GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2022

Janice Ranger
Harbor's Independent Living of East Tawas, Inc.
PO Box 90662
Burton, MI 48509

RE: License #: AS350311823
Investigation #: 2023A0360005
Harbors Independent Living of East Tawas

Dear Ms. Ranger:

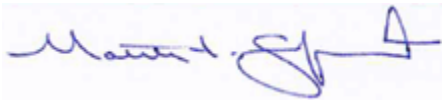
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
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931 S Otsego Ave
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(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS350311823
Investigation #:	2023A0360005
Complaint Receipt Date:	10/18/2022
Investigation Initiation Date:	10/18/2022
Report Due Date:	12/17/2022
Licensee Name:	Harbor's Independent Living of East Tawas, Inc.
Licensee Address:	1010 Alice Street East Tawas, MI 48730
Licensee Telephone #:	(810) 348-0752
Administrator:	Janice Ranger
Licensee Designee:	Janice Ranger
Name of Facility:	Harbors Independent Living of East Tawas
Facility Address:	1010 Alice Street East Tawas, MI 48730
Facility Telephone #:	(989) 362-4655
Original Issuance Date:	01/02/2013
License Status:	REGULAR
Effective Date:	07/01/2021
Expiration Date:	06/30/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was left in two briefs that were soiled.	No
Resident A was yelled at by direct care staff.	No
The medication cabinet was left unlocked.	Yes
Resident A's medications were not filled through the VA and he ran out of several medications.	Yes
Resident A was denied meals and snacks.	No
The bathroom was dirty with feces on clothing sitting in the sink for hours.	No
Resident A's bedding was soiled and sometimes there was no bedding on Resident A’s bed.	No
The facility entrance was blocked.	No

III. METHODOLOGY

10/18/2022	Special Investigation Intake 2023A0360005
10/18/2022	Special Investigation Initiated - Letter aps complaint
10/18/2022	APS Referral online
10/18/2022	Contact - Telephone call made Relative 1-A
10/25/2022	Inspection Completed On-site DCS Dinar Ranger, Resident B, C
10/25/2022	Contact - Telephone call received licensee Jan Ranger
11/03/2022	Contact - Telephone call made Relative 1-A
11/04/2022	Contact - Face to Face Resident A, Relative 1-A, Guardian 1-A
11/07/2022	Contact - Document Received Relative 1-A

12/07/2022	Contact - Document Sent Jan Ranger
12/12/2022	Inspection Completed On-site Jan Ranger, Dinar Ranger
12/14/2022	Contact – Document Received Jan Ranger Licensee Designee
12/15/2022	Exit Conference With licensee designee Jan Ranger

ALLEGATION: Resident A was left in two briefs that were soiled.

INVESTIGATION: On 10/18/2022 I was assigned a complaint from the LARA online complaint system.

On 10/18/2022 I contacted Relative 1-A. Relative 1-A stated that she has been going to the facility for the past few months and has witnessed on multiple occasions Resident A in a soiled brief. She stated most recently on 9/29/2022 when she went to the facility Resident A was wearing two soiled briefs and had a very strong odor. She stated she took him out of the facility, and he is now living with her.

On 10/25/2022 I made an unannounced onsite inspection at the facility. Direct care staff Dinar Ranger stated Resident A was incontinent and often soiled his briefs multiple times a day. She stated he had very bad bowel movements and would make a mess of the bathroom. She stated they have at times put two briefs on Resident A because he would leak through one brief.

While at the facility on 10/25/2022 I was contacted by the licensee designee Jan Ranger. Ms. Ranger stated that Resident A had very serious bouts of diarrhea, but they would always clean him up promptly. She stated when he moved into the facility, he was able to toilet himself. She stated he had mental health issues and was hospitalized through the Veterans Administration for most of the month of July. She stated staff gave him multiple showers a day if he was experiencing diarrhea.

While at the facility on 10/25/2022 I interviewed Resident B. Resident B stated he had no concerns about the facility. He stated the facility is always clean. He gets medications as prescribed, they provide good meals, and the staff are always very helpful with any personal care needs. I then interviewed Resident C. Resident C stated the staff always provide prompt personal care, she receives all her medications as prescribed, the food is great, and the facility is kept very clean.

On 11/03/2022 I contacted Relative 1-A. Relative 1-A stated Resident A has been more difficult to care for than she imagined, and they have found a placement for him

at a facility in Cadillac. She stated we could meet at his guardian's home for an interview tomorrow.

