GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 12, 2022

Catherine Reese
New Friends Dementia Community, LLC
3700 W Michigan Ave
Kalamazoo, MI 49006

RE: License #: AL390299686
Investigation #: 2022A0581025
Vibrant Life Senior Living Kalamazoo 2

Dear Ms. Reese:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

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 #:	AL390299686
Investigation #:	2022A0581025
Complaint Receipt Date:	03/17/2022
Investigation Initiation Date:	03/21/2022
Report Due Date:	05/16/2022
Licensee Name:	New Friends Dementia Community, LLC
Licensee Address:	3700 W Michigan Ave Kalamazoo, MI 49006
Licensee Telephone #:	(734) 819-7790
Administrator:	Laurel Space
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Kalamazoo 2
Facility Address:	3712 W. Michigan Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 372-6100
Original Issuance Date:	06/21/2011
License Status:	REGULAR
Effective Date:	07/26/2021
Expiration Date:	07/25/2023
Capacity:	20

Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility isn't staffed sufficiently.	Yes
Resident C has bruises on her from direct care staff.	No
Incident reports aren't being completed, as required.	No
Resident narcotic medications are missing.	Yes
Residents do not have resident records, as required.	No
The facility has bed bugs that aren't being professionally treated.	No
Ceiling tiles are missing in facility hallway due to a leak.	Yes
Staff cannot access resident bedrooms when locked if they don't have bedroom keys.	Yes

III. METHODOLOGY

03/17/2022	Special Investigation Intake 2022A0581025
03/21/2022	Contact – Telephone call received AFC Consultant, Eli Deleon, reported he had received allegations for another Vibrant Life Lodge, but the allegations belonged to Lodge #2. Added additional allegations.
03/21/2022	Special Investigation Initiated - On Site Interviewed staff, Administrator, obtained documentation and requested documentation
03/22/2022	APS Referral - Via email
03/24/2022	Contact - Face to Face Completed another on-site inspection, observed residents
04/05/2022	Contact – Document Sent Email with APS specialist, Gene Coulter.
04/05/2022	Contact - Telephone call made Interview with direct care staff, Shelley Simmons
04/05/2022	Contact - Telephone call made Left voicemail for direct care staff, Marikka Troxler

04/05/2022	Contact – Document Received Email from Ms. Space containing Griffin Pest Control Solutions documentation.
04/08/2022	Contact - Telephone call received Received additional allegations concerning insufficient staff, water leaking from light in hallway, and staff being unable to enter resident bedrooms.
04/11/2022	Inspection Completed On-site Conducted unannounced on-site
04/12/2022	Contact - Document Received Received fire drills from Administrator, Ms. Space
04/14/2022	Contact - Document Received Received documentation via email from Administrator, Ms. Space
04/15/2022	Contact - Document Received Received additional documentation from Administrator, Ms. Space
04/17/2022	Inspection Completed On-site Interviewed staff, observed facility.
04/20/2022	Contact – Document Sent Requested for documentation from Griffin Pest Solutions.
05/03/2022	Contact – Document Sent Requested resident medication administration records
05/03/2022	Contact – Document Received Resident medication administration records
05/04/2022	Contact – Telephone call made Re-interview with direct care staff, Michael Riggle.
05/04/2022	Contact – Telephone call made Attempted to contact direct care staff, Brooke Dove. Unable to leave voicemail.
05/04/2022	Contact – Telephone call made Attempted interview with direct care staff, Hayle Taylor; however, telephone number was incorrect.
05/04/2022	Contact – Telephone call made

	Left message with direct care staff, Telisha Saunders.
05/04/2022	Contact – Telephone call made Interview with direct care staff, Anna Ludwig.
05/05/2022	Contact – Document Sent Requested resident Individual Plans of Service through the facility's ECP
05/09/2022	Contact – Document Received Resident IPOS' from facility's ECP.
05/11/2022	Exit Conference with licensee designee, Catherine Reese, via telephone.

