GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2022

Brooke Bosman
Rhema-Armada Village Operating, LLC
22600 W. Main Street
Armada, MI 48005

RE: License #: AL500382675
Investigation #: 2023A0617004
Pine View Assisted Living

Dear Ms. Bosman:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500382675
Investigation #:	2023A0617004
Complaint Receipt Date:	10/28/2022
Investigation Initiation Date:	10/28/2022
Report Due Date:	11/27/2022
Licensee Name:	Rhema-Armada Village Operating, LLC
Licensee Address:	22600 W. Main Street Armada, MI 48005
Licensee Telephone #:	(586) 473-3227
Administrator:	Brooke Bosman
Licensee Designee:	Brooke Bosman
Name of Facility:	Pine View Assisted Living
Facility Address:	22580 Main Street Armada, MI 48005
Facility Telephone #:	(586) 473-3227
Original Issuance Date:	08/02/2016
License Status:	REGULAR
Effective Date:	01/01/2021
Expiration Date:	12/31/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility has insufficient staffing to meet the needs of the residents.	Yes
Management Megan Frazier, Sherry Sklba, David Duffy, Kerri is faking staff schedules and putting names on there of people who do not work at the facility to appear fully staffed.	Yes
Resident neglect and abuse are happening in the facility. Resident B has unexplained bruises on her body.	Yes
Resident A fell and was left unattended.	Yes

III. METHODOLOGY

10/28/2022	Special Investigation Intake 2023A0617004
10/28/2022	Special Investigation Initiated - Letter Email was sent to Ms. Boseman the licensing designee
10/28/2022	Contact - Document Sent Email to Ms. Boseman
11/01/2022	Inspection Completed On-site I conducted an unannounced onsite investigation of the facility. During the onsite investigation, I interviewed the unapproved licensee designee David Duffy, office manager Dian Thomas, Nurse Karen Philips, Rebecca Shewfelt, facility scheduler Megan Frazier, and Delaney Verschure.
11/01/2022	Contact - Telephone call made TC to David Duffey
11/01/2022	Contact - Document Sent Email sent to Mr. Duffey
11/01/2022	Contact - Document Sent Email to Ms. Brooke Boseman
11/03/2022	Contact - Document Received I received and reviewed the staff schedule with a print date of 11/3/22 at 3:42PM for the time period of 11/01/22 to 12/03/22.

11/21/2022	Contact - Document Received I received and reviewed a screen shot of a text message from Ms. Frazier to staff
11/21/2022	Contact - Telephone call made TC to Christina Helzer
11/21/2022	Contact - Telephone call made TC to Makenzie Walker
11/21/2022	Contact - Telephone call made TC made to Dawn Chapman
11/21/2022	Contact - Telephone call made TC to Karlie Friedman
11/21/2022	Contact - Telephone call made TC to Tammi Helzer
11/22/2022	Contact - Face to Face I conducted another unannounced onsite investigation at the facility During the onsite investigation, I interviewed staff members Delaney Verschure, Karlie Friedmann, managers Keri Sikora, Sherry Skivba, Diane Thomas and Ruby Buckner. I also interviewed Resident A, Resident B, Resident A and B's (married couple) son and daughter who were onsite visiting.
11/22/2022	Contact - Telephone call received I conducted a phone interview with facility's staff scheduler Megan Frazier.
11/22/2022	Contact - Telephone call made TC to Makenzie Sample
11/22/2022	Contact - Telephone call made TC to Rebecca Shewfelt
11/22/2022	Contact - Document Sent Email sent to Ms. Boseman and Mr. Duffey
11/29/2022	APS Referral An Adult Protective Services (APS) referral was completed
11/29/2022	Exit Conference I held the exit conference with Ms. Boseman and Mr. Duffey via telephone. The findings of the investigations were discussed.

