GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 4, 2022

Tami McKellar
AH Kentwood Subtenant LLC
6755 Telegraph Road Suite
Bloomfield Hills, MI 48301

RE: License #: AL410397694
Investigation #: 2022A0467019
AHSL Kentwood Riverstone

Dear Ms. McKellar:

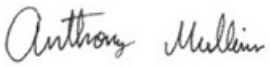
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410397694
Investigation #:	2022A0467019
Complaint Receipt Date:	02/02/2022
Investigation Initiation Date:	02/03/2022
Report Due Date:	04/03/2022
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Tami McKellar
Licensee Designee:	Tami McKellar
Name of Facility:	AHSL Kentwood Riverstone
Facility Address:	5980 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(248) 309-0257
Original Issuance Date:	01/18/2019
License Status:	REGULAR
Effective Date:	07/18/2021
Expiration Date:	07/17/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's family was not made aware of his Coccyx wound until January 2022 even though his decline reportedly began in December 2021.	Yes
On 1/15/22, the facility was insufficiently staffed with 20 residents and only 1 caregiver.	No
Resident A was neglected.	No
Resident A lost a substantial amount of weight within a short period of time.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/02/2022	Special Investigation Intake 2022A0467019
02/03/2022	Special Investigation Initiated - Telephone
02/03/2022	Contact - Telephone call made Call made to Resident A's daughter.
02/17/2022	Inspection Completed On-site
03/04/22	Exit conference completed with licensee designee, Tami McKellar

ALLEGATION: Resident A's family was not made aware of his Coccyx wound until January 2022 even though his decline reportedly began in December 2021.

INVESTIGATION: On 2/2/22, I received a BCAL online complaint listing multiple concerns regarding the facility, as well as their contracted agency, Interim Healthcare. The complaint stated that Resident A's family was unaware of his coccyx wound and that Interim Health care was brought in for wound care. Resident A's coccyx wound reportedly went from a stage 1 to stage 4 in a two-week time frame.

On 2/3/22, I spoke to Resident A's daughter via phone. I informed her of the additional information I needed, specifically the names of the staff members that she spoke with regarding Resident A. Resident A's daughter agreed to send me the names of the staff members via email. I informed Resident A's daughter that I am the licensing authority for the AFC home only and that I do not have any regulatory oversite over Interim Healthcare. I informed Resident A's daughter that I plan to follow-up with her with contact information to allow her to address her concerns with

the appropriate parties. Resident A's daughter is aware that I will investigate any potential licensing rules to determine if the facility was non-compliant. On 2/6/22, Resident A's daughter provided me with names of the two staff members she spoke to, which were Madison Williams and Tommy Stornello.

On 2/17/22, I made an unannounced onsite investigation to the facility. I spoke to Ms. Williams, supervisor of the facility. Ms. Williams stated Resident A did in fact have a guardian, who she identified as his wife. Ms. Williams stated that she has worked for American House for nearly two years, and she has seen Resident A's wife "maybe twice." Ms. Williams stated that she's aware that Resident A had a son, but she had no knowledge that Resident A had a daughter until recently. Ms. Williams was adamant that staff at American house did not withhold information from Resident A's guardian/wife. Instead, she stated that it was difficult for staff to get ahold of Resident A's wife due to her phone number changing. Therefore, making it difficult for staff to inform her of Resident A's status.

Ms. Williams added that once a family signs on to hospice, the hospice provider typically shares information directly with the family. Ms. Williams stated that Resident A's wife was made aware of the hospice referral, and she was in agreement with it as she reportedly signed off on it. Direct care worker, Tommy Stornello, as well as the executive director, Tami McKellar, also stated that it was difficult for staff to get ahold of Resident A's wife due to not having an updated phone number for her.

On 3/2/22, I called Ms. Williams to clarify information regarding staff trying to contact Resident A's family to provide updates. Ms. Williams stated that Dr. Elami told her that he did attempt to contact the family via phone to provide an update on his status. Ms. Williams does not know exactly when or how many times Dr. Elami attempted to call Resident A's wife. I then asked Ms. Williams how many times she attempted to contact Resident A's wife. Ms. Williams estimated that prior to Resident A having a bed sore (coccyx wound), she attempted to call his wife three times to provide her with an update regarding Resident A's decline after contracting Covid-19, which included not eating and not going to the restroom by himself. After Resident A had the bed sore and discussions began to initiate a hospice referral, Ms. Williams estimated that she called his wife twice to update her. The number that was called is the number that is on Resident A's face sheet. Ms. Williams shared that from the time Resident A had the bed sore until the time it started to worsen, was "maybe within a couple of days." Ms. Williams stated that she did not receive the correct phone number for Ms. Williams until the hospice coordinator provided it to her. Regarding alternative measures, Ms. Williams stated that she attempted to call Resident A's son once and his voice mailbox was full. Therefore, she was unable to leave a message. After speaking to Ms. Williams, I reviewed Resident A's identification sheet and it provided names and numbers for two of his sons.

