GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 20, 2023

LeeAnne Love Woolley
621 S M-30
Gladwin, MI 48624

RE: Licensee #: AF260401827
Investigation #: 2023A0466008
La Paz AFC

Dear Mrs. Love Woolley:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality of care violations, disciplinary action against your licensee 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 (517) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

Licensee #:	AF260401827
Investigation #:	2023A0466008
Complaint Receipt Date:	11/23/2022
Investigation Initiation Date:	11/23/2022
Report Due Date:	01/22/2023
Licensee Name:	LeeAnne Love Woolley
Licensee Address:	621 S M-30 Gladwin, MI 48624
Licensee Telephone #:	(989) 701-5717
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	La Paz AFC
Facility Address:	621 S M-30 Gladwin, MI 48624
Facility Telephone #:	(989) 426-8517
Original Issuance Date:	05/27/2020
Licensee Status:	1ST PROVISIONAL
Effective Date:	10/25/2022
Expiration Date:	04/24/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATIONS:

	Violation Established?
Guardian A1 was not informed of Resident A's hospital admittance on 11/22/2022 by licensee LeAnne Love Woolley.	Yes
On 11/21/2022 and 11/22/2022, Resident A, Resident B, Resident C, Resident D and Resident E were left with a person who is not authorized to provide care to them.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/23/2022	Special Investigation Intake- 2023A0466008.
11/23/2022	Special Investigation Initiated – Letter from licensing consultant Jennifer Browning received information from APS Ryan Christensen.
11/23/2022	APS Referral - not required APS worker Ryan Christensen already assigned.
11/28/2022	Contact - Telephone call made to APS Ryan Christensen, message left.
11/29/2022	Contact - Telephone call received from APS Ryan Christensen, interviewed.
11/30/2022	Referral - Recipient Rights.
12/01/2022	Contact - Telephone call received- Sarah Watson ORR interviewed.
12/05/2022	Inspection Completed On-site with ORR Sarah Watson.
12/05/2022	Contact - Telephone call made to case manager Justice Petty, message left.
12/05/2022	Contact - Telephone call made to Kaylynn Drews; phone number did not go through.
12/06/2022	Contact - Telephone call received case manager Justice Petty, interviewed.

12/09/2022	Contact - Telephone call received from ORR Sarah Watson.
12/09/2022	Contact - Telephone call made to Daniel Woolley, interviewed with ORR Sarah Watson.
12/27/2022	Inspection Completed On-site- No one home.
01/09/2023	Inspection Completed On-site.
01/09/2023	Exit Conference with licensee Love Woolley.
01/18/2023	Telephone call to licensee Love Woolley, message left.

ALLEGATION: Guardian A1 was not informed of Resident A's hospital admission on 11/22/2022 by licensee LeeAnne Love Woolley.

INVESTIGATION:
On 11/23/2022, Complainant reported Guardian A1 received a call from Midland Hospital on 11/23/2022 informing Guardian A1 Resident A was ready for discharge. Complainant reported licensee Love Woolley never informed Guardian A1 Resident A was in the hospital. Complainant reported once Guardian A1 was aware Resident A had been in the hospital, it took Guardian A1 several attempts to reach licensee Leeanne Love Woolley by phone. Complainant reported licensee Leeanne Love Woolley told Guardian A1 Resident A aspirated on 11/19/2022 but medical attention was not sought for Resident A until Resident A's scheduled doctor appointment on 11/22/2022. Complainant reported Resident A was taken to the hospital right from the doctor's office per the doctor's order. Complainant reported Guardian A1 was distraught regarding the situation because she could have been at the hospital with Resident A had she known. Complainant reported licensee Love Woolley response was she did not want to say anything to Guardian A1 until she "knew something." Complainant reported licensee Love Woolley failed to take action at the time of the aspiration, and she did not inform Guardian A1 of Resident A's change in medical condition or hospitalization.

On 11/23/2022, licensing consultant Jennifer Browning interviewed Adult Protective Services (APS) worker Ryan Christians who reported he has an open case with Resident A. APS Christians reported he had not been able to follow up with licensee Love-Woolley yet but planned to go to the home the following week to interview licensee Love Woolley about the current allegations.