ALLEGATIONS:

The facility isn't staffed sufficiently.

INVESTIGATION:

The complaint alleged the facility was insufficiently staffed. The complaint did not provide additional or specific information relating to what was occurring or was not occurring within the facility due to the facility being insufficiently staffed. Additionally, the complaint did not provide any specific dates where the facility was insufficiently staffed.

On 03/21/2022, 03/24/2022, 04/11/20220 and 04/17/2022, I completed unannounced on-site inspections at the facility. Specifically, the 04/17/2022 on-site inspection took place on Easter Sunday. During these inspections, I observed multiple direct care staff working, which included at least two direct care staff and an additional direct care staff assigned as the facility's medication passer for a total of three direct care staff working. I also observed additional staff working in the facility during the on-site inspections, such as the facility's activity's coordinator.

On 03/24/2022, I interviewed direct care staff, Anna Ludwig. Ms. Ludwig stated she usually works first shift (7 am – 3 pm) and there are usually three direct care staff working at the facility with one of these staff being identified as a medication passer; however, she indicated the medication passer would also assist with resident care. Ms. Ludwig indicated there were several residents who required two direct care staff members to assist with transfers and mobility such as Resident B and Resident E but indicated most residents were capable of ambulating without staff assistance.

On 04/11/2022, conducted an unannounced on-site inspection. I interviewed direct care staff member Michael Riggle, who reported staff often “call in”; however, there was at least two direct care staff working at the facility with one staff being identified as the facility’s medication passer. He indicated there were more staff during the day shifts due to activity staff also being present.

During the inspection, I also interviewed direct care staff, Jayla Carter, and Serena Ludy. Both Ms. Carter’s and Ms. Ludy’s statements to me regarding the number of staff working at the facility were consistent with Mr. Riggle’s statement to me.

On 04/11/2022, I requested a staff schedule for the facility from 03/12/2022 through 04/11/2022. Upon review of the schedule, there was only one direct care staff working at the facility for five overnight shifts (11 pm – 7 am) on 3/16, 3/18, 3/22, 4/02, and 4/10.

On 04/12/2022, I reviewed a 1st, 2nd, and 3rd shift fire drills for the facility, all dated 03/31/2022, which indicated there were 4, 5, and 3 direct care staff, respectively, who participated in each fire drill.

I also reviewed the facility’s *Resident Register*, which confirmed a total of 14 residents were residing in the facility during this time frame.

On 05/04/2022, I requested Ms. Space provide any additional documentation showing additional staff had been working at the facility where the schedule indicated only one direct care staff was working; however, no additional documentation was received.

On 05/06/2022, I reviewed the facility’s most updated *Individual Service Plans* (ISP) through their Extended Care Professional (ECP) online program for each of the 14 residents. According to these ISP’s, all the residents, except Resident A, E, L, and N, had a diagnosis of Dementia and/or Alzheimer’s.

According to each of their ISPs, all 14 residents, except Resident G, have “little to no understanding or ability with the evacuation process. Will need complete assistance to properly get through evacuation. Verbal and physical cueing necessary.”

Additionally, Resident A, C, and F require “physical and verbal assistance with walking needs. Requires hands-on assistance with getting up, using walking devices, and sitting down/laying down.”

Resident H and Resident L “needs complete supervision and redirection to avoid and prevent wandering episodes.”

Resident F requires “2x assist with transfers, may pivot, wheelchair with alarm.”

On 05/06/2022, Ms. Space emailed indicating additional direct care staff members had been moved from the neighboring facilities on 3/16, 3/18, 3/22, 4/02, and 4/10 so there was a total of two direct care staff members working in the facility (Lodge #2). Ms. Space indicated that while there are timeclocks in each facility, direct care staff are not required to clock in/out of the facility when leaving to work in neighboring facility. Ms. Space indicated it would be difficult to prove staff had been transferred to the facility on the dates in question due to staff not clocking in/out.