On 3/2/22, I also called Mr. Stornello to ask for clarifying information regarding American House staff reaching out to Resident A's family for updates. Mr. Stornello stated that he spoke to Resident A's daughter on or around 12/31/21 when he

arrived at work and saw a sticky note with a message to call her. Mr. Stornello called Resident A's daughter. During the conversation, Mr. Stornello stated that he only had a phone number for Resident A's wife, which was invalid or disconnected. Resident A's daughter stated that there were other people he could have contacted although Resident A's face sheet only listed his wife.

Mr. Stornello stated that Resident A's daughter then provided him with an updated phone number for Resident A's wife. Resident A's daughter explained to Mr. Stornello that she or her mother have provided updated contact information to staff during a previous visit, which he was unaware of. During my interview with Mr. Stornello at the facility on 2/17/22, he confirmed that Resident A's wife was hard to get ahold of. During the conversation with him on this date, he stated that he had not attempted to contact Resident A's wife himself. Instead, he relayed to Resident A's daughter what was relayed to him from Ms. Williams. Within a day of getting Resident A's wife's number from the daughter, Mr. Stornello stated that he called her and provided her with an update.

Mr. Stornello also stated that sometime around early December 2021, when Resident A had a fall, he spoke to Ms. Williams about contacting Resident A's wife. Ms. Williams reportedly shared with him that they did not have a valid number for her. Mr. Stornello stated that he told Ms. Williams that they should send a letter to the home of Resident A's wife in an attempt to get an updated phone number. Ms. Williams reportedly stated that she would try, and Mr. Stornello is unsure if she ever followed through with this.

On 3/2/22, I spoke to Ms. McKellar via phone to follow-up with her regarding staff attempting to contact Resident A's wife to provide updates. Ms. McKellar stated that she personally has not attempted to call Resident A's wife or family. However, Ms. Williams has and relayed this information to her. When asked about alternative measures, Ms. McKellar stated that Ms. Williams has attempted to contact Resident A's son too. Ms. McKellar stated that whenever a resident has a fall or goes to the hospital, they must notify family. Ms. McKellar is not sure if an attempt was made to reach Resident A's wife and didn't answer, leading to Ms. Williams contacting Resident A's son.

On 3/2/22, I sent an email to Resident A's daughter, inquiring about her mother's current phone number and how long she's had the number. Resident A's daughter provided me with a new number than what is provided on Resident A's face sheet. Resident A's daughter also stated that she believes that her mother has had her new phone number since December.

On 3/3/22, I spoke to Resident A's wife via phone. Resident A's wife confirmed that "most of the time," staff at American House did update on her on Resident A's status. However, there were also times that they failed to do so. Resident A's wife confirmed that she did obtain a new telephone number prior to 12/1/21. Resident A's wife stated, "I probably did" when asked if she provided American House with her

new phone number. Resident A's wife recalled visiting her husband at the facility in the middle of December 2021 and stated that she "probably" updated the facility after the visit. Resident A's wife stated that when she obtained a new phone number, she contacted all the important people and agencies involved in her life to provide them with her new number. Resident A's wife stated that she's not ruling out that staff at American House attempted to call her to provide updates regarding her husband. She added that American House also had her son's number as well so if they were unable to get ahold of her, they could have contacted him like they've done in the past.

On 03/04/22, I conducted an exit conference with licensee designee, Tami McKellar. She was informed of the investigative findings and agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(11) A licensee, direct care staff, and an administrator shall be willing to cooperate fully with a resident, the resident's family, a designated representative of the resident and the responsible agency.
ANALYSIS:	Ms. Williams stated that facility staff were unable to contact Resident A's wife/guardian due to not having an updated phone number. As an alternative measure, Ms. Williams stated that she attempted to contact one of Resident A's sons once. She was unable to leave a message due to his voice mailbox being full. Resident A's wife confirmed that she did in fact obtain a new telephone number prior to 12/1/21 and she believes she provided American House with an updated number sometime after her visit to the facility in mid-December 2021. Mr. Stornello and Ms. McKellar stated that neither of them attempted to call Resident A's wife. Instead, this information was relayed to them from Ms. Williams. Ms. McKellar stated that Ms. Williams attempted to contact Resident A's son when she was unable to get ahold of his wife. Based on the information provided, Ms. Williams attempted to contact one of Resident A's son only once after failed attempts

	to get ahold of Resident A's wife. There were no other attempts made to reach one of Resident A's sons although there were two different phone numbers available. Therefore, staff at the facility did not make a reasonable effort to communicate with Resident A's family. Due to this, a preponderance of evidence does exist to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 1/15/22, the facility was insufficiently staffed with 20 residents and only 1 caregiver.