12/01/2022	Contact – Face to Face I conducted an unannounced onsite investigation of the facility. During the onsite investigation, I interviewed the unapproved licensee designee David Duffy, Resident C, Resident D, Resident E, Resident F, and Resident G.
12/2/2022	Contact – Call Received I received a call from Resident A and Resident B's daughter

ALLEGATION:

- **Facility has insufficient staffing to meet the needs of the residents**
- **Management Megan Frazier, Sherry Sklba, David Duffy, Kerri is faking Schedules and putting names on there of people who do not work at the facility to appear fully staffed.**

INVESTIGATION:

On 10/28/22, I received a complaint on the Pine View Assisted Living facility. The complaint indicated that this facility has been reported before, there is no director, management, or staff on the grounds. This facility is being ran by young staff when they are there to work. This is a self-ran facility as the norm is 1 caregiver taking care of 10 residents. Residents have no one to feed, bath or care for them.

On 11/18/22, I received two additional complaints on the Pine View Assisted Living facility. The complaint indicated that residents are not being treated properly, we are extremely understaffed! When we call management about these issues, they won't answer the phone to come in and help us. We have three separate buildings and only two staff members sometimes 1 staff member will be left in the building alone to care for the residents in three separate buildings. Resident neglect and abuse is going on in this building and it has been brought up to management and nothing has been done. We have residents who are more than a two-person assist in this building and multiple staff member have injured themselves, assisting residents. A handful of residents need to be reassessed because they're becoming hard to care for. Residents are falling and no incident reports are being filled out, upper management isn't calling their family members to let them know that they have fell. We just had a state representative (Eric) come in our building on 11/1/22 and talk to staff and management about our staffing issues and they're faking the scheduling book to make it look to state like we're fully staff when in reality we are extremely understaffed!! The resident's family members have complained multiple times about the care their family members are receiving and nothing has changed!

The second complaint indicated that this place needs shut down!!!! We are so badly understaffed that our scheduler and management Megan Frazier, Sherry Sklba, David Duffy, Kerri are faking the schedule and putting names on there of people who aren't even there! The facility was left unattended today. There were only two workers in the entire building. This is how it is! We have no staff! No one to take care of the residents! The neglect is so bad!!! There were three residents who fell and had no incident report made on them. How is this legal?! Staffing is so concerned; they were about to call each family member and let them know what's going on. This is not right at all. Management knows that they have no one in the building and they ignored the calls and cries for help. It's sickening."

On 11/21/22, I received another complaint regarding the facility. The complaint indicated that this facility is extremely short staffed, and the facility is rewriting the schedule to make it seem like the facility is staffed to the state. Managers will leave the care staff on the floor without coverage for the next shift and not answer their phones, staff is being forced to work over resulting in a 16 hour shift multiple times a week. Residents are not being taken care of properly, falls and injuries are happening without the proper paperwork being filled out. Care staff has repeatedly told the managers and corporate about the negligence that is happening in this building, and nothing has been done to improve the quality of care that the residents have received. There are multiple residents that are a two-person assist and sometimes more and multiple care staff has injured themselves with trying to care for these residents! Care staff have been told that if a resident is on hospice that they don't have to get them up out of bed because they are on hospice.

This facility is one of three connected licensed AFC large facilities. The other two connected facilities are AL500382676 The Villages Community and AL500382677 Meadow Ridge Assisted Living.

On 11/01/22, I conducted an unannounced onsite investigation of the facility. During the onsite investigation, I interviewed the unapproved licensee designee David Duffy, office manager Dian Thomas, Nurse Karen Philips, Rebecca Shewfelt, facility scheduler Megan Frazier, and Delaney Verschure.

During the onsite investigation, I interviewed office manager Ms. Dian Thomas. According to Ms. Thomas, there are several residents at the facility who requires at least two staff members to assist with care at times. Ms. Thomas stated that the residents who required multiple staff to assist with care is due to their combative behaviors. The residents do not consistently display the behaviors and it is not possible to predict when the residents' behaviors will change, causing the need for additional staff. Ms. Thomas stated that the facility always staffs at least two staff during the daytime hours.

During the onsite investigation I interviewed staff Delaney Verschure. According to Ms. Verschure there are several residents who need two or more staff to provide proper care. The facility lacks the proper staff to meet all the needs of the residents. There are times when there is only one staff member on shift to care for all of the residents and their needs are too much for one staff member to meet them all. Those residents had to sit in soiled briefs until the next staff member came in. Ms. Verschure stated that there are often multiple residents who need care at the same time.

