GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 30, 2023

Tracey Hamlet
MOKA Non-Profit Services Corp
Suite 201
715 Terrace St.
Muskegon, MI 49440

RE: License #: AS410015507
Investigation #: 2023A0357007
Ridgebluff Home

Dear Ms. Hamlet:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410015507
Investigation #:	2023A0357007
Complaint Receipt Date:	11/22/2022
Investigation Initiation Date:	11/22/2022
Report Due Date:	01/21/2023
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(616) 719-4263
Administrator:	Sergejs Toms Zvirgzds
Licensee Designee:	Tracey Hamlet
Name of Facility:	Ridgebluff Home
Facility Address:	8610 Ridgebluff SW Byron Center, MI 49315
Facility Telephone #:	(616) 878-4063
Original Issuance Date:	03/28/1994
License Status:	REGULAR
Effective Date:	10/22/2022
Expiration Date:	10/21/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A, who is a guarded adult, attempted a sexual assault with Resident B, who is a guarded adult, and the Incident/Accident report explaining the event was not provided to Resident A's guardian. Resident A was admitted to the hospital and his guardian did not receive the Incident/Accident of his admission to the hospital.	Yes
It was alleged that the home had inadequate staffing.	No
Additional Findings	Yes

III. METHODOLOGY

11/22/2022	Special Investigation Intake 2023A0357007
11/22/2022	Special Investigation Initiated - Telephone Contacted Sheryl Williams, Residential Coordinator.
11/22/2022	Contact - Telephone call made Recipient Rights, Kent County, Edward Wilson.
11/22/2022	Contact - Document Received Sent Email to Administrator, Sergejs Toms Zvirgzds, Administrator, Requesting MOKA's policy on reporting Incident and Accidents Reports.
11/29/2022	Contact - Telephone call made To Kent County Department of Health and Human Services, Emile Graves, Adult Protective Services. She reported that they are meeting weekly with Independent Supports Coordination the Hospital staff, and they have not found a placement for Resident A. Resident A remains in the hospital. I also called Resident A's Independent Supports Coordinator, Danielle Ritsema, concerning Resident A and she confirmed that Resident A remains at St. Mary's hospital and that she has not been able to place him.
12/14/2022	Contact - Document Received

	Mr. Zvirgzds sent an email confirming my earlier email.
01/16/2023	Contact - Telephone call made To Ms. Sheryl Williams, Residential Coordinator, and she reported to me that she had been sending me emails and I told her I had not received any from her. She figured out that she was not using my correct email address. Therefore, I had not received her emails. She apologized. I gave her my business card and she found one of my cards in the desk drawer.
01/17/2023	Contact - Document Received Ms. Williams reviewed what she had sent me to the wrong email address and then she these emails to my correct email address: Email dated 09/09/2022 from Ms. Williams which read in part that Resident A's Guardian/Family Member had been to the home to pick up Resident A's belongings and voiced he was filing a complaint with LARA. He stated that he wanted LARA to look at the home's videos. Ms. Williams explained that the home does not have any videos or security cameras.
01/17/2023	Contact - Document Received Ms. Williams sent me her email dated 8/18/2022 that read: Resident A is no longer is a resident of Ridgebluff Home. He was brought to St. Mary's hospital on 07/25/ 2022 and was discharged from the AFC home.
01/17/2023	Contact - Document Received Ms. Williams sent to me to my correct email address: Resident A's Community Living Services Inc., West MI, Individual Plan of Services (IPOS), effective date 11/01/2021. She sent me Resident C's Community Living Services Inc., IPOS effective date 10/21/2021. She sent me Resident D's network 180, IPOS, effective date 08/21/2022. She sent me Resident E's network 180, IPOS effective date 02/01/2022. Ms. Williams stated that the newest resident was admitted in late September 2022.
01/18/2022	I contacted Resident A's, Supports Coordinator, Danielle Ritsema, and she stated that Resident A was discharged from the hospital around Christmas, 2022 and he went home with his guardian/FM1. She did not have the exact date of discharge of Resident A.
01/18/2023	Inspection Completed On-site Announced inspection. Met with Sheryl Williams, Residential Coordinator.
01/18/2023	Contact - Document Received

	Ms. Williams re-sent me the IPOS's of the residents that she originally sent on 12/21/2022.
01/18/2023	Contact - Document Received Ms. Williams provide me with copies of Assessment Plan for AFC Residents for Resident B, C, D, E, and F. I reviewed these documents.[i]
01/18/2023	Contact - Face to Face Conducted Face-to-Face interviews with Direct Care Staff: Kadie Sawoh and Dollar Nyirahabimana. I conducted telephone interviews with Direct Care Staff: Florence Umutoni, Anna Repp, and David Mwee.
01/25/2023	Contact – Telephone made To direct care staff, Rebecca Parsley, interview.
01/26/2022	Contact - Document Received From Sheryl Williams by E-mail: Fire Drill records for 2022, E-Score, and Written Emergency Procedure and Evacuation Plan
01/27/2023	Contact – Telephone call made, conducted interviews To direct care staff, Florence Umutoni, and Anna Repp.
01/27/2023	Contact – Document received Received Resident F's addendum to her IPOS>
01/27/2023	I conducted an exit conference with the Licensee Designee, Tracey Hamlet.