Ms. Space stated in her email that when call-offs occur, the facility's scheduler will now make it a "top priority" to adjust the schedule with staff who are either called in or who are moved from a neighboring facility.

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 investigation, which included reviewing the *Resident Register*, staff schedules, interviewing direct care staff, and my observations during on-site inspections, the ratio of direct care staff to residents was no less than 1 direct care staff to 15 residents during waking hours or not less than 1 direct care staff to 20 residents during normal sleeping hours, as required.
CONCLUSION:	**VIOLATION NOT 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:	My review of all 14 residents' most updated and current *Individual Plans of Service* indicates all 14 residents, except Resident A, E, L, and N, have a cognitive impairment by having a diagnosis of Alzheimer's or dementia. Their ISPs also indicated all 14 residents, except Resident G, have little to no understanding or ability to independently navigate the facility's evacuation process thus requiring complete assistance to properly get through an evacuation, and requiring both verbal and physical cueing to evacuate properly. Additionally, Resident A, C, and F require "physical and verbal assistance with walking needs. Requires hands-on assistance with getting up, using walking devices, and sitting down/laying down". Resident H and Resident L "needs complete supervision and redirection to avoid and prevent wandering episodes" and Resident F requires "2x assist with transfers, may pivot, wheelchair with alarm". My review of the facility's staff schedule from 03/12/2022 through 04/11/2022 indicated only one direct care staff was working at the facility during five overnight shifts (11pm – 7 am) on 3/16, 3/18, 3/22, 4/02, and 4/10. Additionally, my review of the facility's only fire drill for 2022 indicated fire drills have only been practiced utilizing multiple direct staff during an overnight shift, which doesn't reflect the staff schedule of having a minimum of one direct care staff on shift to adequately evacuate the residents in a safe and timely manner. Despite almost all the residents having a cognitive impairment and requiring complete assistance in an evacuation, the facility did not have sufficient direct care staff during the overnight shifts on 03/16, 03/18, 03/22, 04/02, and 04/10 for the protection of the residents and to adequately evacuate them from the facility in the event of an emergency such a fire.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Resident C has bruises on her body from direct care staff.

INVESTIGATION:

On 03/21/2022, Adult Foster Care consultant, Eli Deleon, informed me of additional allegations, which needed to be added to my complaint. He reported he had received a complaint alleging a resident residing in Lodge #3 had bruises on her left and right forearm due to being handled roughly by direct care staff; however, during his investigation he discovered the resident actually resided in Lodge #2, which was later identified as Resident C.

On 03/21/2022, I conducted an unannounced on-site inspection at the facility. I attempted to interview Resident C; however, due to impaired cognition she was unable to answer my questions. I observed an approximate 2-inch circular purple colored bruise on Resident C's right forearm approximately 4 inches above her wrist. I also observed an approximate 2-inch circular dark purple/black colored bruise on Resident C's right forearm right above her wrist. Due to Resident C being unable to be interviewed, she was unable to report how she obtained the bruising or when the bruising occurred.

I interviewed direct care staff, Marikka Troxler. Ms. Troxler acknowledged being aware of Resident C's bruising but could not recall how Resident C obtained them. She denied mistreating Resident C or being aware of any other direct care staff mistreating her. Ms. Troxler indicated she had not seen any observation notes for Resident C regarding the bruises either. She indicated the bruises could have been caused on accident while providing care to Resident C or Resident C could have hit her forearms on something.

I reviewed Resident C's observation notes with Ms. Troxler through the facility's ECP online program for any incidences that could have caused the bruises on Resident C's forearms or a note identifying the bruises; however, none of the notes contained any relevant information.

On 03/24/2022, I interviewed direct care staff, Anna Ludwig. Ms. Ludwig's statement to me was consistent with Ms. Troxler's statement to me.