INVESTIGATION: On 2/2/22, I received a BCAL online complaint stating that the facility had approximately twenty residents and only one caregiver working.

On 2/17/22, I made an unannounced onsite investigation to the facility. I spoke to the supervisor of the facility, Madison Williams. Ms. Williams confirmed that the facility has approximately 13 residents today. Around the time that Resident A was in the facility, Ms. Williams confirmed that the facility was near capacity (20 residents). Ms. Williams acknowledged the facility has had issues with staffing. Despite this, she stated that the facility has never had only one caregiver on the floor by themself. Per Ms. Williams, the facility always has 2-3 staff members working.

After speaking to Ms. Williams, I spoke to direct care worker, Tommy Stornello. He was unable to provide any knowledge related to potential staffing issues as he does work at the facility often. Mr. Stornello later clarified that he has never worked alone at the facility and Riverstone staffing issues was "usually good," except for some 3rd shifts due to staff members calling off. I then spoke to the executive director, Tami McKellar. Ms. McKellar provided me with a staff schedule for Riverstone. Specially, for the day in question, which was 1/15/22. The staff schedule confirmed that there were there were two people scheduled to work each shift that day.

On 03/04/22, I conducted an exit conference with licensee designee, Tami McKellar. She was informed of the investigative findings and denied having any questions.

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:	Ms. Williams confirmed that the facility was near capacity (approximately 20 residents) when Resident A was living there. She stated that the facility always has 2-3 staff members working despite their staffing challenges. Ms. McKellar provided me with a copy of the staff schedule for 1/15/22. I reviewed the schedule, which confirmed that the facility had at two staff members scheduled to work each shift this day. Therefore, a preponderance of evidence does not exist to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was neglected.

INVESTIGATION: On 2/2/22, I received a BCAL online complaint stating that Resident A was neglected while under the care of American house, as well as Interim Healthcare. The allegations included staff not attending to his coccyx wound, Resident A not being seeing by a doctor in 2 months, no evidence of close monitoring in the event that Resident A needed comfort medication, and gaps in documentation suggestion that Resident A received insufficient care.

On 2/17/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to the executive director, Tami McKellar. Ms. McKellar informed me that Resident A's daughter, who resides in Florida has requested records from the facility and Pine Rest. Ms. McKellar stated that the American House Vice President of Wellness is in the process of providing the requested documentation to be sent out to the family.

I then spoke to the supervisor of the facility, Madison Williams. Ms. Williams confirmed that Resident A did in fact have a coccyx wound. During the time that Resident A had his coccyx wound, he contracted Covid-19 and started to decline. Due to Resident A's decline, Ms. Williams stated that she felt it was time for a hospice consultation, to which Dr. Elami agreed. Ms. Williams stated that Dr. Elami provided an order to follow-up with hospice, which staff at the facility did. I reviewed a copy of a 'Physician Order Sheet,' signed by Dr. Elami on 12/28/21 stating, "please d/c psych nursing. Eval for wound care services. Dx: buttocks wound." Ms. Williams stated that once Resident A contracted Covid, "he declined rapidly." Ms. Williams stated that Resident A having Covid and being stationary caused his wound to get worse. Ms. Williams stated that Resident A was put on Hospice sometime after Christmas 2021.

During Resident A's time on hospice, Ms. Williams stated that she spoke to Resident A's daughter via phone and answered a lot of questions as she could. Ms. Williams stated that she was also facetiming with Resident A's daughter, allowing her to see

Resident A. Ms. Williams stated that she also sent Resident A's daughter pictures of Interim Healthcare notes when she could. Ms. Williams stated that Resident A was in pain and she kept him comfortable. Ms. Williams stated that she would change Resident A every 30 minutes to an hour. Ms. Williams stated, "we take care of their loved ones and families don't understand what we go through. We would never hurt them," referring to Resident A. I asked Ms. Williams if she was responsible for treating Resident A's coccyx wound when she reportedly changed him every 30 minutes to an hour. Ms. Williams stated that staff at American House were not able to treat his wound. Instead, treatment of Resident A's wound was strictly done by Interim Healthcare. Prior to Resident A receiving wound treatment from Interim Healthcare, staff at American House applied ointment and bandages. Ms. Williams stated that after hospice signed on, staff at the facility were no longer allowed to care for Resident A's wound.