During the onsite investigation, I interviewed staff Ms. Rebecca Shewfelt. According to Ms. Shewfelt there is not enough staff to meet all the needs of the residents. There have been multiple times when she had to cover multiple buildings at once for care and medication. Ms. Shewfelt stated that afternoons are when the facilities are most short staffed. In this facility there are residents who require two or more staff to properly care for them. There are also two residents who due to their size and physical conditions, require up to four or more staff to assist. This causes issues when there is only one staff member working. According to Ms. Shewfelt, management is rarely available for assistance to staff.

During the onsite investigation, I interviewed facility's staff scheduler Megan Frazier. According to Ms. Frazier, she schedules at least one staff member per facility when she has enough staff to do so. She stated that she does not always have the staff to cover all three buildings and therefore there are times when the facilities are without appropriate staffing and staff would have to cover multiple buildings at once.

During the onsite investigation, Ms. Frazier provided me with a staff schedule that had a print date of 11/1/22 at 12:30PM for the time period of 09/25/22 to 11/05/22. According to the schedule, direct care staff are scheduled from 6 am to 2:15pm, 2pm to 10:15pm, and 10pm to 6:15am. The medication passers are scheduled from 6 am to 2:30 pm and 2pm to 10:30pm.

I observed the following scheduling issues with regards the facility:

- I observed that on 09/27/22, there was no staff scheduled from 10:30pm to 6am.
- I observed that on 09/30/22, there was no staff scheduled from 10:30pm to 6am.
- I observed that on 10/08/22, there was no staff scheduled from 10:15pm to 6am.
- I observed that on 10/08/22, there was no medication passer scheduled from 2pm to 6am.
- I observed that on 10/22/22, there was no staff scheduled from 10:30pm to 6am.
- I observed that on 10/23/22, there was no staff scheduled from 3am to 4:30am.
- I observed that on 10/27/22, there was no staff scheduled from 10:15pm to 6am.

On 11/03/22 at 4:32pm, I received and reviewed the staff schedule that had a print date of 11/3/22 at 3:42PM for the time period of 11/01/22 to 12/03/22. The staff schedule showed a fully staff schedule with coverage for all shifts.

On 11/21/22, I received and reviewed a screen shot of a text message from Ms. Frazier to staff on 11/3/22 at 2:03pm stating, “Alert: I am testing something for the schedule, please don’t freak out if you see changes, please go off your normal schedule. It will be fixed by tomorrow mid-morning thank you.” I also received several pictures of Resident A with bruises on her side.

On 11/22/22, I conducted an unannounced onsite investigation at the facility. During the onsite investigation, I interviewed staff members Delaney Verschure, Karlie Friedmann, managers Keri Sikora, Sherry Skivba, Diane Thomas and Ruby Buckner. I also interviewed Resident A, Resident B. Resident A and B’s (married couple) son and daughter who were onsite visiting.

During the investigation I interviewed staff Karlie Friedmann. She stated that caring for the residents at the facilities is too much work for one person to do alone. She has often had to pass medications and care for the residents at the same time. According to Ms. Friedmann, there are times where she is forced to take residents around the facility while she cares for other residents in their room because she is scared to leave the residents unattended. She believes that this is an invasion of the resident’s privacy but due to being short staffed she had to prioritize the safety of the residents over resident privacy. According to Ms. Friedmann, she was scheduled to work yesterday 11/21/22, from 6 am to 2pm. She did not specify which home and she was not listed on the schedule that the facility provided. There was no other med tech schedule to work after 2pm. She texted Ms. Frazier and asked her what to do and Ms. Frazier stated that manager Sherry Skivba said to pass the evening medications early and leave at 3pm. Ms. Friedmann stated that she felt that was wrong and she did not feel comfortable doing that to the residents so she stayed until 7 pm to ensure that the residents would receive their medication at the appropriate time. Ms. Friedmann showed me a text message from Ms. Frazier that stated, “if you go to Diane, she will print you the paper MAR (Medication Administration Record) and you could do the meds and be done by 3 if you don’t mind staying an extra 30 minutes”.

During the investigation I interviewed staff Delaney Verschure. According to Ms. Verschure, the facility is still extremely short staffed and there is a growing concern for the wellbeing of the residents. When the facility is short staffed and does not have anyone to pass medications, manager Sherry Skivba tells her to pass the evening medications early and chart it on a paper copy of the Medication Administration Record and Ms. Skivba will put it in the system at 6pm to make it look like it was given at the appropriate time. Ms. Verschure stated that she has given evening medications to residents that were not to be given prior to 6pm as early as 2 or 3 pm. Ms. Vershure was visibly upset as she stated it is not okay how the residents are being treated.