On 11/04/2022 I interviewed Resident A, Relative 1-A and Guardian 1-A. Relative 1-A stated the facility was neglecting Resident A's care. She stated while he was with her Resident A was able to toilet himself for the most part. She stated he still was wearing briefs but was having fewer accidents. Guardian 1-A stated she brought Resident A for an assessment to Medi-Lodge, and he was denied admission. She stated Resident A was hospitalized in July for a "psychological break." I then interviewed Resident A privately. Resident A was oriented to time, place, and person with the assistance of his watch. Resident A stated he was able to toilet himself and the staff helped him when he soiled his briefs. He did not remember being left in soiled briefs.

On 12/07/2022 I contacted the licensee, Jan Ranger. Ms. Ranger agreed to meet at the facility on 12/12/2022.

On 12/12/2022 I interviewed the licensee designee Jan Ranger. Ms. Ranger denied that Resident A was ever left in a soiled brief. She stated he had serious diarrhea on multiple occasions, and they would often have to shower him 3-4 times per day. She stated Resident A could be very difficult to manage because he would be very pleasant one minute and then make sexually inappropriate comments to the staff the next. She stated he had paranoid behaviors and suffered from PTSD. She stated sometimes he would refuse to shower. Ms. Ranger stated when Resident A was admitted to the facility Guardian 1-A provided her with a letter requesting that Relative 1-A not be allowed any medical information or contact with Resident A because of family issues. Ms. Ranger provided me a copy of this letter. She stated after Resident A's hospitalization in July the guardian was allowing contact with Resident A. She stated she thought she had a good working relationship with the family and does not understand why they didn't come to her with any concerns.

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:	Relative 1-A stated Resident A had two soiled briefs on when she visited the facility on 9/29/2022. Relative 1-A also stated that after she brought Resident A to her home, he was able to toilet himself with minimal prompts or assistance.

	Resident A stated he could toilet himself and that staff helped him when he soiled his briefs. He did not remember being left in soiled briefs. The licensee designee Jan Ranger and direct care staff Dinar Ranger both stated Resident A had serious bouts of diarrhea and frequently needed to be changed and showered multiple times a day. They denied every leaving him in soiled briefs. There is not a preponderance of evidence that Resident A's personal care and protection was not attended to at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was yelled at by direct care staff.

INVESTIGATION: On 10/18/2022 I contacted Relative 1-A. Relative 1-A stated that she has been going to the facility for the past few months and has witnessed a direct care staff yelling at Resident A because of a missed doctor appointment. She stated she could not remember the name of the staff, but they no longer work at the facility.

On 10/25/2022 I made an unannounced onsite inspection at the facility. Direct care staff Dinar Ranger stated she is not aware of any direct care staff that have yelled at Resident A.

While at the facility on 10/25/2022 I was contacted by the licensee designee Jan Ranger. Ms. Ranger stated she is not aware of any staff yelling at Resident A and would not tolerate any staff doing that.

While at the facility on 10/25/2022 I interviewed Resident B. Resident B stated he has no concerns about the facility. He stated the facility is always clean. He gets medications as prescribed; they provide good meals, and the staff are always very helpful with any personal care needs. Resident B denied being yelled at by any staff or that any staff have yelled at other residents. I then interviewed Resident C. Resident C denied that any staff have yelled at her or any other residents.

On 11/03/2022 I contacted Relative 1-A. Relative 1-A stated Resident A has been more difficult to care for than she imagined, and they have found a placement for him at a facility in Cadillac. She stated we could meet at his guardian's home for an interview tomorrow.

On 11/04/2022 I interviewed Resident A, Relative 1-A and Guardian 1-A. Relative 1-A stated she was at the facility in August and a staff person came into his room and started yelling at him regarding missing a medical appointment. She stated she did not know the name of the staff but that they no longer work at the facility. I then

interviewed Resident A. Resident A stated there was a staff person at the home who yelled at him and threw a shoe and hit him in the face. He stated he does not remember the name of the staff person. He stated Dinar Ranger and Jan Ranger are both very nice and they never yelled at him. He stated when the incident with the staff yelling at him happened, he never told anyone. He stated it happened a couple of times that they were yelling at him. He stated he could not remember if it was a male or female staff.

On 12/07/2022 I contacted the licensee, Jan Ranger. Ms. Ranger agreed to meet at the facility on 12/12/2022.