Ms. Williams stated that after Interim Healthcare signed on to care for Resident A's wound, it took them approximately four days to come assess his wound. Ms. Williams stated that hospice typically assess their patients within 24-48 hours. Ms. Williams stated that Interim healthcare signed on around the holidays to provide care to Resident A. Ms. Williams was unable to state exactly when wound care started from Interim Healthcare.

Despite Resident A's hospice admission around the holidays, Ms. Williams confirmed that in early December, Resident A did not present with the same issues. Ms. Williams stated that Resident A is a diabetic and he often refused his medication when he was healthy.

It should be noted that the allegations state that Ms. Williams told Resident A's daughter that she contracted Covid-19 when Resident A had his coccyx wound. As a result of contracting Covid-19, Ms. Williams reportedly told Resident A's daughter that she had to go into isolation for two weeks. Prior to going into isolation, Resident A's wound was a stage 1. Reportedly upon Ms. Williams' return, Resident A's wound had progressed to stage 4. Ms. Williams stated that she never told Resident A's daughter that she contracted Covid-19 and needed to isolate. Instead, Ms. Williams stated that she had a couple days off work, no more than 3 days and when she returned to work the wound was worse.

Regarding Interim Healthcare treatment for Resident A's wound, Ms. Williams stated that they were coming to the facility approximately twice a week to care for the wound. Ms. Williams stated that she was on-call at one point and spoke to the staff at Interim, informing them that they need to be at the facility daily to treat Resident A's wound due to it leaking. Ms. Williams stated that Interim Healthcare did not provide American House staff with any training to provide the appropriate care for Resident A's wound as American House staff are not allowed to care for the wound after hospice signs on.

Ms. Williams acknowledged that some of the documentation submitted to me, specifically 'observation notes' regarding Resident A's care from American House staff is "skippy." She expanded on her statement by stating that sometimes, staff forget to enter in an observation note for Resident A. Despite the gaps in Resident A's observation notes, Ms. Williams assured me that Resident A received care. Ms. Williams stated that everyone in the facility receives observation notes daily. Although it is concerning that there are several days with no documentation regarding Resident A's care from the facility, this is an internal process as opposed to a licensing requirement.

After speaking to Ms. Williams, I spoke to direct care worker, Tommy Stornello. Mr. Stornello stated that he believes he was made aware of Resident A's wound sometime around the first week of January. Mr. Stornello stated that he never spoke to Resident A's family about the wound. Instead, he did speak to his colleague, Ms. Williams. Mr. Stornello stated that he told Ms. Williams that Resident A's wound looked like it got worse. Ms. Williams reportedly told Mr. Stornello that she would address it, which is when she reportedly got ahold of hospice for wound care. Although a specific time frame is uncertain, Mr. Stornello recalled putting a new dressing on Resident A's coccyx wound after he had a bowl movement. Mr. Stornello stated that he applied the dressing to the wound as a barrier. Staff at the facility eventually applied zinc to the wound as well. Mr. Stornello stated that hospice staff said if the wound became soiled, staff at American House could apply a new bandage although it was primarily hospice job. Mr. Stornello stated that Resident A was incontinent and his dressing was wet from that and a bowel movement, which led to him changing the dressing. Mr. Stornello stated that he was never trained by hospice to care for Resident A's wound and he is unsure if other staff were.

Mr. Stornello confirmed that it appeared as if Resident A was doing well after he returned to the facility from Pine Rest in early December. Although Resident A was doing well, Mr. Stornello described Resident A as being lethargic but he was taking his medication and his behaviors improved. Mr. Stornello stated that Resident A eventually went to the hospital due to contracting Covid-19, at which point Mr. Stornello noticed Resident A starting to decline. Mr. Stornello stated that around 12/31/21, he spoke to Resident A's daughter via phone and tried directing her to Ms. Williams and hospice. Resident A's daughter reportedly asked him if Resident A was going to pass away. Mr. Stornello stated that he didn't think Resident A would pass away and that he felt Resident A's presentation was related to Covid-19.

Resident A's 'Uniform Evaluation Tool" was observed, which is also known as the resident's assessment plan. There was nothing documented indicating that American House doctor was to see Resident A periodically or that American House staff was responsible for providing wound care. The assessment plan did state Resident A "requires at least weekly visual monitoring of skin impairments. Examples are diabetic feet or incontinence related excoriation."