On 11/22/22, I conducted a phone interview with facility’s staff scheduler Megan Frazier. According to Ms. Frazier, she was unable to meet with me during my onsite investigation at the facility today because she was instructed by the facility’s unapproved acting licensee designee David Duffey that when I come to the facility, she is to leave and take a lunch until I am gone to avoid being interviewed by me. Ms.

Frazier believes that Mr. David Duffey, Keri Sikora, and Sherry Skivba are trying to "throw her under the bus" for the staffing issues. Ms. Frazier stated that she has made Mr. David Duffey, Keri Sikora, and Sherry Skivba aware multiple times about the staffing issues, and they did not care. Ms. Frazier stated that when I conducted my onsite investigation on 11/01/22, she was yelled at and berated by Mr. Duffey for not lying to me about the scheduling issues. During the onsite investigation on 11/1/22, I requested a copy of November's staff schedule. I was told that the schedule would be scanned and emailed to me. Ms. Frazier stated that she was instructed by Mr. David Duffey, Keri Sikora, and Sherry Skivba to fill in every hole in the November schedule, even if she had to include the names of employees who no longer work at the facility so that it would look full. Once completed and the schedules were sent to me, she was then instructed to go back and take out the added names. Ms. Frazier stated she told Mr. Duffey that she was not comfortable with lying and he threatened to take disciplinary action against her. According to Ms. Frazier, on 11/3/22, Mr. David Duffey, Keri Sikora, and Sherry Skivba instructed Ms. Frazier to send out a staff wide email to the staff indicating to ignore the schedule changes and to continue to use their normal schedule as she would adjust the schedules back the next morning

According to Ms. Frazier, the facility is going down fast and the care the residents are receiving is not adequate and does not meet their needs. The facility is losing staff at an alarming rate due to the staffing conditions at the facility. According to Ms. Frazier, Mr. David Duffey, Keri Sikora, and Sherry Skivba are never in the building and never available to assist. Whenever Ms. Skivba is contacted for assistance, she just tells them to figure it out. Ms. Skivba told Ms. Frazier that staff will be okay working short staff as they will get used to it. According to Ms. Frazier, Ms. Skivba has instructed staff to pass evening medications early because they are so short staffed, and Ms. Skivba goes back and enters into the system so it will appear that the meditations were given at the appropriate time. Ms. Frazier stated that the residents require too much care for just one or two staff members per building to handle. Even though she is not care staff she has volunteered time assisting the residents because of the staffing crisis. Ms. Frazier stated that during the night shift there is usually at least two people covering the three buildings. According to Ms. Frazier, after I left the facility, Mr. David Duffey, Keri Sikora, and Sherry Skivba made the staff stay for another 8-hour shift with no prior notice due to being short staffed. Ms. Frazier stated that by forcing staff to work 16 straight hours is going to exhaust the staff which will impact the care of the residents. Many of the staff that is there today, has to be back at 6 am the morning. According to Ms. Frazier, she submitted her resignation today because she can't continue to work under these conditions and circumstances. She stated that the residents are in danger due to the lack of staffing and negligence.

On 11/22/22, I conducted a phone interview with staff Ms. Makenzie Sample. According to Ms. Sample, lack of staffing is a huge concern. Management is putting the names of people on the schedule who no longer works at the facility so the schedule appears full but it is not. Staff will often not show, and management will not provide coverage. Ms. Sample stated she has been put on the schedule multiple times for 16-hour shifts but she only worked 8 hours. Ms. Sample stated that there have been times when she had

to work all three facilities simultaneously due to the staff shortage. There are times when she must provide care and pass medications, which is too much for one staff member to complete because of the resident's needs. This is also cause for many medications to be given late. On 11/21/22, Ms. Sample was forced to provide medications to all three facilities from 5:57am to 11:48am. Ms. Sample, did not specify which facility, but stated that residents are not being taken care of properly, and resident falls are increasing. The falls are not being properly documented and the families are not being notified.