The complainant included in a letter that Resident A was inappropriately discharged from the Ridgebluff Home. Our Director, Jay W. Calewarts, responded that we will not be looking into the alleged inappropriate discharge of Resident A because we have already completed an investigation and we did not find there was a violation to the rule. (Special Investigation 2022A0357031 dated 10/04/2022.) Therefore, we will investigate the two new allegations that were in the letter that have not been previously investigated.

ALLEGATION: Resident A, who is a guarded adult, attempted a sexual assault with Resident B, who is a guarded adult, and the Incident/Accident report explaining the event was not provided to Resident A's guardian.

INVESTIGATION: On 11/22/2022, I contacted Ms. Sheryl Williams, Residential Coordinator, by telephone and I explained that I was conducting a complaint investigation on the Ridgebluff home. During this interview I asked if she had provided the Incident/Accident Report to Resident A's guardian/Family Member 1, concerning the incident where Resident A had attempted to sexually assault Resident B on 07/22/2022. Ms. Williams explained that she had made numerous

attempts over six days to reach guardian/FM1, by emails, text messages, and phone messages, to call her, but there was no response. She reported that she left up to eight messages a day. She stated further that she felt she could not leave a message describing the incident in any of her three ways that she had attempted to reach guardian/FM1, but for each message she left, she explained that the incident was serious and that she needed to speak to him immediately. She explained that she did not send him the Incident/Accident Report because she understood that they were to contact the guardian, of the resident to verbally explained what had happened and then that individual was to request the Incident/Accident report, and since she had not received any response from guardian/FM1, she did not send the I/R. She did acknowledge that guardian/FM1 had contacted her by telephone on 07/27/2022 at 10:00 PM. She said he did not request the I/R. I then asked her about the I/R when Resident A was transported to the hospital on 07/25/2022. She verbally acknowledged that she did not send the I/R to the guardian/FM1, with the information that Resident A had been sent to the St. Mary's hospital. She explained further that Resident A was diagnosed at the hospital emergency room with COVID and was admitted to the Med/Surg Unit.

On 11/29/2022, I spoke by telephone with Emily Graves, Adult Protective Services. She reported that she along with the hospital staff have been meeting with Resident A's, Supports Coordinator, on a weekly basis and they had not found a suitable placement for Resident A. She reported that there had not been any Adult Foster Care home that were willing to take Resident A.

On 12/08/2022, I spoke by telephone with Resident A's, Supports Coordinator, Danielle Ritsema, and she confirmed that they had not found a suitable placement for Resident A, and he remained in St. Mary's hospital.

On 12/13/2022, I sent an email to Mr. Zvirgzds requesting the information I had asked for earlier.

On 12/14/2022, Mr. Zvirgzds, Administrator, sent me an email, MOKA's Policy and Procedure's related to reporting Incidents and Accidents, which I reviewed. Their policy was reviewed on 08/16/2019. Under their Procedure letter F, it read that their employees will cooperate with AFC, licensing. Under letter L it stated in part: Department Supervisors will ensure that competed Incident Accident Reports are routed as specified by the Regional/Division Director, (to) AFC Licensing, … Under their letter O it read in part: Incident reports involving …hospitalization, displays of serious hostility, attempts at harm to self or others,...require an attempt to contact the individual's guardian, responsible agency, by telephone and in (a licensed residential) follow with a written report to the individual guardian…Adult Foster Care Licensing within 48 hours. The MPower Incident Report from will be used to document all contacts and attempts to contact individuals as required by the AFC licensing rules. The contents of this document confirmed that Resident A's guardian/FM1, was to receive the two Incident/Accident Reports concerning the

sexual aggressiveness of Resident A to Resident B and for Resident A being admitted to St. Mary's hospital.

