STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

March 18, 2022

Anna Hinton
Pioneer Resources
Suite 100
601 Terrace St.
Muskegon, MI 49440

RE: License #:	AS610237359
Investigation #:	2022A0356016
	Riverwood

Dear Ms. Hinton:

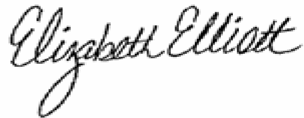
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610237359
Investigation #:	2022A0356016
Complaint Receipt Date:	01/21/2022
Investigation Initiation Date:	01/21/2022
Report Due Date:	03/22/2022
Licensee Name:	Pioneer Resources
Licensee Address:	Suite 100 601 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(231) 773-5355
Administrator:	Anna Hinton
Licensee Designee:	Anna Hinton
Name of Facility:	Riverwood
Facility Address:	2743 S Riverwood Twin Lake, MI 49457
Facility Telephone #:	(231) 773-5355
Original Issuance Date:	08/08/2001
License Status:	REGULAR
Effective Date:	02/20/2020
Expiration Date:	02/19/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Destiny Davis used a gait belt to restrain Resident A to a dining room chair.	Yes
Some of Resident A's medication, Klonopin, a controlled substance, is unaccounted for.	Yes
Unknown staff grabbed Resident B's arms causing bruises.	No
Additional Finding	Yes

III. METHODOLOGY

01/21/2022	Special Investigation Intake 2022A0356016
01/21/2022	Special Investigation Initiated - Telephone APS-Ken Beckman, Muskegon DHHS.
01/21/2022	APS Referral Ken Beckman investigating.
01/21/2022	Contact - Document Received Incident Reports
01/25/2022	Contact - Document Sent Ken Beckman re: contact info for staff.
02/04/2022	Contact - Telephone call made Kory Bickford re: Resident A & B.
02/04/2022	Contact - Telephone call made Sarah Cunningham, RN, Health West.
02/08/2022	Inspection Completed On-site via zoom due to COVID19 in the home. Interviewed Kory Bickford, Anna Hinton, Licensee Designee.
02/08/2022	Contact - Document Sent Anna Hinton, LD.
02/14/2022	Contact - Document Sent Larry Spataro, ORR, Health West.

02/14/2022	Contact - Telephone call made APS-Ken Beckman.
02/14/2022	Contact-Document received Anna Hinton, LD
02/16/2022	Contact - Telephone call made Staff interview: Destiny Davis.
02/16/2022	Contact - Document Received Facility documents sent by Kory Bickford.
02/17/2022	Contact - Telephone call made Staff interviews: Tracy Cross, Tami Grasmeyer, Alice Ostrander, Jeff Taylor, and Samantha Fernandez.
02/18/2022	Contact-Document received Larry Spataro-ORR report-substantiated.
03/11/2022	Contact-Document received Ken Beckman-APS, status report-substantiated.
03/17/2022	Exit conference-Anna Hinton, Licensee Designee.

ALLEGATION: Staff Destiny Davis used a gait belt to restrain Resident A to a dining room chair.

INVESTIGATION: On 01/21/2022, I received a complaint from MDHHS (Michigan Department of Health and Human Services) APS (Adult Protective Services) reporting that on 01/19/2022, Resident A was observed restrained to a chair at the facility. Resident A had a gait belt around his chest area which was holding him to the chair. The complainant reported the gait belt was tied behind the chair so Resident A was not able to get out of it, even if the gait belt was tied in front of Resident A, he still would not be able to get out of it due to his severe mental disability. The complainant reported restraining Resident A is not in his treatment plan. Resident A was restrained so he would eat all of his dinner, Resident A has no problem eating his food on a regular basis. The complainant reported the staff that restrained Resident A was Destiny Davis. She is still employed with the facility however, an internal investigation is ongoing. Resident A was not injured as a result of the restraint. APS Worker, Ken Beckman has an open investigation.