On 03/04/22, I conducted an exit conference with licensee designee, Tami McKellar. She was informed of the investigative findings and denied having any questions.

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:	Resident A's assessment plan included no indication that American House staff were responsible for providing wound care. Ms. Williams and Mr. Stornello were both adamant that Interim Healthcare was responsible for providing wound care for Resident A. There was also no indication that American House doctors were required to assess Resident A periodically. Therefore, there is not a preponderance of evidence to support that American House was not providing Resident A care as specified in his assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A lost a substantial amount of weight within a short period of time.

INVESTIGATION: On 2/17/22, I made an onsite investigation to the facility. I spoke to Ms. Williams regarding Resident A's weight loss. Ms. Williams stated that Resident A had been losing weight since he's been at American House. Per Ms. Williams, Resident A weighed 116 pounds the last time he was weighed. Ms. Williams stated that Resident A was a good eater until the last month of his life. Ms. Williams stated that Resident A lost weight when he returned from his Pine Rest Psychiatric Hospital in December 2021.

Mr. Stornello was asked about his knowledge of Resident A's weight loss as well. Mr. Stornello stated that he was made aware of the weight loss in January while speaking to Ms. Williams. However, he is unsure as to how much weight Resident A lost. Mr. Stornello stated that he witnessed Resident A refusing food and medications often. Mr. Stornello stated that when Resident A did take his food, it looked as if he would poor liquids into it as opposed to eating it. Mr. Stornello stated that Resident A would tell staff no or curse at them when refusing.

Due to concerns of Resident A's weight, I requested a copy of Resident A's weight record for the last several months from the facility. Ms. McKellar provided me with

his weight record from July 2021 through January 2022. Per the weight record, Resident A weighed 160 pounds between July 2021-September 2021. There was no weight recorded for the month of October. Resident A's next weight was recorded on 11/1/21, which was listed at 125 pounds, indicating that in a two-month period, he lost approximately 35 pounds. Ms. McKellar stated that Resident A had a history of refusing to eat. In addition to this, Ms. McKellar stated that Resident A contracted Covid-19 in November 2021, which she feels contributed to his weight loss.

It should be noted that Resident A was admitted to Pine Rest Psychiatric hospital from 11/12/21 to 12/6/21 for increased aggressive behavior and refusing to take his medication. Resident A weighed 146 pounds when he was at Pine Rest per records review. 3 days after discharging from Pine Rest (12/9/21), Resident A was sent at Mercy Health Saint Mary's Emergency room for a fall. During that visit, records indicated that he weighed 156 pounds. On 12/19/21, resident A was seen in the ED again for 'altered mental status' and Covid-19. During this visit, Resident A weighed 155 pounds. The documentation that was reviewed showed some discrepancies in Resident A's weight or significant weight changes in a short period of time.

On 03/04/22, I conducted an exit conference with licensee designee, Tami McKellar. She was informed of the investigative findings and agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Ms. McKellar provided me with a copy of Resident A's weight records between July 2021 and January 2022. There was no weight recorded for the month of October 2021. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegations listed above, I reviewed Resident A's assessment plan. While doing so, I observed that the assessment plan was not signed by his guardian or the licensee designee.

On 03/04/22, I conducted an exit conference with licensee designee, Tami McKellar. She was informed of the investigative finding and agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's assessment plan detailed his level of supervision and personal care. However, the assessment plan was not signed by Resident A's guardian or the licensee designee, Tami McKellar. Therefore, a preponderance of evidence exists to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

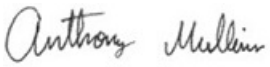
INVESTIGATION: During the process of investigating the above allegations, it was determined that I had not received an incident report from staff regarding Resident A's death. During my unannounced onsite investigation, I spoke to the wellness director, Carrie Arp. I asked Ms. Arp if she sent me an incident report to inform me of Resident A's passing. Ms. Arp confirmed that she did not send an incident report to me due to Resident A being on Hospice. I then explained to Ms. Arp that regardless of a resident's hospice status, licensing rules requires that an incident report is sent.

On 03/04/22, I conducted an exit conference with licensee designee, Tami McKellar. She was informed of the investigative finding and agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1)(a) The death of a resident.
ANALYSIS:	Ms. Arp acknowledged that she failed to send me an incident report to inform me of Resident A's passing. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

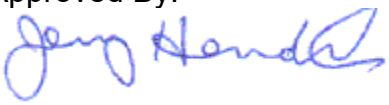
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



03/04/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



03/04/2022

Jerry Hendrick Date
Area Manager