On 04/05/2022, I confirmed with Adult Protective Services specialist, Gene Coulter, via email he had been assigned the complaint for investigation. He indicated he met with Resident C and facility staff and also determined Resident C is "very limited cognitively" and direct care staff informed him the bruises may have occurred while staff were attempting to get Resident C out of bed due to Resident C not having a hospital bed, but the facility had since ordered one.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my investigation, there is no way to determine how Resident C obtained the bruises on her forearms. Additionally, there is no evidence indicating any direct care staff handled her roughly or harmed her in any other manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Incident reports aren't being completed, as required.

INVESTIGATION:

The complaint alleged there were direct care staff who were not completing incident reports, as required. There was no additional information provided, which included no specific incidences that would have warranted an incident report and one was not completed.

On 03/21/2022, I conducted an unannounced on-site inspection at the facility. I interviewed direct care staff, Ms. Troxler, who stated incident reports were being completed, as required. She reported she understood how to complete an incident report as well and showed me how staff complete them in the facility's ECP online system.

Administrator, Ms. Space, indicated *Incident / Accident Reports* (IR) were being completed, as required. Ms. Space provided all IRs for residents for 2022. She reported in addition to IR's, facility staff also complete fall reports, which are sent to the facility's nurse for review.

On 04/11/2022 and 05/04/2022, I interviewed direct care staff, Michael Riggle. Ms. Riggle indicated he was aware of how to complete *Incident / Accident Reports* at the facility and had completed them while working. He indicated the IRs were completed on the ECP system. He reported he knew when an IR had to be completed (i.e.,

falls, unusual marks on the body, etc.) and who needed to be notified of the IR (i.e., resident physician, family members, etc.).

On 03/24/2022 and 05/04/2022, I interviewed direct care staff, Anna Ludwig. Ms. Ludwig's statement to me was consistent with Mr. Riggles' statement to me. Additionally, she reported when IRs are completed, they are reviewed by the facility's Resident Care Coordinator. Ms. Ludwig also reported in addition to IR's staff complete fall reports.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**
ANALYSIS:	Due to the complaint not providing specific information and the facility's Administrator, Laurel Space, being able to provide *Incident / Accident Reports* for residents indicates *Incident / Accident Reports* are being completed. Additionally, the direct care staff I interviewed also indicated they were aware of when *Incident / Accident Reports* needed to be completed and how to complete one.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident narcotic medications are missing.

INVESTIGATION:

The complaint alleged the facility had missing narcotic medications and indicated this being an ongoing issue. The complaint alleged the facility's Administrator, Laurel Space, was aware of the missing narcotics and would change the narcotic count sheets to reflect the correct number of pills.

On 03/21/2022, I completed an unannounced on-site inspection at the facility. I interviewed direct care staff, Ms. Troxler. Ms. Troxler stated narcotic counts are completed before and after shift changes to ensure narcotics are accounted for after each shift. She indicated most of the resident narcotic counts were correct; however, she indicated Resident D's and Resident E's narcotic counts were off by one or two pills.

Ms. Troxler showed me the facility's online controlled substance counts for all the residents who require a controlled substances or narcotics, which included Resident A, D, E, F, G, H, and I. Resident A's, F's, G's, H's, I's narcotic counts matched the number of pills left in their bubble packs/containers; however, Resident D and Resident E's narcotic counts did not match the number of pills left in their bubble packs.

According to Resident D's narcotic count sheet, she should have had 51 pills left of her Clonazepam; however, I counted 52 Clonazepam pills in the bubble packs indicating one pill had not been administered to Resident D. Based on the prescription fill date, 03/16/2022, Resident D had 60 pills left in her bubble pack that included the instructions "TAKE 1 TABLET BY MOUTH TWICE DAILY". At the time of my on-site, Resident D should have received her Clonazepam nine times indicating she would have had 51 pills left in the bubble packs.

Despite there being 52 pills left in Resident D's Clonazepam bubble pack, her March 2022 Medication Administration Record (MAR) indicated she had been administered all her required doses of Clonazepam medication, as prescribed.