On 01/21/2022, I interviewed Mr. Beckman via telephone. Mr. Beckman stated no injuries were noted by Health West RN (registered nurse) Sarah Cunningham, she went to the facility and checked on Resident A. Mr. Beckman stated home manager, Kory Bickford entered the facility on 01/19/2022 and observed Resident A restrained to the dining room chair with a gait belt around his chest. Mr. Beckman stated Ms.

Davis was suspended pending the outcome of the investigation, all reports were filed, and APS has an open investigation.

On 01/21/2022, I reviewed the IR (Incident Report) dated 01/19/2022, written by Kory Bickford on 01/20/22. The IR documents the incident occurred on 01/19/2022 at 6:30p.m. Ms. Bickford documented the following information, *'I, Kory Bickford, walked into the Riverwood home and noticed that (Resident A) was restrained to a dining room chair with a large vinyl blue belt. I asked why he was belted to the chair. Destiny stated that staff Tami Grasmeyer told her to use the belt so he will eat all of his dinner. That "they" do this all the time. I have never seen this belt nor its use on (Resident A), nor does he have a plan in place for its use. The belt was removed, and I put the belt in my office and told Destiny and Samantha that it is not to be used. I checked (Resident A) over for any injuries. He did not appear to have any injuries nor marks on his person. I called my Supervisor Anna Hinton, Director of Residential Program, I contacted (Resident A's) guardian, Terri McLellan and explained the situation to her. I left a message for nurse at HeathWest, Supports Coordinator and filed a recipient rights complaint. I am also taking measures to correct staff. Which could lead up to termination. Anna Hinton and I are going to find out where the idea of belting (Resident A) to the chair originated from and take proper corrective action. I will also post a memo stating necessary information.'*

On 02/04/2022, I conducted the special investigation via virtual meetings and telephone calls due to COVID19 positive cases. I did not interview Resident A in regard to this allegation as Resident A is nonverbal and unable to provide pertinent information due to cognitive impairment.

On 02/04/2022, I interviewed Sarah Cunningham, Health West RN via telephone. Ms. Cunningham stated she received an IR (Incident Report) from Resident A's Health West supports coordinator, Carly Campbell, submitted to Ms. Campbell and written by Ms. Bickford on 01/19/2022. Ms. Cunningham stated she responded by going to the facility on 01/21/2022 and checked Resident A over for injury, which there were none. Ms. Cunningham stated according to the IR she reviewed, Ms. Davis reported that experienced staff, Tami Grasmeyer told new staff they use the gait belt to keep Resident A in a chair to eat. Ms. Cunningham stated Ms. Davis reported that is why she used that method.

On 02/08/2022, I interviewed Ms. Bickford by virtual means and Ms. Hinton, Licensee Designee was present during this meeting. Ms. Bickford stated she walked into the facility on 01/19/2022 at 6:30p.m. and observed Resident A restrained to a chair with a posey gait belt (a belt to assist with transferring residents with mobility issues, Resident A does not have mobility issues). Ms. Bickford stated direct care workers (DCWs) Destiny Davis and Samantha Fernandez were on duty. Ms. Bickford stated she asked the DCWs why Resident A had a gait belt around him at the dining room table and Ms. Davis responded that it was to assist him with staying at the table so he would eat all of his dinner. Ms. Bickford stated it is common for Resident A to walk around while he is eating, he stops back at the table and gets

more food and then walks. He does not sit at the table to eat his meals even though staff do try to get him to do that. Ms. Bickford stated the belt was situated between Resident A's waist and chest and dinner is served at 5:00p.m. and this was 6:30p.m. Ms. Bickford stated staff told her when dinner was served, Resident A was not restrained. Ms. Bickford stated Resident A is non communicative and unable to provide information pertinent to this investigation. Ms. Bickford stated Office of Recipient Rights Officer, Larry Spataro has been out to investigate this allegation.