On 12/12/2022 I interviewed the licensee designee Jan Ranger. Ms. Ranger denied that she was aware of any staff yelling or throwing a shoe at Resident A. She stated she would not tolerate that from any of her staff.

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:	Relative 1-A stated in August 2022 an unknown direct care staff came into Resident A's room and yelled at him for missing a doctor appointment. Resident A stated a direct care staff threw a shoe at him and hit him in the face and yelled at him but he could not remember if it was a male or female staff. The licensee and direct care staff Dinar and Jan Ranger both denied that they were aware of any staff yelling at Resident A. Resident B and C both denied ever being yelled at by staff or that they have heard staff yell at other residents. There is not a preponderance of evidence that a former direct care staff did not treat Resident A with dignity.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The medication cabinet was left unlocked.

INVESTIGATION: On 10/25/2022 I made an unannounced onsite inspection at the facility. Direct care staff Dinar Ranger stated the medication cabinet is always kept locked when they are not administering medications. I observed the medication cabinet to be locked.

While at the facility on 10/25/2022 I interviewed Resident B. Resident B stated he had no concerns about the facility. He stated he gets medications as prescribed and did not know anything about the medication cabinet being left unlocked. I then interviewed Resident C. Resident C stated she receives all her medications as prescribed and did not know anything about the medication cabinet being left unlocked.

On 11/03/2022 I contacted Relative 1-A. Relative 1-A stated Resident A has been more difficult to care for than she imagined, and they have found a placement for him at a facility in Cadillac. She stated we could meet at his guardian's home for an interview tomorrow.

On 11/04/2022 I interviewed Guardian 1-A. Guardian 1-A provided me with a photograph that she took at the facility on 9/29/2022 in which the medication cabinet padlock is unlocked. She stated there was no staff in kitchen at the time she took the photo where the medication cabinet is kept. The photo also shows an upside-down prescription bottle on the top of the cabinet, but no pills are visible in the bottle.

On 12/07/2022 I contacted the licensee, Jan Ranger. Ms. Ranger agreed to meet at the facility on 12/12/2022.

On 12/12/2022 I interviewed the licensee designee Jan Ranger. Ms. Ranger denied that the medication cabinet is ever left unlocked. I showed her the picture of the padlock not locked on the medication cabinet from 9/29/2022. She stated the direct care staff would have been actively passing medications which is the only reason the padlock was unlocked. She stated the staff put the pill bottles upside down when they are out of pills for that bottle. I then interviewed Dinar Ranger. Ms. Ranger stated she would have been actively passing the medications which is why the padlock would have been unlocked. She stated the pill bottle on top of the cabinet was empty. The medication cabinet is located in the kitchen and if staff are passing medications in the resident bedrooms the cabinet is left unsupervised. I observed the medication cabinet to be locked during my onsite inspection.

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 drawe/r, and refrigerated if required.
ANALYSIS:	Guardian 1-A provided a picture of the padlock unlocked that she stated she took while at the facility on 9/29/2022. During my onsite inspections on 10/25/2022 and 12/12/2022 the medication cabinet was locked. The licensee designee was shown the photograph from Guardian 1-A and stated that the direct care staff would have been actively passing medications. Direct care staff Dinar Ranger stated the staff would have been actively passing medications during the time the padlock was unlocked. The medication cabinet is located in the kitchen and if staff are administering medications in the resident bedrooms the unlocked cabinet is being left unsupervised. There is a preponderance of evidence that the medication is not kept in a locked cabinet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's medications were not filled through the VA and he ran out of several medications.

INVESTIGATION: On 10/18/2022 I contacted Relative 1-A. Relative 1-A stated that when she picked Resident A up on 9/29/2022 four different medications Resident A is prescribed were not filled. She stated she could not remember which medications but believes two of them were called Divalprex and Donepezil.

On 10/25/2022 I made an unannounced onsite inspection at the facility. Direct care staff Dinar Ranger stated Resident A did run out of one medication for 7-10 days because of a delay from the VA filling his medications. She stated all other medications were administered as prescribed. Ms. Ranger provided Resident A's medication administration record for September 2022. Divalprex and Donepezil were documented that they were administered as prescribed through 9/30/2022. There were no other medications listed as not administered.

While at the facility on 10/25/2022 I was contacted by the licensee designee Jan Ranger. Ms. Ranger stated that she could not remember which medications the VA

did not fill but that they kept calling and calling until the VA finally filled his prescription.