According to Resident E's narcotic count sheet, she had 16 pills left of her Alprazolam .5 mg tablets; however, I counted 46 pills left in Resident E's Alprazolam bubble pack. Ms. Troxxler indicated an additional month's (30 days) worth of the Alprazolam medication had not been counted in with the remaining 16 pills. Based on the prescription fill date, 02/22/2022, Resident E had 150 pills with the instructions "TAKE 1 TABLET BY MOUTH FOUR TIMES DAILY ROUTINE, AND 1 TABLET DAILY AS NEEDED".

I reviewed Resident E's February 2022 MAR, which showed her Alprazolam medication was administered on 02/23/2022 for every day except 02/24/2022 when the MAR indicated it wasn't administered at 8 am, which was the first dose of the day, because it was "NOC." The MAR indicated NOC stands for "Medication Not On Cart" despite it having been administered four times, as prescribed, on 02/23/2022. Additionally, on 02/24/2022, the MAR indicated the medication was administered as a PRN, an as needed medication, at 12 pm, but then again as a scheduled medication at 12:19 pm.

Resident E's March 2022 MAR showed Resident E's Alprazolam was routinely administered to her except for her 8 pm dose on 03/04/2022 when the MAR indicated it wasn't administered because it was "NOC" or "Medication Not On Cart." The medication was then routinely administered to Resident E up to the day I completed my on-site investigation.

According to Resident E's February 2022 and March 2022 MARs her Alprazolam medication was administered 104 times; leaving 46 pills left in the bubble packs and indicating her Alprazolam medication had been administered correctly, as required.

On 05/03/2022, I interviewed Ms. Space regarding the inconsistency with the medication. She reported the direct care staff, Dijainique Smith, who was the identified medication passer on 02/24/2022, had been terminated and was no longer working in the facility and therefore she was unable to obtain any clarification regarding the documentation errors on Resident E's eMAR. Additionally, she indicated the facility's nurse, who was also not working at the facility, would have kept records for reasons a resident medication was not passed. She reported she would contact the facility's current nurse and obtain the records if they were available.

Ms. Space was unable to provide any documentation as to why staff indicated Resident E's medication was listed as "NOC" on 02/24 and 03/04. Additionally, she had no indication as to why the medication was administered as a PRN. Ms. Space indicated she is now reviewing the MARs every hour for alerts if staff haven't followed up on a PRN, haven't indicated the reason it was provided or if the PRN helped the resident.

Ms. Ludwig indicated there had not been any recent issues with narcotic medication counts not being consistent with what was in the medication bubble packs. Ms. Ludwig had no knowledge of any direct care staff members taking medications and attributed the errors to staff not counting correctly. She also confirmed narcotic medication counts were completed at each shift change.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation, there is no evidence resident's narcotic medication is being used by other individuals in which the medication is not prescribed. There is no indication resident medication was missing or not in the medication cart, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Resident E's electronic Medication Administration Record indicated Resident E's .5 mg Alprazolam prescription was not in the facility's medication cart as staff had indicated "NOC" for Resident E's 8am dose on 02/24/2022 or her 8pm dose on 03/04/2022, despite staff indicating Resident E received the medication the day before and the day after, respectively. Based on my investigation, staff were not properly completing Resident E's electronic Medication Administration Record, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	There was no documentation available for review as to why facility direct care staff administered Resident E's Alprazolam .5 mg as needed medication, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents do not have resident records, as required.

INVESTIGATION:

The complaint alleged residents in the facility do not have resident records. No additional information was provided.

On 03/24/2022, I completed an on-site inspection at the facility. According to the resident register there were 14 residents currently residing at the facility. I reviewed all 14 resident files and determined all 14 residents had the required documentation in their individual resident records.

APPLICABLE RULE	
R 400.15316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**

ANALYSIS:	I reviewed all 14 resident records and determined all 14 residents had the appropriate documentation, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility has bed bugs that aren't being professionally treated.

INVESTIGATION:

The complaint provided no additional information other than the facility had bed bugs, but it wasn't being treated.