On 02/14/2022, I corresponded with Ms. Hinton via email. Ms. Hinton documented that Ms. Davis reported that Tami (Grasmeyer) told her she could use the gait belt on Resident A so he would eat all of his food. She stated "Tami told us that she never said that to Destiny, nor has she ever tied him to the chair herself. Destiny knew better than to think it was ok to do this, we all know (Resident A) has absolutely no problem eating all of his food." Ms. Hinton stated Ms. Davis has been working at the facility since last summer 2021 and completed the same training as all other DCWs. Ms. Hinton stated Ms. Davis used what is called a "posey gait belt" to secure Resident A in a chair at the dining room table in an attempt to get him to eat all his food at one sitting and this method is not taught to any DCWs.

On 02/16/2022, I interviewed Ms. Davis via telephone. Ms. Davis stated she sat Resident A down for dinner and put the belt on him and another employee showed her how to do it. Ms. Davis stated the gait belt was in his closet and she "thought it was an idea for him to eat his meal" and that it'd be a good way to get him to stay seated. Ms. Davis stated Resident A was only belted in the chair for 15 minutes before Ms. Bickford arrived and asked who "did this?" Ms. Davis stated she told Ms. Bickford she did it and that a more experienced staff had shown her how to do it. Ms. Davis stated she is not the only DCW that uses this method to keep Resident A in his chair at mealtime. Ms. Davis stated the gait belt is used around Resident A's waist and the belt is not tight. Ms. Davis stated she did not know the belt was not Resident A's belt, he would go along with being belted into the chair and he "didn't fight it." Ms. Davis stated one of the staff that showed her how to do this does not work at the facility anymore and the other experienced staff is Tami Grasmeyer. Ms. Davis stated, "yes, I used the gait belt to get him (Resident A) to sit in the chair to eat dinner."

On 02/16/2022, I received and reviewed Resident A's Behavior Support Plan dated 09/15/2021 and signed by Brian Plumhoff, LPC, QIDP, Master's Level Clinician from Health West (mental health). The plan does not include any information regarding the use of assistive devices or restraints for Resident A.

On 02/16/2022, I received and reviewed Resident A's assessment plan for AFC residents. The assessment plan documents Resident A requires assistance with eating/feeding and describes assistance as follows, '*will take food off others plates or put his food on theirs, staff must monitor, remind to sit during meals, chopped diet-Healthcare guideline in place for PICA.'* The assessment plan does not document any information regarding the use of assistive devices for eating. The

assessment plan documents Resident A does not require the use of any assistive devices such as a gait belt.

On 02/17/2022, I interviewed DCW Tracy Cross via telephone. Ms. Cross stated staff “never” use a restraint, gait belt, any device to keep a resident in a chair to eat a meal. Ms. Cross stated she has never seen any staff do this and she has never done this. Ms. Cross stated they are not trained to use any device to keep a resident in a chair. Ms. Cross stated the experienced workers in the facility would never train a newer staff to use this method to keep a resident in a chair. Ms. Cross stated the residents are served dinner between 5:00-5:30p.m. and there would be no food in front of Resident A at 6:00-6:30p.m. because dinner is done and cleaned up by then. Ms. Cross stated Resident A does “drive by eating” which is where he walks around constantly but approaches the table, eats some food, and then continues walking, that is how he does it and they do not have any problems with Resident A eating and finishing his meals. Ms. Cross stated Samantha Fernandez was a brand new DCW on duty on 01/19/2022 with Ms. Davis.

On 02/17/2022, I interviewed DCW Tami Grasmeyer via telephone. Ms. Grasmeyer stated she has never used or seen any other staff use a gait belt to make Resident A, or any other resident at the facility, sit in a chair. Ms. Grasmeyer stated she never taught new staff this method for any reason. Ms. Grasmeyer does not know why Ms. Davis would report that she trained her to use a gait belt in this manner.