On 11/22/22, I conducted a phone interview with staff Rebecca Shewfelt. According to Ms. Shewfelt, resident neglect and abuse is happening in all three facilities. There are several residents who require more than a two-person assist in this building. There are several residents due to their physical size require more than two staff members to assist. There was a resident who fell last week and due to his size the fire department was called to assist with getting him up. There have been times when staff members have injured themselves, assisting residents. Residents are being neglected and not properly cared for. There are residents being sent to the hospital without the families being notified. Hospice residents are not being adequately cared for, especially their hygiene needs. Management is faking the schedule to make it look like the facilities are fully staffed but they are not. According to Ms. Shewfelt, after I left management made the staff stay for another 8-hour shift with no prior notice due to being short staffed.

On 12/01/22, I conducted an unannounced onsite investigation of the facility. During the onsite investigation, I interviewed unapproved licensee designee David Duffy, Resident C, Resident D, Resident E, Resident F, and Resident G.

According to Resident C, in general the facility is good, but they are short staffed. She doesn't always get served right away and sometimes it is hard to find staff when needed. However, there has not been a time when she needed staff and could not get them.

According to Resident D, the facility is a good and secure place. The facility needs a lot more employees because one staff member can't care for the entire facility. There are always staff available to assist but she must wait a long time for them to come. Resident D stated that it could take staff 10-15 minutes to come to her and if she needed immediate help, she would push her call button rapidly to get a faster response.

According to Resident D, the facility needs more help. The food is always cold, as she has never eaten much cold food.

According to Resident E, the staff is very nice and provides good care to her. The facility is short handed and sometimes staff must go to other buildings to help. There is always someone available for assistance if she needs it and she has no issues finding staff for help. However, Resident E stated that she must wait approximately 10 minutes before staff will come.

According to Resident F, the care she receives is fine and no concerns other than there is not enough staff to help her. Resident F stated that there has been times when she needed staff and couldn't get anyone to help her. Sometimes she has to wait a long time for staff to come to help her. Resident F was observed sitting in her wheelchair in her room. Resident F stated that she did not feel good and wanted to lay down in bed but she could not find her call button. According to Resident F, she had been sitting in her wheelchair for a long time and staff does not check on her often. I could not find a call button for Resident F and had to go around the facility looking for staff to assist Resident F.

According Resident G, the care is very good and staff is wonderful. The facility is short staffed but she has no concerns to report. Resident G stated that she waits less than 5 minutes for staff to come when assistance is requested.

On 12/2/22, I received a phone call from Resident A and Resident B's daughter. According to Resident A and Resident B's daughter, she has growing concerns on the staff shortage at the facility. Resident A and B's daughter stated that her parents are not receiving adequate care to the family's standards due to the lack of staffing. Resident A and B's daughter stated that the family is looking to discharge Resident A and Resident B soon to place them somewhere better suited to meet their needs.

I conducted an exit conference on 11/29/22 with Mr. Duffey. Mr. Duffey stated that he would call Ms. Boseman on a three-way conference call. A woman said hello but did not interact or speak during the conference. I could not confirm that Ms. Boseman was the female individual on the conference call. Ms. Boseman has not responded to any emails or phone call attempts since 10/11/22. The findings of the investigations were discussed during the conference.

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:	I observed the following scheduling issues with regards the facility: On 09/27/22, there was no staff scheduled from 10:30pm to 6am. On 09/30/22, there was no staff scheduled from 10:30pm to 6am. on 10/08/22, there was no staff scheduled from 10:15pm to 6am. on 10/08/22, there was no medication passer scheduled from 2pm to 6am. on 10/22/22, there was no staff scheduled from 10:30pm to 6am. on

	10/23/22, there was no staff scheduled from 3am to 4:30am on 10/27/22, there was no staff scheduled from 10:15pm to 6am. According to the staff schedules, the facility did not have at least one person working at all times. Therefore, the facility does not have sufficient direct care staff on duty at all times. The facility does not having at least 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.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0617017 dated 06/30/22; CAP dated 7/13/22.**

