GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 8, 2022

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

RE: License #: AL500382677
Investigation #: 2023A0617007
Meadow Ridge 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. A recommendation for revocation is also being made in Special Investigation Report #2023A0617011. 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 #:	AL500382677
Investigation #:	2023A0617007
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:	Meadow Ridge Assisted Living
Facility Address:	22590 W. 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?
Insufficient staffing to meet the needs of the residents.	Yes
Management Megan Frazier, Sherry Sklba, David Duffy, Kerri are faking staff schedules and putting names of people on the schedule who do not work at the facility to appear fully staffed.	Yes
Resident A was observed with dried feces on her skin in the vaginal area, pubic, and groin.	Yes

III. METHODOLOGY

10/28/2022	Special Investigation Intake 2023A0617007
10/28/2022	Special Investigation Initiated – Letter Email was sent to licensee designee (LD) Ms. Boseman
10/28/2022	Contact - Document Sent Email sent 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 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 with Mr. Duffey
11/01/2022	Contact - Document Sent Email sent to Mr. Duffey
11/01/2022	Contact - Document Sent Email sent to Ms. Boseman
11/01/2022	Contact - Telephone call made I conducted a phone interview with Resident A daughter

11/01/2022	Contact - Document Received Received email from Resident A daughter that contained a signed IR and several pictures
11/03/2022	Contact - Document Received I received 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 a screen shot of a text message from Ms. Frazier to staff
11/21/2022	Contact - Telephone call made Christina Helzer
11/21/2022	Contact - Telephone call made Makenzie Walker
11/21/2022	Contact - Telephone call made Dawn Chapman
11/21/2022	Contact - Telephone call made Karlie Friedman
11/21/2022	Contact - Telephone call made Tammi Helzer
11/22/2022	Contact - Face to Face 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.
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

11/23/2022	Contact - Document Received I received a statement from Resident A's granddaughter.
11/29/2022	APS Referral I made an Adult Protective Services (APS) referral.
11/29/2022	Exit Conference I held an 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 unapproved licensee designee David Duffy, Resident B's daughter.
12/02/2022	Contact- Telephone call received I conducted an interview with Resident B's second daughter

ALLEGATION:

- **Insufficient staffing to meet the needs of the residents**
- **Management Megan Frazier, Sherry Sklba, David Duffy, Kerri are faking staff schedules and putting names of people on the schedule who do not work at the facility to appear fully staffed.**
- **Resident A was observed with dried feces on her skin in the vaginal area, pubic, and groin.**

INVESTIGATION:

On 10/28/22, I received a complaint on Meadow Ridge Assisted Living facility. The complaint stated 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 them or bath them or care for them. Upon changing Resident A's brief, I found her with dried feces on her skin in the vaginal area, pubic, and groin. There were also feces dried up in pubic hair. I checked for the last time she was given a shower and it was two weeks prior. I had a caregiver by name of Delaney view the feces on her and asked for it to be documented. I also took a picture of the feces too. I have incident documented and signed by a facility caregiver.

On 11/18/22, I received two additional complaints on Meadow Ridge Assisted Living facility. The complaint stated 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 one staff member will be left in the building alone to care for the residents in three separate buildings. Resident neglect and abuse are going on in this building and it has been brought up to management and nothing has been done. 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 stated 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 stated 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.

This facility is one of three connected licensed AFC large facilities. The other two connected facilities are AL500382675 Pine View Assisted Living and AL500382676 The Villages Community.

On 11/01/22, I interviewed Resident A's daughter. According to Resident A's daughter, upon changing Resident A's brief, she found Resident A with dried feces on her skin in the vaginal area, pubic, and groin. There were also feces dried up in pubic hair. Resident A's checked for the last time she was given a shower and it was two weeks prior. She had a caregiver Delaney view the feces on her and asked for it to be documented. Resident A's daughter also took a picture of the feces too. Resident A's daughter sent me an incident report signed by Delaney Verschure. According to the incident report dated 10/15/22 at 10:45am, Resident A had dried up BM in groin, and pubic area. Nurse notified; Midnights had gotten her up. According to Resident A's daughter, on 10/25/22, Resident A was over medicated by Med Tech Heidi and licking the table with her tongue because she was so over medicated.

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

During the onsite investigation I interviewed staff Delaney Verschure. 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. On 10/30/22, Ms. Verschure stated that she worked from 6am to 2pm and there were 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. There are times when one staff will have to do care and medications for the Meadow Ridge facility. There is not enough time to properly do both with just one staff due to the high needs of the residents. On 10/24/22 from 4:30pm to 2:15am, they were short staffed and all of the residents' needs were not met.

According to Ms. Verschure, on 10/15/22, Resident A and Resident A's daughter were in the salon doing Resident A's hair. Resident A's daughter called Ms. Verschure over and complained that Resident A was not being properly cleaned and had dried feces on her vaginal area. Ms. Verschure stated that she did not see any feces, but the area was very red. Ms. Verschure completed an incident report at the request of Resident A's daughter to make her happy even though she did not see any feces.

During the onsite investigation on 11/01/22, I interviewed Resident A. According to Resident A, all staff takes too long to change her briefs and staff is hard to find. Resident A was unable to tell me if, when or how often she is showered. Resident A stated that she thinks she bathes herself, but she was unsure.

During the onsite investigation on 11/01/22, I interviewed staff Hedi Junga. According to Ms. Junga, she does not believe she gave Resident A more medication than what was prescribed. Ms. Junga stated that if she gave Resident A extra medication or medication at the incorrect time, the computer system used to document medication administration would give an error and Ms. Junga did not receive one. According to Ms. Junga, Resident A did not show any signs of being overmedicated or any abnormal behavior. Ms. Junga, stated that Resident A's daughter who was present on 10/25/22, is not very involved in her mother's care and is unaware of her medical needs.