On 02/17/2022, I interviewed DCW’s Alice Ostrander & Jeff Taylor independently via telephone. Ms. Ostrander and Mr. Taylor stated they have never seen any other staff, nor have they used a gait belt on Resident A to keep him in a chair for meals. Ms. Ostrander stated the only time a gait belt is used to assist a resident for any reason, is if it is documented in the resident’s assessment plan and PCP (person centered plan). Ms. Ostrander and Mr. Taylor stated they were never trained to use a gait belt to restrain a resident or Resident A in a chair, nor have they ever trained new staff to use a gait belt in that manner.

On 02/17/2022, I interviewed Samantha Fernandez via telephone. Ms. Fernandez stated that she was working with Ms. Davis on 01/19/2022 but that she was in the kitchen and did not see anything that happened regarding a gait belt and Resident A in the dining room. Ms. Fernandez stated she is a new DCW and was never trained by any of the experienced staff or throughout any CMH (community mental health, Health West) training she has had on using a gait belt to keep Resident A or any of the residents seated.

On 02/18/2022, Mr. Spataro substantiated the ORR report for “restraint.”

On 03/11/2022, Mr. Beckman substantiated the APS case.

On 03/17/2022, I conducted an Exit Conference with Ms. Hinton via telephone. Ms. Hinton stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14305	**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:	The complainant reported Resident A was secured to a chair by a gait belt. The complainant reported using this method is not in Resident A's treatment plan. Mr. Beckman reported Ms. Bickford observed Resident A with a gait belt around his chest attached to a chair. The IR documents on 01/19/2022 Ms. Bickford observed Resident A restrained to a dining room chair with a large vinyl blue belt. Ms. Bickford, Ms. Hinton, Ms. Cross, Ms. Ostrander, and Mr. Taylor reported they have never seen a gait belt used on Resident A and they have never used that method or taught new staff to use that method on Resident A. Ms. Davis stated Ms. Grasmeyer showed her how to secure Resident A by using a gait belt. Ms. Davis acknowledged she used a gait belt to keep Resident A in a dining room chair. Ms. Grasmeyer stated she has never taught Ms. Davis or any new DCW to use a gait belt on any resident including Resident A. Ms. Grasmeyer stated she has never used a gait belt to secure Resident A in a chair nor has she seen any other DCW use a gait belt on Resident A. Ms. Fernandez acknowledged she was working with Ms. Davis on 01/19/2022 but stated she did not see Ms. Davis use a gait belt on Resident A to keep him seated in a chair. Ms. Fernandez stated she has not been taught to use a gait belt in this manner nor has she seen any of the DCWs using this method to keep Resident A seated.

	Resident A's Behavior Support Plan does not include any information regarding the use of assistive devices or restraints for Resident A. Resident A's assessment plan does not document any information regarding the use of assistive devices for eating and Resident A does not require the use of any assistive devices such as a gait belt. Based on investigative findings, there is a preponderance of evidence to show that on 01/19/2022, Resident A was secured to a chair at the facility by Ms. Davis with the use of a gait belt. Resident A's PCP or assessment plan does not document the use of a gait belt for Resident A for any reason. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Some of Resident A's medication, Klonopin, a controlled substance, is unaccounted for.

INVESTIGATION: On 01/21/2022, I reviewed an IR dated 01/19/2022 written by Ms. Bickford. Ms. Bickford documented the staff *'involved/witness' to the incident as Ms. Cross, Ms. Grasmeyer, Mr. Taylor, and Ms. Ostrander on 01/18/2022. The IR documents the following information, 'When medication count was done on 01/17/2022 for (Resident A's) Klonopin .5mg, there were 69 remaining at 10 p.m. on 01/18/2022, 6 a.m. count was 67, leaving two pills missing. Staff call home supervisor, nurse, wrote IR. Home supervisor spoke to nurse who informed supervisor to make a police report. Filed a police report with Muskegon County officer Bush. Supervisor to put in effect updated procedures with med counting and med cabinet key responsibility.'*