On 11/29/2022, APS Christians reported he met with Resident A and licensee Love Woolley today. APS Christians reported licensee Love-Woolley confirmed she took Resident A to a scheduled primary care physician (PCP) appointment on 11/22/2022 at which time the physician called for an ambulance and Resident A was taken to My Michigan Hospital in Midland. The appointment was scheduled due to Resident A

aspirating on 11/19/2022 despite having ingested no food or drink. This occurred with no known cause according to licensee Love Woolley. APS Christians reported licensee Love-Woolley again confirmed Resident A was taken to the hospital due to the physician's concern she could have pneumonia after. APS Christians reported Guardian A1 had not been notified of Resident A's hospitalization on 11/22/2022 by licensee Love-Woolley rather Guardian A1 was notified by the hospital of Resident A's admission. APS Christians reported licensee Love-Woolley said, "in my defense it was really late that night" when she got home from the hospital, so she decided it was better to call Guardian A1 the next day. Licensee Love Woolley also stated she called the hospital three times for updated information on Resident A's condition but could not speak with anyone who could provide an update. Given she did not have current information, licensee Love Woolley stated she did not want to Guardian A1 to "worry needlessly" so she was waiting to obtain more information before calling. APS Christens stated licensee Love-Woolley talked with Guardian A1 later in the day on 11/23/2022 and Guardian A1 was upset with her for not notifying her immediately of Resident A's hospitalization. APS Christens reported that licensee Love-Woolley's waiting to inform Guardian A1 with an update versus calling Guardian A1 right away was a "lesson learned."

On 12/05/2022, Sarah Watson, Office of Recipient Rights (ORR) Officer and I conducted an unannounced onsite investigation and we interviewed licensee Love Woolley who reported Resident A aspirated three times: on 11/19/2022, 11/20/2022 and 11/21/2022. Licensee Love Woolley reported that on 11/19/2022 when Resident A did not have any food or drink in front of her, she simply started coughing which licensee Love Woolley reported was not typical. Licensee Love-Woolley reported that on 11/20/2022 while eating "mashed up" cake and ice-cream to minced moist texture, Resident A aspirated and was "holding her head like she had a headache." Licensee Love Woolley reported because Resident A was still breathing and did not require cardiopulmonary resuscitation (CPR), she did not feel the need to contact an ambulance or have Resident A medically examined. Licensee Love Woolley reported she took Resident A's vitals which she stated were "normal", but licensee Love Woolley did not have any written documentation of Resident A's vitals. Licensee Love Woolley reported Resident A's blood oxygen level was "good" and she did not have a fever but reported that she did not document those results in Resident A's record either at the time of this choking incident. Licensee Love Woolley reported that on 11/21/2022 while in the van without any food or drink in front of her Resident A was coughing/choking again. Licensee Love Woolley reported since this was the third time Resident A was coughing/choking for no reason she became concerned, so she scheduled a doctor appointment for 11/22/2022. Licensee Love Woolley reported that when she and Resident A arrived at the doctors' office on 11/22/2022 around 2pm and Resident A was anxious, so the doctor directed her to take Resident A directly to the hospital. Licensee Love Woolley reported an ambulance was not called rather she transported Resident A to the hospital. Licensee Love Woolley reported she was at the hospital with Resident A from about 2:30pm until midnight and although some tests had been done, licensee Love Woolley reported she did not have any of those results, so she opted

to wait for that information before calling Guardian A1 about Resident A's hospitalization. Licensee Love Woolley reported early the next morning (11/23/2022) Guardian A1 called yelling at her about not being informed about Resident A being hospitalized. Licensee Love Woolley reported although she talked with Guardian A1 on the phone about Resident A's hospitalization, she never submitted anything in writing to Guardian A1 about the hospitalization. Licensee Love Woolley reported she submitted a written incident report to Resident A's case manager Justice Petty. Licensee Love Woolley reported she went back to the hospital on 11/23/2022 when Resident A was discharged. Licensee Love Woolley reported when Resident A was discharged, she was told that Resident A was treated for pneumonia and was prescribed an antibiotic for three days.