Direct care staff, Ms. Troxler, stated she hadn't observed any bed bugs in the facility, but indicated other staff have observed them in the facility's staff break room. She stated the facility's maintenance person removed the staff couch where the bed bug had been observed. She reported she's observed the facility being treated for pests once a month. Ms. Troxler stated she had not observed any bed bugs in resident bedrooms or any residents having marks or bites from any bed bugs.

Administrator, Ms. Space, stated she was not aware of any current bed bug issues, but indicated the facility was treated for them approximately one year ago. She stated she had a contract with Griffin Pest Solutions and if bed bugs were observed then they would be treated.

On 04/05/2022, Ms. Space forwarded me documentation from Griffin Pest Solutions, dated 05/28/2021, showing one bedroom in the facility had been inspected for bed bugs, but none were found; however, the underside of the bedroom furniture was treated, the baseboards were treated, cracks and crevices were treated, and the mattress was vacuumed.

On 04/06/2022, Ms. Space emailed indicating a third shift staff reported to her a suspected bed bug sighting. She indicated the facility's Director of Operations, Alex Bierling, had contacted Griffin Pest Solutions and scheduled a canine inspection for 04/07/2022. Ms. Space provided documentation from Griffin Pest Solutions confirming the canine inspection for 04/07/2022.

Direct care staff, Shelley Simmons stated she had observed bed bugs in the facility's staff break room "a couple weeks ago." Ms. Simmons did not indicate observing bed bugs in resident bedrooms or residents being bitten by them. She stated she hadn't observed any pest control company treating the facility.

Neither direct care staff, Mr. Riggle nor Ms. Ludwig, reported any personal knowledge or observation of bed bugs at the facility; however, they both Mr. Riggle and Ms. Ludwig reported they had observed a pest control company treating the

neighboring facilities. They both reported if they observed any bed bugs, they would report it to maintenance.

I completed on-site inspections on 03/21/2022, 03/24/2022, 04/11/20220 and 04/17/2022 and did not observe any bed bugs in the facility. Additionally, direct care staff did not report any current bed bugs issues.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	I did not observe any bed bugs during my on-site inspection on 03/21/2022, 03/24/2022, 04/11/20220 and 04/17/2022. Direct care staff at the facility did not report any current bed bug sightings or concerns residents were being bitten by any bed bugs. Additionally, the facility's Administrator, Laurel Space, provided documentation the facility treated a specific resident bedroom for bed bugs in 05/2021 when a bed bug was observed by a facility staff. Additionally, Ms. Space has a contract with Griffin Pest Solutions and when a staff brought a possible bed bug sighting to her attention, she contacted Griffin Pest Solutions for a canine inspection on 04/07/2021. Subsequently, the facility has a pest control program in place to continually protect the health of the residents, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Ceiling tiles are missing in facility hallway due to a leak.

INVESTIGATION:

The complaint alleged the ceiling tiles in the facility's "long hallway" were missing and water was dripping through a ceiling light.

During my 04/11/2022 on-site inspection with Bureau of Fire Services inspector, Ken Howe, we observed missing ceiling tiles in the facility's long hallway, which is located on the northern end of the facility. Mr. Howe stated he had cited the facility for missing ceiling tiles during his annual inspection and it was indicated to him at

that time by the facility's Director of Operations, Alex Bierling, the sprinkler system had a leak, but the leak had been fixed. Mr. Howe had informed Mr. Bierling the ceiling tiles needed to be replaced as the sprinkler heads would not function properly without the tiles in place. Mr. Howe indicated the ceiling tiles had been missing for approximately one month.

Ms. Space stated she would contact Mr. Bierling and request he replace the tiles immediately.

During the inspection, neither Mr. Howe nor I observed any current leaks or water dripping from the pipes or sprinkler head.

On 04/12/2022, Mr. Howe stated he had received pictures of the replaced ceiling tiles indicating the facility was in compliance with BFS rules.