On 02/04/2022, I interviewed Sarah Cunningham, Health West RN via telephone. Ms. Cunningham stated she received the IR written by Ms. Bickford documenting Resident A's missing Klonopin medications. Ms. Cunningham followed-up at the facility on 01/21/2022 and stated there were no notes on why the Klonopin was missing, there is no reason why any pills should be gone, there is documentation of Resident A's Klonopin being administered to Resident A on 01/17/2022 and 01/18/2022 but the medication count for the Klonopin was off by two pills. Ms. Cunningham stated, "it seemed weird to me that double counts are almost always done except the morning that they went missing," documentation and following medication protocol was not done properly by staff at the facility.

On 02/08/2022, I interviewed Ms. Bickford via virtual means, Ms. Hinton attended this meeting. Ms. Bickford stated she does not know what happened with the missing Klonopin tablets but all four DCWs documented on the IR, Ms. Cross, Ms.

Grasmeyer, Mr. Taylor, and Ms. Ostrander handle the keys to the medication cart. Ms. Bickford stated she has changed the protocol for handling the keys to the medication cart, the med passer has to sign the keys in and out and keep the keys on their person during the entire shift. Ms. Bickford stated they have reinstated two staff counting the medications rather than just 1 staff doing the counts.

On 02/16/2022, I interviewed Ms. Davis via telephone. Ms. Davis stated she typically works 2nd shift and is new to administering medications to residents. On the evening of 01/17/2022, she was at the facility when "this incident happened" (meaning when the medication count was taking place), Ms. Davis stated she was done with her shift but still at the facility and thought "maybe I did a med error" but Ms. Bickford said, "I did everything ok so I don't know what happened."

On 02/16/2022, I received and reviewed the MAR (medication administration record) for the month of January 2022 for Resident A. Resident A's Clonazepam (Klonopin), 0.5 mg, take one tablet by mouth three times daily, 30 days. The MAR is signed as administered by staff every day for the month at 8:00 a.m., 4:00 p.m. and 8:00 p.m. except for 01/15/2022 at 4:00 p.m. where there is no staff signature indicating the medication had been administered. In addition, the MAR shows a time of 12:00 p.m. for administration but that was crossed out and no staff signatures were on the MAR for that time of day.

On 02/16/2022, I received and reviewed the medication count log for the month of January 2022. This document showed each time the medication Klonopin was administered to Resident A with a running count down of the number of tablets left. On 01/17/2022 the document showed a count of 69 pills at 10:00 p.m. and at the 6:00 a.m. count there were 67 pills. The document is signed by staff, Ms. Cross, Ms. Grasmeyer and Mr. Taylor along with an agency staff, Erin Perry who signed as counting the medications on 01/17/2022 and 01/18/2022.

On 02/17/2022, I interviewed DCW Tracy Cross via telephone. Ms. Cross stated she works 3rd shift and on 01/17/2022 at the beginning of her shift, she counted with Mr. Taylor (from 2nd shift) and got a count of 69 Klonopin for Resident A. Ms. Cross stated then, when 1st shift came in, she conducted a count at 6:00 a.m. on 01/18/2022 with Ms. Grasmeyer and there were only 67 Klonopin pills. Ms. Cross stated, "I know this looks bad for me, but I did not do it, I know it was on my shift, but I did not do it." Ms. Cross stated she looked everywhere for the missing medications and could not find them anywhere. Ms. Cross stated after she and Mr. Taylor concluded the medication count, the only other person in the facility was Ms. Davis. Ms. Cross stated Ms. Davis was still at the facility after her shift ended on 01/17/2022 because she was waiting for a ride, she was present when the medications were counted, and she sat in the medication room alone waiting for her ride and the medication cart keys were available.