On 12/05/2022, I reviewed Resident A's *After Visit Summary* dated 11/22/2022-11/23/2022 which listed the following reason, "hypoxia/observation." The discharge instructions had information pertaining to pneumonia and stated a follow-up was required with her physician within 1 week.

On 12/05/2022, I reviewed Resident A's record and did not find a written *AFC Incident/Accident Report Form* regarding Resident A's hospitalization on 11/22/2022.

On 12/06/2022, I interviewed Resident A's case manager Justice Petty who reported she contacted licensee Love Woolley on 11/23/2022 around 9:55 am to schedule a home visit and licensee Love Woolley did not mention anything about Resident A's hospitalization. Case manager Petty reported at approximately noon on 11/23/2022 Guardian A1 contacted her about Resident A's hospitalization and being upset licensee Love Woolley did not inform her Resident A's hospitalization. Case manager Petty reported at around 2pm on 11/23/2022 licensee Love Woolley called her to report Resident A had aspirated on 11/19/2022, 11/20/2022 and 11/21/2022 as previously described above. Case manager Petty reported licensee Love Woolley sent her an incident report about the hospitalization via email. Case manager Petty reported she did not believe the incident report was sent to Guardian A1 as she does not have an email address. Case manager Petty reported being at the AFC home on 11/29/2022 and reported she did not observe Resident A cough while she was there. Case manager Petty reported licensee Love Woolley did not report Resident A had any follow-up care from her primary care physician (PCP) nor any appointment had been scheduled for Resident A since being discharged from the hospital on 11/23/2022.

On 12/12/2022, Guardian A1 reported Resident A was hospitalized during the late hours of 11/22/2022 early morning hours of 11/23/2022. Guardian A1 reported licensee Love Woolley never contacted her to inform her of Resident A's hospitalization rather she learned of Resident A's hospitalization when the hospital contacted her after Resident A was ready for discharge. Guardian A1 stated she was contacted after the hospital could not get a hold of licensee Love Woolley to inform her Resident A was ready for discharge and pick-up. Guardian A1 reported that she contacted licensee Love Woolley who stated she was waiting to get more information about test results before she called her about the hospitalization.

Guardian A1 reported licensee Love Woolley never gave her a written report related to Resident A's hospitalization. Guardian A1 reported Resident A is non-verbal and had she known she was hospitalized she would have immediately gone to the hospital so Resident A did not have to be alone. Guardian A1 admitted she was upset with licensee Love Woolley for not letting her know immediately Resident A was in the hospital. Guardian A1 reported when Resident A was hospitalized last year, she stayed with Resident A at the hospital during that time. Guardian A1 reported licensee Love Woolley knew Guardian A1 stayed with Resident A while she was hospitalized the last time so it did not make any sense to Guardian A1 why licensee Love Woolley would not inform her of the current hospitalization.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by telephone, followed by a written report to the resident's designated representative and responsible agency within 48 hours of the following: **(b) Any accident or illness requiring hospitalization.**
ANALYSIS:	Licensee Love Woolley reported on 11/22/2022 Resident A was admitted to the hospital late on 11/22/2022 or the early morning hours of 11/23/2022. Guardian A1 contacted licensee Love Woolley to get more information about Resident A's hospitalization by phone on 11/23/2022. Licensee Love Woolley admitted she did not provide Guardian A1 with a written report about Resident A's hospitalization even though a verbal report was provided within 48 hours of hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 11/21/2022 and 11/22/2022, Resident A, Resident B, Resident C, Resident D and Resident E were left with a person who is not authorized to provide care to them.

INVESTIGATION:
On 12/12/2022, Complainant reported that on 11/21/2022 and 11/22/2022, Resident A, Resident B, Resident C, Resident D and Resident E were left with a person who was not authorized to provide care to them. On 11/22/2022, Resident B, Resident C, Resident D and Resident E were left with a person who is not authorized to provide care to them.