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:	I observed the following scheduling issues with regards to the facility: on 09/27/22, there was no staff scheduled from 10:30pm to 6am; on 09/30/22, there was no staff scheduled from 10:30pm to 6am; on 10/08/22, there was no staff scheduled from 10:15pm to 6am; on 10/08/22, there was no medication passer scheduled from 2pm to 6am; pn 10/22/22, there was no staff scheduled from 10:30pm to 6am; on 10/23/22, there was no staff scheduled from 3am to 4:30am; on 10/27/22, there was no staff scheduled from 10:15pm to 6am. Multiple staff report that the facility does not have the necessary staffing to meet the needs of the residents. In addition, the facility did not have resident assessment plans with the required information.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0617017 dated 06/30/22; CAP dated 7/13/22.**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Multiple staff report that the facility does not have the necessary staffing to meet the needs of the residents. The facility did not have resident assessment plans with the required information. According to Ms. Verschure there are several residents who need two or more staff to provide proper care. The facility lacks the proper staff to meet all the needs of the residents. On 10/30/22, Ms. Verschure worked from 6am to 2pm and there were three residents she did not have time to change their briefs after lunch. Those residents had to sit in soiled briefs until the next staff member came in. According to Ms. Verschure, there are often multiple residents who need care at the same time. According to Ms. Friedmann, there are times where she is forced to take residents around the facility while she cares for other residents in their room because she is scared to leave the residents unattended. Ms. Sample stated that residents are not being taken care of properly, and resident falls are increasing. The falls are not being properly documented and the families are not being notified.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0617017 dated 06/30/22; CAP dated 7/13/22.**

ALLEGATION:

- **Resident neglect and abuse are happening in the facility, Resident B has unexplained bruises on her body.**
- **Resident A fell and was left unattended**

INVESTIGATION:

During the onsite, I interviewed Resident A and Resident B. According to Resident A, he has trouble walking but he manages to get around. A few weeks ago, he went to the restroom alone and fell forward and hit his head. He stated he felt like he was left on the floor for a “really long time”. When staff found him on the floor they were unable to get him up due to his size. Staff had to call for the local fire department to come and help him up. Resident A did not report any injuries other than a headache from hitting his head.

According to Resident B, Resident A was in the bathroom when he fell. Resident B stated it took a long time for staff to come and help Resident A.

Resident B was observed to have bruising on the sides of her body as well as on her breast. Resident B stated that staff uses a sit to stand assistive device, or they tie gait belts around her body to get her up and transport her. Resident B believes the straps are the cause of her bruising. Both Resident A and Resident B stated that staff are very nice and friendly with them and they have no issues to report.

According to Resident A and Resident B's son, the facility's lack of staffing is an issue, and more staff could improve the care provided for the residents.

According to Resident A and Resident B's daughter, the facility is short staffed and there has been issues with getting Resident B up and to the bathroom. She does not believe the straps from the devices are causing the bruising on Resident B's breast. Resident A and B's daughter stated that Hospice provided a sit to stand assistive device, but the facility is not using it but instead using their own sit to stand which has straps that the hospice approved device does not. During the interview I observed both devices in Resident A and Resident B's room.

I requested resident assessment plans for Residents A and Resident B from Keri Sikora, Diane Thomas and Sherry Skivba who were the managers present during the onsite investigation. However, the facility could not provide assessment plans with the appropriate information that is required.

During the investigation I interviewed staff Karlie Friedmann. According to Ms. Friedmann, Resident B requires at least two staff members to get her up and transport her. Ms. Friedmann stated that two staff are required even if the assistive devices are used.

On 11/22/22, I conducted a phone interview with staff Rebecca Shewfelt. According to Ms. Shewfelt, resident neglect and abuse is happening in all three facilities. There are several residents who require more than a two person assist in this building. There are several residents due to their physical size require more than two staff members to assist. Resident A fell last week and due to his size the fire department was called to assist with getting him up. Resident B has bruising due to staff not properly transporting her. Resident B requires two or more staff to properly care for her needs due to her physical condition.

