelly and Ms. Thorne were scheduled to work the Memory Care facility; however, the updated staffing schedule indicated Ms. Penny was assigned to both the Memory Care and Assisted Living facilities while Ms. Thorne was working in Memory Care; however, based on my interviews with direct care staff, Ms. Kellogg and Ms. Kelly worked in the Memory Care facility during 3rd shift on 12/08/2021 while Ms. Penny was working at the Assisted Living facility. The updated staffing schedule did not reflect Ms. Kelly as even working 3rd shift that night.

Additionally, my review of the facility's timesheets indicated on 12/13/2022 there was only two direct care staff working between the two facilities from approximately 6 pm

until approximately 11 pm; despite the updated staffing schedule indicating there were three staff working 2nd shift between the two facilities.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Upon my review of two facility staffing schedules for the time frame of 11/21/2021 – 12/25/2021, the licensee was not updating staffing schedules to reflect the actual staff working at the facility for the days and shifts indicated on the schedules or any scheduling changes, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/07/2022, I attempted to conduct an exit conference with the licensee designee, Connie Clauson, via telephone and email. To conduct my exit conference, I contacted the facility's Administrator, Kim Barber, and informed her of my findings. On 02/08/2022, Ms. Clauson contacted me, and I was able to conduct my exit conference, inform her of my findings and recommendation. Ms. Clauson indicated she would review the report and address the area of concern.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend a provisional license due to the severe and repeat quality of care violations cited in the report.

02/04/2022

_____

Cathy Cushman Date
Licensing Consultant

Approved By:

02/04/2022

_____

Dawn N. Timm Date
Area Manager