On 01/27/2023, I conducted a telephone exit conference with the Licensee Designee, Tracey Hamlet and she agree with my findings.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	It was alleged that the guardian/FM1 of Resident A did not receive the two Incident/Accident Reports from the AFC home concerning Resident A. Ms. Williams acknowledged that she had made reasonable attempts to contact Resident A's guardian/FM1, by telephone, emails, and text messages. There was no response from Resident A's guardian/FM1unitl six days after the incident. Ms. Williams acknowledged that she did not provide a written report for Resident A attempting to sexually assault Resident B on 07/22/2022 and she did not send the report for Resident A's admission to St. Mary's hospital on 07/25/2022. During the investigation there was evidence discovered that the guardian/FM1 of Resident A did not receive a written report on Resident A's sexual aggression/assault with Resident B on 07/22/2022. The AFC home sent Resident A to St. Mary's hospital on 07/25/2022 and did not send the written report to Resident A's guardian/FM1. Therefore, there is a violation to this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: It was alleged that the home had inadequate staffing.

INVESTIGATION: On 11/22/2022, I contacted Ms. Sheryl Williams, Residential Coordinator, by telephone and I explained that I was investigation a complaint on Ridgebluff home. I requested information on each resident, including their assessment plans, IPOS, and any behavioral treatment plans. She confirmed she would work on supplying me with these documents.

On 11/22/2022, I sent an email to Sergejs Toms Zvirgzds, the Administrator an email explaining that I was investigating a complaint of the Ridgebluff home. I also reported to him that I had contacted Ms. Williams and requested resident records.

On 11/29/2022, I telephoned Kent County Department of Health and Human Services, Emile Graves, Adult Protective Services. She reported that they are meeting weekly with Independent Supports Coordination, Danielle Ritsema, and the Hospital staff, and they have not found a placement for Resident A. Ms. Graves reported that Resident A remains in the hospital. I also contacted Ms. Ritsema and she confirmed that she had not been able to find a suitable placement for Resident A, although she has contacted numerous agencies and Adult Foster Care Homes. She confirmed he remains a patient at St. Mary's hospital.

On 01/16/2023, I telephoned Ms. Williams asking about the resident information I had requested, and she reported to me that she had been sending me emails and was wondering why I had not responded. I told her I had not received any from her. She figured out that she was not using my correct email address. Therefore, I had not received her emails. She apologized. I gave her my correct email

On 01/17/2023, Ms. Williams sent me information with my correct email address. Email dated (originally dated 09/09/2022) from Ms. Williams which read in part that Resident A's guardian/FM1 had been to the home to pick up Resident A's belongings and he said he wanted the videos from the home. Ms. Williams explained that the home does not have any videos or security cameras.

On 01/17/2023, Ms. Williams sent the following to my correct email address: Resident A's Community Living Services Inc., West MI, Individual Plan of Services (IPOS), effective date 11/01/2021. She sent me Resident C's Community Living Services Inc., IPOS effective date 10/21/2021. She sent me Resident D's network 180, IPOS, effective date 08/21/2022. She sent me Resident E's network 180, IPOS effective date 02/01/2022. Ms. Williams stated that their newest resident was admitted in late September 2022.

On 01/18/2023, Ms. Williams reported that when Resident A was in the home he urinates anywhere in the AFC home, for example: on his bed, on clothes which are often on the floor of his room, on the floor anywhere in the home and the home staff have made every effort to keep his room clean and free of smells. She also explained that he can be resistive to help from the staff. He often refuses to get up for breakfast

and then at lunch time he wants his breakfast and his lunch at the same time. He has refused to go to his physician's appointments or other medical appointments despite that the staff remined him the night before and they offered him a special breakfast.

On 01/18/2023, I contacted Resident A's Supports Coordinator, Danielle Ritsema and she stated that Resident A was discharged from the hospital around Christmas, 2022 and he went home with his guardian/FM1. She did not have the exact date of his hospital discharge. She explained that she continues to seek a suitable placement for Resident A.

On 01/18/2023, I made an announced inspection to the Ridgebluff Home. I met with Ms. Williams. Ms. Williams provide me with copies of Assessment Plan(s) For AFC Residents: Residents B, C, D, E, and F. These identified residents were living in the home at the time of the incident, 07/22/2022. We discussed the residents' needs. Ms. Williams explained that these vulnerable adults have no ability to defend themselves in anyway. She also reported that they all require total care. Three residents are in wheelchairs. She reported that each resident is guarded. She explained the staffing ratio of two staff on first and second shift and one awake on third shift. She also reported that the 3rd. shift staff check each resident every two hours or more depending on the needs of the resident. We reviewed the staff schedule. Ms. Williams stated that they have tried to have a third staff member on first and second shift for outings and medical appointments, but since COVID they have had a staff shortage as every AFC home has. She said they are constantly seeking new staff. I asked her if anyone had complained about not having their needs met. She said no one has complained. She said the staff do their very best and she has not observed any resident needs gone unmet. She stated that the staff work very hard to meet all of the residents' needs. She stated that Resident A had been in the hospital since his discharge from the AFC home. The home is licensed for six residents. Ms. Williams introduced me to the new Home Manager and explained she has one other home to care for, but she will be staring soon in the Ridgebluff Home. Ms. Williams express hope. She also reported that she is in the AFC home often. She stated that they have had sufficient staff on duty at all times.