On 12/05/2022, ORR Watson and I conducted an unannounced onsite investigation and we interviewed licensee Love Woolley who reported that on 11/21/2022 while she was at a personal doctor appointment she left Resident A, Resident B, Resident C, Resident D and Resident E in the van and in the care Daniel Woolley. Licensee

Love Woolley reported Daniel Woolley has not been trained as a responsible person to care for Resident A, Resident B, Resident C, Resident D and Resident E as he is not a direct care worker instead, he is a member of household only. Licensee Love Wooley also reported Daniel Woolley has not been fingerprinted through the Michigan Workforce Background Check system. Licensee Love Woolley reported Daniel Woolley has been with the residents in the van without her on other occasions such as when she has an appointment, has to run into the store or if another resident has a doctor or dental appointment because she cannot bring all the residents into the medical office with her.

Licensee designee Love Woolley reported that on 11/22/2022, Resident A was sent to the hospital while at a doctor appointment, so from about 2pm until midnight on 11/22/2022 she left Resident B, Resident C, Resident D and Resident E in the care of Kaylynn Drews who was not trained as a responsible person to care for residents nor had she been fingerprinted through the Michigan Workforce Background Check system. Licensee Love Woolley reported Kaylynn Drews had been "shadowing her" as she wanted Kaylynn Drews to get to know the residents before she trained her as it has been her past experience that potential responsible person employees leave once they get to know the residents as they do not want to care for their personal needs. Licensee Love Woolley reported she does not have a trained responsible person available to provided care for up to 72 hours in the event of an emergency. Licensee Love Woolley reported she has not had a responsible person available in this capacity or any responsible person to work at the AFC family home for at least two years. Licensee Love Woolley did not report the name of the responsible person that she had when she was issued her license.

On 12/05/2022, ORR Watson and I asked to interview Daniel Woolley, however licensee Love Woolley reported he was in bed sick with the flu. Licensee Love Woolley yelled for him a couple of times and he refused to be interviewed.

On 12/05/2022, I attempted to call Kaylynn Drews but the number provided by licensee Love Woolley did not go through.

On 12/09/2022, ORR Watson and I interviewed Daniel Woolley who confirmed that on 11/21/2022 while licensee designee Love Woolley was at a personal doctor appointment, he was left in the van with Resident A, Resident B, Resident C, Resident D and Resident E to provide supervision, protection, and personal care. Daniel Woolley reported he was not trained to care for the residents, nor had he been fingerprinted through the Michigan Workforce Background Check system. Daniel Woolley confirmed this was not the first time that he has been in the van alone with the residents. Daniel Woolley reported he stays in the van with the remaining residents while other residents have appointments as licensee Love Woolley cannot take them all into the medical office. Daniel Woolley reported he also stays in the van with the residents when licensee Love Woolley has a personal appointment or if she needs to run into the store. Daniel Woolley reported licensee Love Woolley was in the process of training Kaylynn Drews, who care for residents

on 11/22/2022 while licensee Love Woolley was with Resident A at the hospital. Daniel Woolley denied caring for the residents on 11/22/2022.

On 12/09/2022, ORR Watson and I asked to review employee records for Daniel Woolley, licensee Love Woolley and Kaylynn Drews however licensee Love Woolley reported she did not have any documents available for review for any responsible person/employee. This included fingerprint results, physical healthcare statements and/or negative TB test results.

On 01/09/2022, I conducted a second unannounced onsite investigation and interviewed licensee Love-Woolley who reported neither Daniel Woolley nor Kaylynn Drews have been fingerprinted as required. Licensee Love Woolley reported she still does not have anyone trained, fingerprinted and available as a responsible person to provide care in an emergency for up to 72 hours. Licensee Love Woolley reported that she is the only person who works at the facility.

On 01/09/2023, I asked a licensee Love Woolley again to review responsible people/employee records for Daniel Woolley, licensee Love Woolley and Kaylynn Drews and again licensee Love Woolley reported she did not have any documents available to review for any responsible person/employee.

On 01/17/2023, I completed a file review in the Bureau Information Tracking System (BITS) and there was no responsible person listed in the facility file.