While at the facility on 10/25/2022 I interviewed Resident B. Resident B stated he had no concerns about the facility. He stated the facility is always clean. He gets medications as prescribed; they provide good meals, and the staff are always very helpful with any personal care needs. I then interviewed Resident C. Resident C stated the staff always provide prompt personal care, she receives all her medications as prescribed, the food is great, and the facility is kept very clean.

On 11/03/2022 I contacted Relative 1-A. Relative 1-A stated Resident A has been more difficult to care for than she imagined, and they have found a placement for him at a facility in Cadillac. She stated we could meet at his guardian's home for an interview tomorrow.

On 11/04/2022 I interviewed Resident A, Relative 1-A and Guardian 1-A. Relative 1-A stated when Resident A was discharged there were four medications that were not filled. She stated she did not have any documentation as to which medications were not filled. She stated she would send them later. She stated there was also a pill that looked different from other pills in a bottle, but she did not remember which medication it was. I then interviewed Resident A. Resident A stated he received his medications as he was supposed to.

On 12/07/2022 I contacted the licensee, Jan Ranger. Ms. Ranger agreed to meet at the facility on 12/12/2022.

On 12/07/2022 I contacted Relative A who stated the missing medications were Donepezil, Lisinopril, and Trazadone.

On 12/12/2022 I interviewed the licensee designee Jan Ranger. Ms. Ranger provided Resident A's medication administration record for August 2022. She stated from 8/9/2022-8/22/2022 Resident A was out of Escitalapram. She stated she contacted the VA and notified them that they had not sent the medication. She stated she did not have any documentation to verify that she contacted the VA. She stated Resident A was not prescribed Lisinopril or Trazadone. These medications were not listed on Resident A's medication administration record. She stated she documented the medications provided to the family at discharge but could not find it. She stated if she found the form, she would fax it.

On 12/14/2022 I received a copy of a discharge note dated 10/1/2022 from licensee designee Jan Ranger. The note indicated that "I have received all medications" and was signed by Resident A and Guardian 1-A.

APPLICABLE RULE	
R 400.14312	**Resident medications.**

	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Relative A stated when Resident A was discharged from the home, he had four prescription medications that were not filled. The licensee designee Jan Ranger stated Resident A's medications were filled as prescribed and the only medications he ran out of was Escitalapram from 8/9/2022-8/22/2022. Ms. Ranger stated she contacted the VA on multiple occasions to get the prescription filled but did not have any documentation to verify these efforts. There is a preponderance of evidence that Resident A's medications were not filled, and he did not get his medications as prescribed from 8/9/2022-8/22/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was denied meals and snacks.

INVESTIGATION: On 10/18/2022 I contacted Relative 1-A. Relative 1-A stated Resident A reported to her that the facility would not let him eat.

On 10/25/2022 I made an unannounced onsite inspection at the facility. Direct care staff Dinar Ranger stated Resident A was never denied any food or meals. She stated he kept flushing wrappers down the toilet from snack foods he kept in his room and plugging the toilet, so they kept his snacks in the kitchen. Ms. Ranger provided me with Resident A's weight records from April 2022 through September 2022 and he went from 224 to 230 lbs.

While at the facility on 10/25/2022 I was contacted by the licensee designee Jan Ranger. Ms. Ranger stated Resident A ate well and they did not ever deny him meals.

While at the facility on 10/25/2022 I interviewed Resident B. Resident B stated he had no concerns about the facility. He stated they provide good meals. I then interviewed Resident C. Resident C stated the food is great. I observed the lunch meal being served.

On 11/04/2022 I interviewed Resident A and Relative 1-A. Relative 1-A stated Resident A told her that the facility denied him meals. I interviewed Resident A privately. Resident A stated he does not remember a time when he did not get food or meals.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Resident A stated he did not remember a time when he did not get food or meals while at the facility. The licensee designee stated Resident A was always provided meals and snacks as requested. Resident A's weight increased while at the facility. There is not a preponderance of evidence that Resident A was not provided meals as required.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The bathroom was dirty with feces on clothing sitting in the sink for hours.

INVESTIGATION: On 10/18/2022 I contacted Relative 1-A. Relative 1-A stated that she was at the facility on 9/29/2022 and Resident A's soiled clothing was in the sink and tub of the bathroom and the toilet seat had feces on it.