During the onsite investigation on 11/01/22, I completed a medication review of Resident A's medication. No errors were observed.

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. According to Ms. Shewfelt, management is rarely available for assistance to staff. Residents are not being changed in timely fashion due to the lack of staffing.

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 to the facility:

- On 09/26/22, there was no staff scheduled from 2:30pm to 10pm.
- On 10/29/22, there was no staff scheduled from 6:30pm 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."

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."

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

During the onsite investigation, I interviewed staff Karlie Friedmann. She stated that caring for the residents at the three 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. There was no other med tech schedule to

work after 2pm. She did not specify which building and she was not listed on the schedule that the facility provided.

During the onsite 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. Ms. Verschure stated that she has given evening medications to residents as early as 2 or 3 pm that were not to be given prior to 6pm, because of lack of staffing. 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 whole 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 stating 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. Ms. Skivba then 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. Ms. Frazier 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. On 11/12/22, Ms. Sample was on the schedule to work from 6am to 10:30pm but she was only supposed to work until 2:15pm. Ms. Sample clocked out at 2:38pm. I checked the staff schedule provided to me by the facility on 11/3/22, and Ms. Sample was scheduled to work from 6am to 10:30pm. 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 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. Residents are being neglected and not properly cared for. There are residents being sent to the hospital without the families being notified. 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 11/23/22, I received a statement from Resident A's granddaughter. According to Resident A's granddaughter, on 10/25/22, she arrived at the facility to have dinner with Resident A and visit.

On 12/1/22, I conducted an unannounced onsite investigation of the facility along with Licensing Consultant, Kristen Donnay. During the onsite investigation, I interviewed unapproved licensee designee David Duffy and Resident B's Daughter.

According to Resident B's daughter, the facility needs more staff but the staff they do have is amazing with her mother. Sometimes there is only one staff member in the facility to care for the residents and staff will have to call for assistance from other buildings. Resident B's daughter stated that she visits her mother almost three times a week and when she is with her mother, she tries to do as much care for her to lighten the load of the staff due to their staffing issues. Resident B's daughter stated that she had a concern and complained about how the facility handled her mother having COVID. When her mother contracted COVID, she was transferred to an affiliated Orchards facility in Detroit. The family was not notified in advance of the move. Once Resident B was at the Detroit location, the family did not have access to her or any updates on her condition. After about 13 days, Resident B was transferred back to the Meadow Ridge facility. According to Resident B's daughter, the transfer had an incredibly negative impact on her mother's mental and physical health. It took Resident B several days to calm down from the trauma of being transferred out for an extended period of time. Resident B's daughter stated that it was an extremely frustrating and a scary experience for the family.

On 12/02/22, I received a call from Resident B's second daughter. According to Resident B's second daughter, she has major concerns about the facility. The facility is facing serious staffing issues which is impacting the care that Resident B is receiving. When Resident B first arrived at the facility it was under a different ownership group. Since the ownership change the quality of care at the facility has declined greatly. According to Resident B's second daughter, Resident B contracted COVID in September of this year and was transported to another facility in Detroit without the family's approval or even being notified. Resident B was out of the facility for 13 days and the family received minimal updates. When Resident B's second daughter attempted to call management, she felt like she was being given "the run around" as to what was going on. She made several attempts to get updates with no success. Resident B's second daughter reported that management was very rude and unprofessional. Resident B's second daughter stated that the family receives very little updates on Resident B's medical status. They are not made aware of appointments or the results of the appointments. Resident B's second daughter has additional concerns with regards to Resident B's medications. Resident B's second daughter was told by staff when she was visiting that her mother had been having issues with low potassium. After reviewing Resident B's medication with her son, Resident B's second daughter discovered that one of Resident B's medications is conflicting with another one of her medications that is causing the low potassium. Resident B's second daughter tried to go over the medication with staff at the facility, but they did not seem to be knowledgeable. Resident B's second daughter believes that the facility is not doing an adequate job of keeping the family informed on the care of Resident B. Resident B's second daughter stated that on 11/13/22, she went to the facility to visit Resident B and Resident B's brief and clothing were soaking wet. It appeared that she had not been changed in hours due

to the amount of urine that was present. According to Resident B's second daughter, there was another time she went to visit her mother and her mother was still wearing the same clothes from the previous day. It did not appear she was changed into pajamas and redressed the next day. Since the change of ownership, the lack of staffing has increased as there are now only 1 or 2 staff working per shift and that is not enough to care for the residents.

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 to the facility: on 09/26/22, no staff scheduled from 2:30pm to 10pm; on 10/29/22, no staff scheduled from 6:30pm 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 #2022A0617020 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 the facility: on 09/26/22, there was no staff scheduled from 2:30pm to 10pm. on 10/28/22, there was no staff scheduled from 6:30pm to 6am on 10/29/22. 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 #2022A0617020 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 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 400.15303	**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:	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 stated that she worked from 6am to 2pm and there were 3 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. 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:	**VIOLATION ESTABLISHED**

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 stated 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 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:	**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 Resident A and Resident B from Keri Sikora, Diane Thomas and Sherry Skivba who were the managers present during the onsite investigation. The managers could not provide assessment plans with the appropriate information that is required.
CONCLUSION:	**VIOLATION ESTABLISHED**

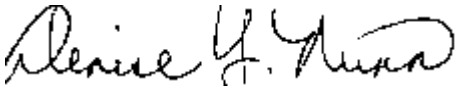
IV. RECOMMENDATION

I recommend revocation of the license, which is also being made in Special Investigation Report #2023A0617011.

12/07/22

Eric Johnson Date
Licensing Consultant

Approved By:



12/08/2022

Denise Y. Nunn Date
Area Manager