Special Investigation # 2022A0466054 dated 09/29/2022 established rule violation of MCL 400.734 (b)(2) because licensee Love Woolley allowed Daniel Woolley to provide personal care to Resident A on 08/22/2022 despite not being fingerprinted.

Special Investigation # 2022A0466054 dated 09/29/2022 established rule violation R400.1404 (8) because licensee Love Woolley reported her responsible person died several months ago and she admitted she did not have a current arrangement with a responsible person in case of emergency.

APPLICABLE RULE	
MCL 400.734	**400.734b. This amended section is effective January 9, 2009 except Section 734b(1)(e)(iv) after the word "or" which will not be effective until October 31, 2010.** **Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents after April 1, 2006 until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5). This subsection and subsection (1) do not apply to 18 an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. Beginning April 1, 2009, an individual who is exempt under this subsection shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (12). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006. That individual may transfer to another adult foster care facility that is under the same ownership with which he or she was employed or under contract. If that individual wishes to transfer to an adult foster care facility that is not under the same ownership, he or she may do so provided that a criminal history check is conducted by the new facility in accordance with subsection (4). If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under subsection (1)(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	Licensee Love Woolley and household member Daniel Woolley both reported that on 11/21/2022 while licensee Love Woolley was at a personal doctor appointment, she left Resident A, Resident B, Resident C, Resident D and Resident E in the car in the care Daniel Woolley knowing he was not fingerprinted through the Michigan Workforce Background Check system and not cleared to provide care to vulnerable adults. Additionally, on 11/22/2022 licensee Love Woolley and Daniel Woolley both reported licensee Love Woolley and Daniel Woolley left Resident B, Resident C, Resident D and Resident E in the care of Kaylynn Drews for over nine hours knowing she was not fingerprinted and cleared through the Michigan Workforce Background Check to provide care to vulnerable adults.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2022A0466054 AND CAP DATED 10/24/2022].**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility. **(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all of the following areas:** **(a) An introduction to community residential services and the role of direct care staff.** **(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home.** **(c) Basic interventions for maintaining and caring for a client's health, for example, personal hygiene, infection control, food preparation, nutrition and special diets, and recognizing signs of illness.** **(d) Basic first aid and cardiopulmonary resuscitation** **(e) Proper precautions and procedures for administering prescriptive and nonprescriptive medications.**

	(f) Preventing, preparing for, and responding to environmental emergencies, for example, power failures, fires, and tornados. **(g) Protecting and respecting the rights of clients, including providing client orientation with respect to the written policies and procedures of the Licensed facility.** **(h) Non-aversive techniques for the prevention and treatment of challenging behavior of clients.** **(3) Training shall be obtained from individuals or training organizations that use a curriculum that has been reviewed and approved by the department.**
ANALYSIS:	On both 11/22/20222 and 11/23/2022, licensee Lee Anne Love Woolley knowingly left Residents A, B, C, D and E in the care of individuals who were not trained in all the required training elements for residents living in a facility with a special certification license. On 11/22/2022 residents were left with Daniel Woolley who was not trained and on 11/23/2022 residents were left with Kaylynn Drews who was also not trained. During the course of the investigation, Daniel Woolley reported he has been left alone with residents on numerous occasions to provide personal care, supervision, and protection to residents despite not being a trained responsible person/employee of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(8) A licensee shall have an arrangement with a responsible person who is available to provide care in an emergency for up to 72 hours.
ANALYSIS:	On 12/05/2022 and on 01/09/2022, licensee Love Woolley reported she still does not have anyone trained, fingerprinted and available to provide care in an emergency for up to 72 hours and has not had a responsible person for the past two years. Licensee Love Woolley reported that she and has been the only responsible person at the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2022A0466054 AND CAP DATED 10/24/2022].**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 12/05/2022, ORR Watson and I conducted an unannounced investigation and licensee Love Woolley could not provide any documentation that Daniel Woolley, Kaylynn Drews and licensee Love Woolley had been tested for communicable tuberculosis.