On 02/17/2022, I interviewed DCW Tami Grasmeyer via telephone. Ms. Grasmeyer stated when she began her 1st shift duties on 01/18/2022, Ms. Cross left and she

(Ms. Grasmeyer), Ms. Bickford and Ms. Ostrander looked for the missing pills but were unable to find them. Ms. Grasmeyer stated Ms. Bickford filed a police report and when Ms. Davis came in for 2nd shift, "we were counting meds together and I told her a police report was made." Ms. Grasmeyer stated that is when Ms. Davis said, "uh oh, I think I accidentally did something. I think I accidentally gave him (Resident A) too much of something, but I don't know which one it was." Ms. Grasmeyer stated she tried to get Ms. Davis to show her what medication she (Ms. Davis) thought she gave Resident A too much of, but Ms. Davis could not tell her (Ms. Grasmeyer) what medication it was.

On 02/17/2022, I interviewed Ms. Ostrander via telephone. Ms. Ostrander stated she came on to 1st shift with Ms. Grasmeyer on 01/18/2022. Ms. Ostrander stated Ms. Cross caught the count being off and later in the day when Ms. Davis came on her shift, she heard Ms. Davis say she may have made a medication error. Ms. Ostrander stated now there is a new protocol in place to count the medications to prevent this from happening in the future. Ms. Ostrander explained when each shift prepares to leave and the next shift comes on duty, both med leads count the pills together and initial the med count sheet, keeping a running total. Ms. Ostrander stated the medication cart keys are on "our person" and signed out each shift to the med lead who keeps track of the keys their entire shift.

On 02/17/2022, I interviewed Mr. Taylor via telephone. Mr. Taylor stated he conducted the Klonopin count with Ms. Cross on 01/17/2022 and the count came out correct at 69 pills. Mr. Taylor stated the medications are counted together each shift with the next shift. Mr. Taylor stated Resident A is administered Klonopin 4 times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. Mr. Taylor stated he does not know what happened to the medications that were missing.

On 03/17/2022, I conducted an Exit Conference with Ms. Hinton via telephone. Ms. Hinton stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	An IR dated 01/19/2022 documents 2 Klonopin tablets missing from Resident A's medication count. Ms. Bickford and Ms. Hinton reported the 2 Klonopin tablets missing from Resident A's medications and there is no documentation as to what may have happened to those tablets. Ms. Cunningham stated documentation and medication protocol was not done properly and 2 of Resident A's Klonopin tablets are unaccounted for. Ms. Davis stated she may have made a medication error, but she does not know what happened to the 2 unaccounted for Klonopin medications for Resident A. Resident A's MAR for January 2022, Klonopin 0.5 mg is signed as administered by staff every day for the month except for 01/15/2022 at 4:00 p.m. where there is no staff signature indicating the medication had been administered. The count log showed on 01/17/2022 a count of 69 pills at 10:00 p.m. and at the 6:00 a.m. count there were 67 pills. Ms. Cross, Ms. Grasmeyer, Ms. Ostrander, and Mr. Taylor reported counting the medications and having knowledge that 2 of Resident A's Klonopin tablets went missing and remained unaccounted for but none of the DCW's know what happened to the medication. Based on investigative findings, there is a preponderance of evidence to show that 2 of Resident A's Klonopin, 0.5 mg tablets were unaccounted for from 10 p.m. on 01/17/2022 to 6:00 a.m. on 01/18/2022 and remained unaccounted for. In addition, on 01/15/2022, Resident A's 4:00 Klonopin tablet was not signed by staff as administered on the MAR. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Unknown staff grabbed Resident B's arms causing bruises.

INVESTIGATION: On 01/21/2022, I reviewed an IR dated 01/19/2022, written by Kory Bickford and documented Ms. Ostrander as '*other person involved/witness*.' The IR documents the following information, *'I noticed that (Resident B) had two small circle shaped bruises. One on each forearm, it appeared to be thumb prints like someone had grabbed or held on to her. I looked (Resident B) over for any other*

injuries, she didn't have any. Nor did she seem to be in any pain or distress. Home supervisor will remind staff that we are to gently guide and are to never use force.'