On 10/25/2022 I made an unannounced onsite inspection at the facility. Direct care staff Dinar Ranger stated Resident A was incontinent and often soiled his briefs multiple times a day. She stated he had very bad bowel movements and would make a mess of the bathroom. She stated they would change him multiple times a day, but they would always change his clothes and take them to the laundry. She stated the bathroom would be cleaned up right away. I then observed all of the resident bathrooms at the facility and they were all very clean.

While at the facility on 10/25/2022 I was contacted by the licensee designee Jan Ranger. Ms. Ranger stated that Resident A had very serious bouts of diarrhea, but they would always clean him up promptly. She stated when he moved into the facility, he was able to toilet himself. She stated he had mental health issues and was hospitalized through the Veterans Administration for most of the month of July. She stated the staff would give him multiple showers a day if he was experiencing diarrhea. She stated he may have attempted to change himself and put his soiled

clothing in the bathroom, but they would have picked up the clothing and brought it to the laundry for cleaning.

While at the facility on 10/25/2022 I interviewed Resident B. Resident B stated he had no concerns about the facility. He stated the facility is always clean. His clothes are laundered regularly, and the bathrooms are maintained very clean and the staff are always very helpful with any personal care needs. I then interviewed Resident C. Resident C stated the staff always provide prompt personal care, she receives all her medications as prescribed, the food is great, and the facility is kept very clean.

On 11/04/2022 I interviewed Resident A and Relative 1-A. Relative 1-A provided me with photos she stated she took on 9/29/2022 of Resident A's soiled clothing in his bathroom sink and tub as well as the toilet seat which had some feces on it. She stated she thinks the clothing was being rinsed in the sink and tub and was left there. I then interviewed Resident A. Resident A stated he did not remember how the clothes got in the sink and tub but that sometimes it would be a couple days before his soiled clothes and linens would be changed and washed.

On 12/07/2022 I contacted the licensee, Jan Ranger. Ms. Ranger agreed to meet at the facility on 12/12/2022.

On 12/12/2022 I interviewed the licensee designee Jan Ranger. Ms. Ranger denied that Resident A's soiled clothing was left in the tub and sink. I showed her the photo of the clothing in the tub and sink and the feces on the toilet seat. She stated that Resident A was having multiple bowel movements and soiling his clothing and that his clothes would have been changed immediately and laundered immediately. She stated Resident A was having very bad diarrhea that morning and the toilet seat would've been cleaned promptly. While at the facility I again inspected all resident bathrooms which were very clean with no evidence of soiled clothing or feces.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Relative 1-A provided photos of Resident A's bathroom that showed Resident A's clothing bunch up in the sink and tub as well as some feces smeared on the toilet seat. The licensee Jan Ranger stated Resident A was having bowel issues and the toilet and his clothing would've been cleaned promptly.

	All of the resident bathrooms during the 10/25/2022 and 12/12/2022 were very clean. There is not a preponderance of evidence that the home is not maintained to provide adequately for the health, safety, and well-being of occupants.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's bedding was soiled and sometimes there was no bedding on Resident A's bed.

INVESTIGATION: On 10/18/2022 I contacted Relative 1-A. Relative 1-A stated that she was at the facility on 9/14/2022 and noticed Resident A's bedding had feces stains on it and she has been at the facility on other days when there was no linens on Resident A's bed.

On 10/25/2022 I made an unannounced onsite inspection at the facility. Direct care staff Dinar Ranger stated Resident A was incontinent and often soiled his briefs multiple times a day. She stated he would sometimes soil his bedding which would be changed the same day. While at the facility I inspected each resident bedroom. All the rooms and bedding were clean and there was no odor of urine or feces.

While at the facility on 10/25/2022 I was contacted by the licensee designee Jan Ranger. Ms. Ranger stated that Resident A had very serious bouts of diarrhea, but they would always clean him and his bedding daily.

While at the facility on 10/25/2022 I interviewed Resident B. Resident B stated he had no concerns about the facility. He stated the facility bedding is always clean. I then interviewed Resident C. Resident C stated the facility bedding is kept very clean.

On 11/03/2022 I contacted Relative 1-A. Relative 1-A stated Resident A has been more difficult to care for than she imagined, and they have found a placement for him at a facility in Cadillac. She stated we could meet at his guardian's home for an interview tomorrow.