On 01/09/2022, I came to the facility for a second time unannounced and I interviewed licensee Love Woolley reported she could not provide any documentation that Daniel Woolley, Kaylynn Drews and licensee Love-Woolley had been tested for communicable tuberculosis within the last three-year period.

APPLICABLE RULE	
R 400.1405	**Health of a Licensee, responsible person, and member of the household.**
	(3) A Licensee shall provide the department with written evidence that he or she and each responsible person in the home is free from communicable tuberculosis. Verification shall be within the 3-year period before employment and verification shall occur every 3 years thereafter.
ANALYSIS:	On 12/05/2022 and on 01/09/2022, licensee Love-Woolley could not provide any documentation Daniel Woolley, Kaylynn Drews and licensee Love-Woolley had documentation of a negative communicable tuberculosis test result within the last three years as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 12/05/2022, ORR Watson and I conducted an unannounced investigation and licensee Love-Woolley could not provide us with any records or documentation for Resident A, Resident B, Resident C, Resident D and Resident E's therefore we could not review any residents' written assessment plans nor the resident care agreements.

On 01/09/2022, I came to the facility for a second time unannounced and I interviewed licensee Love-Woolley who reported that she has not been keeping up the resident records including the written assessment plans nor the resident care agreements for Resident A, Resident B, Resident C, Resident D and Resident E since August 2022. Licensee Love- Woolley reported that the "resident records are here somewhere probably in the shed," but she did not know where they were at the time of the inspection.

Special Investigation # 2022A0466054 dated 09/29/2022 established rule violation R 400.1416 (6) because Resident A's record did not contain any documentation the written resident care agreement had been reviewed annually in 2021 and 2022 with the resident or the resident's designated representative and responsible agency.

R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.** **(b) The kinds of services and skills required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	On 12/05/2022 and on 01/09/2022, licensee Love-Woolley could not provide documentation of a completed resident assessment plan for Resident A's Resident B, Resident C, Resident D and Resident E. This part of the resident record was not available for review.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2022A0466054 AND CAP DATED 10/24/2022].**

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(6) A Licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency at least annually or more often if necessary.

ANALYSIS:	On 12/05/2022 and on 01/09/2023, licensee Love Woolley could not provide documentation of a written resident care agreement for review for Resident A Resident B, Resident C, Resident D and/or Resident E.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2022A0466054 AND CAP DATED 10/24/2022].**

INVESTIGATION:
On 12/05/2022, I reviewed Resident A's record which contained an *After Visit Summary* dated 11/22/2022-11/23/2022 with "hypoxia/observation" listed as reason for the visit. The discharge instructions had information pertaining to pneumonia and stated follow-up was required with her physician within one week. I reviewed Resident A's record and found no written documentation Resident A had a follow-up appointment with her physician since being discharged from the hospital on 11/23/2022.

On 12/05/2022, ORR officer Watson and I conducted an unannounced on-site investigation and we interviewed licensee Love Woolley who reported Resident A has not seen her physician nor has licensee Love Wooley made any phone calls to her physician since Resident A's hospital discharge. Licensee Love Woolley stated she did not know realize a follow-up physician appointment was required.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician with regard to such items as medications, special diets, and other resident health care needs that can be provided in the home.
ANALYSIS:	Resident A was discharged from the hospital on 11/23/2022 with written discharge instructions to follow up with her physician within 1 week. On 12/05/2022, 12 days after Resident A had been discharged from the hospital, no follow-up appointment had been made with Resident A's physician as licensee Love-Woolley reported that she did not realize one was required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 12/05/2022, ORR officer Watson and I conducted an unannounced investigation and we interviewed licensee Love Woolley who reported Resident A was discharged from the hospital on 11/23/2022. Licensee Love Woolley reported when Resident A

was discharged, she was told Resident A was treated for pneumonia and was prescribed an antibiotic for three days. Licensee Love Woolley reported she administered Resident A the antibiotic as prescribed however Licensee Love Woolley reported she did not have Resident A's medication administration record (MAR) available for review and that the prescription medication bottle had been thrown out after she administered the last dose.