On 02/04/2022, I interviewed Ms. Cunningham stated she checked Resident B on 01/21/2022 for injury and viewed the small bruises on Resident B's forearms. Ms. Cunningham stated the bruises did appear to look like thumb marks where someone may have been holding on to Resident B by the forearms tightly. Ms. Cunningham stated Resident B had no other marks or injuries.

On 02/04/2022, I received and viewed pictures of Resident B's forearms. The pictures depict reportedly Resident B's arms with a small bruise visible on Resident B's right forearm and a slightly larger bruise on the upper part of the inner left forearm. The bruises are light but visible and the bruise on the right arm is round and the bruise on the left arm is oblong.

On 02/08/2022, I interviewed Ms. Bickford virtually with Ms. Hinton present. Ms. Bickford stated she noticed little bruises on both of Resident B's forearms. They were concerning because Resident B can be stubborn and pushy with staff, and the bruises appeared to be finger marks as though someone grabbed on to her forearms. Ms. Bickford stated Ms. Ostrander told her she did not notice the bruises on Resident B's forearms. Ms. Bickford stated Resident B is non communicative and ambulatory, so she does bump into things as she walks. Ms. Bickford stated Resident B sometimes grabs other residents which could be an explanation for the bruises. Ms. Bickford stated she took photos of the bruises and sent them to the nurse at Health West.

On 02/16/2022, I interviewed Ms. Davis via telephone. Ms. Davis stated she heard from other staff that Resident C pinched Resident B, but she (Ms. Davis) never saw any bruises on Resident B. Ms. Davis stated staff hold Resident B by her forearms to guide her while she walks. Ms. Davis stated maybe someone got frustrated and squeezed, "I don't know, I never saw staff do that." Ms. Davis stated staff walk with Resident B and when she (Ms. Davis) walks with Resident B she, "holds her by her wrists" because she has "poor balance, or I hold her by the back of her upper arms to keep her stable but not for long, just to keep her from falling, she can walk on her own once she's stable."

On 02/16/2022, I received and reviewed Resident B's assessment plan for AFC residents. The document shows that Resident B does control aggressive behavior but comments that Resident B will '*sometimes pinch others*.' The assessment plan also documents that Resident B '*exhibits self-injurious behaviors*' but then comments, *'Not that I have seen.'* The assessment plan documents under walking/mobility, '*when standing up, must stand for a minute before walking to gain balance, standby assist with gait belt or wheelchair (PRN-as needed) when in the community, unsteady days or unlevel ground. Avoid stairs as her gait is unsteady, has a history of falls and her bones break easily.'*

On 02/17/2022, I interviewed DCW Tracy Cross via telephone. Ms. Cross stated Resident B has an unsteady gait, she walks really fast and at times, she will fall. Ms. Cross stated if Resident B begins to fall, she will "grab whatever I can to prevent her from falling." Ms. Cross stated staff do not "guide" Resident B by holding on to her forearms, she has never done that, nor has she seen other staff do that. Ms. Cross stated she works 3rd shift, so she does not do much with Resident B because she is sleeping during her shift. Ms. Cross stated she did not see the bruises on Resident B's arms until another staff pointed them out to her. Ms. Cross stated Resident C is Resident B's roommate and Resident C pinches but, Ms. Cross stated she has never seen Resident C pinch Resident B. Ms. Cross stated it is "out of the ordinary" for Resident B to have bruises on her and she would not "put it past" Resident C to pinch someone but if staff have to guide Resident B, we put our arm under her arm at the armpit to guide her. Ms. Cross stated the only time anyone would "grab" Resident B is to prevent her from falling.

On 02/17/2022, I interviewed Ms. Grasmeyer via telephone. Ms. Grasmeyer stated she has never seen staff grab, pull or squeeze Resident B's arms. Ms. Grasmeyer stated Resident B is capable of ambulating independently and does not need anyone to hold on to her. Ms. Grasmeyer stated Resident A pulls at people and grabs at their arms, Resident C only pinches Resident A on occasion, Resident C is "motherly" and is like a "mother hen" to Resident B so she (Ms. Grasmeyer) does not see her pinching or grabbing Resident B.