On 11/04/2022 I interviewed Resident A, Relative 1-A and Guardian 1-A. Relative 1-A stated she was at the facility on 9/14/2022 and noticed two feces stains on his bedding. Relative 1-A provided me a photo of Resident A's bedding. The photo showed two spots on the sheets that had a feces stain on them. I then interviewed Resident A privately. Resident A was oriented to time, place, and person with the assistance of his watch. Resident A stated he was able to toilet himself and the staff helped him when needed. He stated his sheets would get cleaned but sometimes it would be a couple of days.

On 12/07/2022 I contacted the licensee, Jan Ranger. Ms. Ranger agreed to meet at the facility on 12/12/2022.

On 12/12/2022 I interviewed the licensee designee Jan Ranger. Ms. Ranger denied that Resident A's bedding was not laundered after being soiled. She stated his sheets would be replaced with new linens when soiled and his bedding never went without linens. She stated he had been having serious bowel issues and would take his clothes off and sit on his bed naked. She stated there were days that they would give him 3-4 showers because of his accidents. While at the facility I inspected all the residents bedding which was clean.

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	Relative 1-A provided a photo she stated was taken on 9/14/22 that showed two small feces stains on the sheets. Resident A stated the bedding would be cleaned but sometimes it would take a couple of days. The licensee designee Jan Ranger stated the linens were always changed if soiled and that Resident A would frequently sit on his bedding after soiling his briefs and taking a shower which would require his bedding to be changed. During two onsite inspections on 10/25/2022 and 12/12/2022 all of the residents bedding was in good condition and clean. Residents B and C both stated the facility bedding is always kept clean. There is not a preponderance of evidence that Resident A's bedding was not changed and laundered at least once a week or more often if soiled.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility entrance was blocked.

INVESTIGATION: On 10/18/2022 I contacted Relative 1-A. Relative 1-A stated that since the beginning of September and for about three weeks there were boxes blocking the front entrance of the facility hallway.

On 10/25/2022 I made an unannounced onsite inspection at the facility. The front entrance to the facility was clear. Direct care staff Dinar Ranger stated the home has been replacing flooring throughout the facility. She denied that the facility entrance has ever been blocked. While at the facility I observed several flooring contractors replacing flooring in the facility.

While at the facility on 10/25/2022 I was contacted by the licensee designee Jan Ranger. Ms. Ranger stated that the facility entrance has not been blocked. She stated they have been replacing flooring in the facility and may have moved furniture to block a hallway while they repair flooring. She denied that any means of egress was blocked.

While at the facility on 10/25/2022 I interviewed Resident B. Resident B stated he had no concerns about the facility. He stated the facility flooring has been getting repaired, but the means of egress has never been blocked. I then interviewed Resident C. Resident C stated the facility flooring has been getting repaired, but the hallways are never blocked.

On 11/04/2022 I interviewed Relative 1-A. Relative 1-A stated the front entrance of the facility was blocked with boxes for several weeks. She provided me with a photo showing the front entrance of the home with a bench and small chest in the middle of the hallway.

On 12/07/2022 I contacted the licensee, Jan Ranger. Ms. Ranger agreed to meet at the facility on 12/12/2022.

On 12/12/2022 I interviewed the licensee designee Jan Ranger. Ms. Ranger denied that the facility entrance was ever blocked. I showed her the photo of the bench and chest in the middle of the hallway. Ms. Ranger stated that that day the facility carpet was being replaced and the floor was very sticky. She stated they put the bench and chest there to divert resident traffic away from the area. She stated at no point were means of egress blocked and there were at least two other means of egress from the resident hallways.

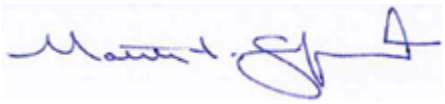
APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(2) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.

ANALYSIS:	Relative 1-A provided a photo that she stated was taken in September 2022 in which there is a bench and chest in the hallway. The licensee designee Jan Ranger stated the facility was having the flooring replaced and the bench and chest was diverting traffic away from the construction area. She stated at no time were means of egress blocked. There is not a preponderance of evidence that a means of egress was not maintained to provide free and unobstructed egress from all parts of the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 12/15/2022 I conducted an exit conference with licensee designee Jan Ranger. Ms. Ranger stated she will remind staff to lock the medication cabinet anytime it is going to be left unsupervised. She stated she made numerous calls to the VA to get Resident A's prescription filled and will document all attempts in the future. She stated she will submit a corrective action plan for approval.

IV. RECOMMENDATION

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



12/15/2022

Matthew Soderquist Date
Licensing Consultant

Approved By:

12/15/2022

Jerry Hendrick Date
Area Manager