On 01/09/2023, I conducted a second unannounced investigation and I interviewed licensee Love Woolley who reported she did not have MARs for Resident A, Resident B, Resident C, Resident D and Resident E because she has not been keeping MARs for any of the residents since August 2022. Licensee Love Woolley reported the residents do not take many medications and that she is administering all medications as prescribed, so she is "just not documenting it." Licensee Love Woolley reported Resident A and Resident B moved to another facility, so their medications were not available for review. I did review the medications for Resident C, Resident D and Resident E. I compared the date the medications were filled to the current date (01/09/2023) and the medications appeared to be administered as prescribed. I could not compare the medications to Resident C, Resident D and Resident E's MARs as those were not available for review.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	During unannounced onsite investigations on 12/05/2022 and again on 01/29/2023, I was not able to review the medication administration records for Residents A, B, C, D, or E as Licensee Love Woolley had not maintained medication administration records for Resident A, Resident B, Resident C, Resident D or Resident E since August 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 12/05/2022, ORR officer Watson and I conducted an unannounced investigation and licensee Love-Woolley could not provide us with Resident A, Resident B, Resident C, Resident D and Resident E's resident records for review. Licensee Love-Woolley could not provide us with any residents' identifying information in

writing nor could she provide any resident weight records while we were at the home to review.

On 01/09/2022, I conducted a second unannounced onsite investigation and I interviewed licensee Love-Woolley who reported that she has not been “keeping up” the residents’ records including the identifying information and weight records for Resident A, Resident B, Resident C, Resident D and Resident E since August 2022.

Special Investigation # 2022A0466054 dated 09/29/2022 established rule violation R. 400.1422 (1)(a)(g) because Resident A’s record did not contain a monthly weight for Resident A since October 14, 2020. There were also no weight records for Residents B, C, D, and E.

APPLICABLE RULE	
R 400.1422	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number.** **(iii) Home address.** **(iv) Name, address, and telephone number of the next of kin or designated representative.** **(v) Name, address, and telephone number of person or agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(g) Weight record.**
ANALYSIS:	On 12/05/2022 and on 01/09/2022, licensee Love Woolley did not have any resident records including resident identifying information or weight records from August 2022 through December 2022 for Residents A, B, C, D, and E.
CONCLUSION:	**VIOLATION ESTABLISHED [SEE SIR#2022A0466054 AND CAP DATED 10/24/2022].**

INVESTIGATION:
On 12/05/2022, ORR officer Watson and I conducted an unannounced investigation and went into the first-floor resident bedroom shared by three female residents. While in the bedroom, we saw two closets that contained the family’s washer and

dryer. Licensee Love Woolley reported the washer and dryer are utilized by her and they have been in this location since the license was issued.

APPLICABLE RULE	
R 400.1431	**Bedrooms generally.**
	(4) Traffic to and from any room shall not be through a resident bedroom.
ANALYSIS:	The location of the washer and dryer in a resident bedroom creates traffic through that resident bedroom anytime the licensee or a household member uses the appliances. Given licensee Love-Woolley and/or household member utilize these appliances regularly, traffic through this resident bedroom is created to reach the appliances.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: **(p) The right of access to his or her room at his or her own discretion.** **(2) A licensee shall provide the resident and the resident's designated representative with a written copy of the rights outlined in subrule (1) of this rule upon a resident's admission to the home.**
ANALYSIS:	The washer and dryer create traffic into the residents' bedroom from those that need to use them therefore invading on the privacy of the residents in that bedroom because licensee Love Woolley needs access to the washer and dryer.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/09/2023, I conducted an exit conference with licensee Love Woolley who reported that she understood the findings of the investigation. Licensee Love Woolley reported she no longer wanted to own/operate an adult foster care facility.

IV. RECOMMENDATION

Due to the severity of the quality-of-care violations and repeated substantial non-compliance with the rules, I recommend revocation of the licensee.

01/18/2023

_____

Julie Elkins Date
Licensing Consultant

Approved By:

01/20/2023

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Dawn N. Timm Date
Area Manager