On 04/17/2022, I conducted an unannounced on-site at the facility and observed the ceiling tiles had been put into place.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	When I conducted my 04/11/2022 unannounced on-site inspection at the facility, I observed missing ceiling tiles in the facility's northern long hallway, as alleged. Per the Bureau of Fire Services inspector, Ken Howe, the missing ceiling tiles can compromise the integrity of the sprinkler system.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Staff cannot access resident bedrooms when locked if they don't have bedroom keys.

INVESTIGATION:

On 04/08/2022, I received additional allegations alleging sometimes when direct care staff come to work there are not keys in the facility to open resident bedrooms.

After receiving the allegations, I contacted Ken Howe, Bureau of Fire Services (BFS) inspector, to inform him of the allegations and to determine if it was a BFS violation.

Mr. Howe indicated BFS did not have specific rules regarding locking against ingress.

On 04/11/2022, I conducted an unannounced on-site at the facility, as part of my investigation, in conjunction with Mr. Howe. We interviewed Ms. Space who indicated the facility's identified medication passer and one direct care staff hold onto facility keys, which open all the resident bedroom doors. She indicated only the medication passer had a set of keys with a key to the medication cart. She also indicated direct care staff members do not take the keys home with them and the keys are left at the facility.

During our inspection, Mr. Howe and I interviewed direct care staff, Jayla Carter. Ms. Carter stated she had a set of facility keys; however, she had given them to another staff in the facility. Ms. Carter was unable locate the staff who had her keys for approximately three to five minutes. Once Ms. Carter located the direct care staff who had her keys, she showed them to me and Mr. Howe. The keys were labeled AA for Lodge 1, AB for Lodge 2, and AC for Lodge 3. Ms. Carter's statement regarding what the keys unlocked was consistent with Ms. Space's statement to us; however, Ms. Carter indicated she also had her house key on the key ring and took the keys home with her, which was inconsistent with what was reported to us by Ms. Space.

Ms. Space demonstrated for Mr. Howe and I how the resident bedroom doors are non-locking against egress. It was also demonstrated how the keys unlock resident bedroom doors. Consequently, residents are able to easily get out of their bedrooms even if the door is locked but the resident must be able to understand and remember how to open the door.

Ms. Ludwig's statement to me was consistent with Ms. Carter's statement to me.

APPLICABLE RULE	
R 400.15408	**Bedrooms generally.**
	(4) Interior doorways of bedrooms that are occupied by residents shall be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	All the facility's resident bedroom doors are non-locking against egress, as required. There are no specific rules relating to locking against ingress, which was alleged in the complaint.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14318	**Emergency preparedness**
	(1) A licensee shall have a written emergency procedure and evacuation plan to be followed in case of fire, medical, or severe weather emergencies. The evacuation plan shall be prominently posted in the home. Residents who require special assistance shall be identified in the written procedure.
ANALYSIS:	The facility's resident bedrooms are locking against ingress meaning they are unable to be opened if a resident locks the door from the inside unless direct care staff members utilize the facility keys. The facility's population is aged and Alzheimer's. A review of resident *Assessment Plans for AFC Residents* indicated all the residents have a diagnosis of Dementia or Alzheimer's further indicating the residents have cognitive decline. I reviewed the facility's evacuation plan, which did not indicate the procedure for placement of facility keys to open resident bedrooms in the event of an emergency and resident bedrooms were locked against ingress. As evidenced during my on-site investigation, direct care staff member Jayla Carter allowed another direct care staff member to borrow her facility keys which made it impossible for her to open locked resident rooms. Further it was not clear if direct care staff members take the facility keys home as Ms. Carter also had her personal house key on her facility key chain and stated she takes her set home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/11/2022, I conducted an exit conference with both the facility's Administrator, Laurel Space, and licensee designee, Catherine Reese, via telephone. They acknowledged the findings and indicated they would submit a corrective action plan addressing the violations.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

05/09/2022

Cathy Cushman — Date
Licensing Consultant

Approved By:

05/12/2022

Dawn N. Timm — Date
Area Manager