On 02/17/2022, I interviewed Ms. Ostrander via telephone. Ms. Ostrander stated she noticed the bruises, that Resident B "grabs us (staff)" but never saw staff grab Resident B. Ms. Ostrander stated staff do not have to hold on to or guide Resident B, she can be guided verbally and without physical guidance. Ms. Ostrander stated she has never seen Resident C pinch other residents including Resident B and has never seen Resident A pull or grab at anyone in the facility. Ms. Ostrander stated it is out of the ordinary to see Resident B with bruises on her.

On 02/17/2022, I interviewed Mr. Taylor and Ms. Fernandez independently via telephone. Mr. Taylor and Ms. Fernandez stated they have never seen any other staff or residents grab, pinch, or pull Resident B. Mr. Taylor and Ms. Fernandez stated Resident C can get aggressive at times and scratch or pinch but never towards another resident. Mr. Taylor and Ms. Fernandez stated Resident B is capable of ambulating independently without the need for guidance from staff.

On 03/17/2022, I conducted an Exit Conference with Ms. Hinton via telephone. Ms. Hinton stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14305	**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:	Ms. Bickford wrote an IR and documented two small circle shaped bruises, one on each forearm on Resident B. Ms. Bickford documented the bruises appeared to be thumb or finger marks. Ms. Cunningham stated the bruises did appear to look like thumb marks where someone may have been holding on to Resident B by the forearms tightly. I observed from photos, bruises on Resident B's right and left forearms. Ms. Bickford stated Resident B is ambulatory, but she does bump into things as she walks, also, Resident A sometimes grabs other residents which could explain the bruises. Ms. Davis stated staff hold Resident B by her forearms to guide her while she walks. Ms. Davis stated she never saw any bruises on Resident B. Ms. Cross stated if Resident B begins to fall, she will "grab whatever I can to prevent her from falling." Ms. Cross stated staff do not "guide" Resident B by holding on to her forearms. Ms. Grasmeyer stated she has never seen staff grab, pull or squeeze Resident B's arms. Ms. Ostrander stated she has never seen staff grab or hold Resident B. Ms. Ostrander stated she has never seen Resident C pinch other residents including Resident B and has never seen Resident A pull or grab at anyone in the facility. Mr. Taylor and Ms. Fernandez stated they have never seen any other staff or residents grab, pinch, or pull Resident B. Resident B's assessment plan documents she sometimes pinches others and exhibits self-injurious behaviors. The

	assessment plan also documents Resident B's unsteady gait and need for standby assistance from staff for mobility at times. Based on investigative findings, there were visible bruises on Resident B's forearms, however, there is not a preponderance of evidence to show that staff caused the bruises or failed to protect Resident B from being bruised by another resident. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

Additional Finding

Investigation: On 02/16/2022, I received and reviewed Resident A's assessment plan for AFC residents dated 10/16/2019, the plan does not have any signatures for the Licensee Designee, Resident A's designated representative or responsible agency.

On 02/16/2022, I received and reviewed Resident B's assessment plan for AFC residents, the plan is dated 02/29/2021. The assessment plan is not signed by the Licensee Designee, Resident B's designated representative or responsible agency.

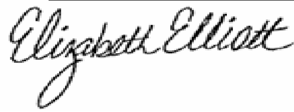
On 03/17/2022, I conducted an Exit Conference with Ms. Hinton via telephone. Ms. Hinton stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14301	**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 is outdated and not signed by the Licensee Designee, the resident's designated representative or the responsible agency. Resident B's assessment plan is not signed by the Licensee Designee, the resident's designated representative or the responsible agency.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



03/17/2022

Elizabeth Elliott Date
Licensing Consultant

Approved By:

03/18/2022

Jerry Hendrick Date
Area Manager