I conducted an exit conference on 11/29/22 with Mr. Duffey. Mr. Duffey stated that he would call Ms. Boseman on a three-way conference call. A woman said "hello" but did not interact or speak during the conference. I could not confirm that Ms. Boseman was the female individual on the conference call. Ms. Boseman has not responded to any emails or phone call attempts since 10/11/22. The findings of the investigations were discussed during the conference call.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident B was observed to have bruising on the sides of her body as well as on her breast. Resident B stated that staff uses a sit to stand assistive device, or they tie gait belts around her body to get her up and transport her. According to Resident A, he felt like he was left on the floor for a “really long time”. When staff found him on the floor, they were unable to get him up due to his size. Staff had to call the local fire department to come and help him up. On 10/30/22, Ms. Verschure worked from 6am to 2pm and there were three residents she did not have time to change their briefs after lunch. Those residents had to sit in soiled briefs until the next staff member came in. Ms. Verschure stated that there is often multiple resident who need care at the same time. The facility did not have resident assessment plans with the required information.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0617017 dated 06/30/22; CAP dated 7/13/22.**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident B was observed to have bruising on the sides of her body as well as on her breast. Resident B stated that staff uses a ‘sit to stand’ assistive device, or they tie gait belts around her body to get her up and transport her. According to Resident A, a few weeks ago, Resident A went to the restroom alone and fell forward and hit his head. According to Resident A, he felt like he was left on the floor for a “really long time”. When staff found him on the floor they were unable to get him up due to his size. Staff had to call for the local fire department to come and help him up. On 10/30/22, Ms. Verschure worked from 6am to 2pm

	and there were three residents she did not have time to change their briefs after lunch. Those residents had to sit in soiled briefs until the next staff member came in. Ms. Verschure stated that there is often multiple resident who need care at the same time. The facility did not have resident assessment plans with the required information.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0617017 dated 06/30/22; CAP dated 7/13/22.**

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.** **(b) Be capable of appropriately handling emergency situations.** **(c) Be capable of assuring program planning, development, and implementation of services to residents consistent with the home's program statement and in accordance with the resident's assessment plan and care agreement.**
ANALYSIS:	According to several staff members, the management team of Megan Frazier, Sherry Sklba, David Duffy, and Kerri are faking the schedule by putting names of people on the schedule who do not work at the facility. Ms. Frazier stated that she was instructed by Mr. David Duffey, Keri Sikora, and Sherry Skivba to fill in every 'hole' in the November schedule, even if she had to include the names of employees who no longer work at the facility so that it would look full. Once completed and the schedules were sent to me, Ms. Frazier was then instructed to go back and take out the added names. Ms. Frazier told Mr. Duffey that she was not comfortable with lying and he threatened to take disciplinary action against her. On 11/21/22, I received a screen shot of a text message from Ms. Frazier to staff on 11/3/22 at 2:03pm indicating, "Alert: I am testing something for the schedule, please don't freak out if you see changes, please go off your normal schedule. It will be fixed by

	tomorrow mid-morning thank you." Although the schedules were adjusted to show no openings, staff were told to continue using the old schedule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15209	**Home records; generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(d) Resident records.**
ANALYSIS:	During the onsite investigation, I requested resident assessment plans for Residents A and Resident B from Keri Sikora, Diane Thomas and Sherry Skivba who were the managers present in the home. However, the facility could not provide assessment plans with the appropriate information that is required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(6) A licensee and the administrator shall have a high school diploma, or general education diploma or equivalent and not less than 1 year of experience working with the population identified in the home's program statement and admission policy.
ANALYSIS:	On10/11/22, Licensee designee/administrator, Brooke Boseman, submitted documentation to remove herself as licensee designee and appoint Mr. David Duffey to replace her as the Licensee Designee. However, after review of the submitted documentation, it was determined that Mr. Duffey did not meet the qualifications required to be licensee designee. Mr. Duffey's documentation did not show proof of 1 year of experience working directly with the resident population. After submitting the documentation, Ms. Boseman went on an extended leave until 1/17/23, leaving the facility without a department approved licensee designee or administrator. Mr.

	Duffey has assumed the position since 10/11/22. I attempted to contact Ms. Boseman multiple times via email and telephone without success.
CONCLUSION:	**VIOLATION ESTABLISHED**

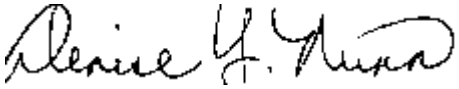
IV. RECOMMENDATION

I recommend revocation of the license.

12/07/22

Eric Johnson Date
Licensing Consultant

Approved By:



12/08/2022

Denise Y. Nunn Date
Area Manager