On 01/18/2023, I had a short interview with Resident D. I asked her if all of her needs were met and she said, "Yes." I asked her if she receives her medication and she said, "Yes." I asked her if she felt safe in the and she said, "Yes." We had small talk about eating. Resident D was clean and neat and well dressed. Resident D appeared to be receiving adequate care and supervision.

On 01/18/2023, I met with Resident E, and we had a short interview. He indicated that all of his needs were met, and he had no concerns or complaints. He indicated he felt safe in his home. Resident E appeared to be receiving adequate care and supervision.

Resident B was observed but he is unable to speak. Resident F was resting, and she is unable to speak. Residents B and F appeared to be receiving adequate care and supervision.

On 01/18/2023, I conducted face-to-face interviews with Direct Care Staff: Kadie Sawoh and Dollar Nyirahabimana. I conducted telephone interviews with Direct Care Staff: Florence Umutoni, Anna Repp, Rebecca Parsley, and David Mwee. All staff reported they were fully trained. Upon questioning, each staff had an acute awareness of each resident's individual needs, including data sheets, and required documentation. Each staff spoke of the busyness of the job. They have many loads of laundry to do daily due to the incontinence of the residents. They reported that there is no time for breaks.

On 01/18/2023, several of the staff spoke of physical injures, received from Resident A when he was in the home. He would fight staff about everything. They also spoke about his behaviors, his aggression, and his urination in his room and occasional throughout the home. Direct care staff, Ms. Sawoh pointed to the floor just outside the kitchen and stated: "He just walked up here and peed on the floor." Ms. Sawoh reported Resident A hurt her physically and Ms. Repp reported that Resident A kicked her in the stomach and hurt her physically several times.

On 01/18/2023, I asked each individual staff if at any time they had not met any resident's specific needs. Each staff stated that they had met all of the resident's needs. They denied that any resident need when unmet. Direct Care staff, Ms. Umutoni, reported that maybe one resident's shower may have to be moved to the next day. I asked about being short of staff. Each staff expressed the same concern that they do not have a third staff on first and second shifts to help with outings and medical appointments. This was their concern that the residents can't go on their outings, and they all felt bad about it. Resident B was discussed, and he requires two staff on an outing and if only two staff are working, he cannot go out. They were stressed if a resident had a medical appointment and one staff had to take the resident and that would leave the home with only one staff member unless Ms. Williams was there. They also reported that they have open shifts on the staff schedule, and many reported that they will fill in those shifts. They reported that they two staff on first and second shifts and one on third shift when the residents are sleeping. I asked about change of shift concerns and the current staff (Ms. Parsley) for third shift reported that when she comes into work, she had found some residents were unchanged because of urine found in their adult protection. We discussed the incontinence of all of the residents and the fact that you can change them and in the next few minutes they urinate, and this can happen when they lay them back down. They all reported that they have been without a Home Manager for many months. All staff stated they enjoyed their job and they felt good about helping residents that needed their care.

On 01/18/2022, I conducted a telephone with direct care staff David Mwee. He confirmed that he has been working third shift. He reported that he works mostly on

3rd shift, since the last of August 2022. I asked if he had completed a fire drill on third shift and he reported he had not. We talked about the challenging behaviors, one resident with a Hoyer lift transferred to a wheelchair and she cannot move the wheelchair herself and two others in wheelchairs and he stated it could be tricky. He said: 'he would just do it.' He said Resident A use to be helpful, but he is no longer at the home.

On 01/18/2022, I conducted a telephone interview with direct care staff, Rebecca Parsley. She reported she has worked for MOKA for six years, but five of those years were with CLS and she had been in the Ridgebluff Home for a year. She explained that she had recently moved to third shift from first shift. She reported she only works part time, 16 hours, two shifts a week. I asked her if had completed a fire drill and she said only a couple times on first and second shift with two staff on duty.

On 01/19/2023, I reviewed the residents' documents provided by Ms. Williams. I reviewed Resident A's, Individual Plan of Service (IPOS), dated 11/01/2021. This was his plan at the Ridgebluff Home at that time of the incident on 07/22/2022. Resident A lived in this Specialized Residential home with community living supports, personal care, and supervision. His IPOS noted he has a tendency to just throw things on the floor instead of putting them away. He can be careless and breaks things. He also had a tendency to change his clothes multiple times per day. He will sometimes go into other resident's room and take their clothing to put on. Staff are to help him with maintaining appropriate boundaries and interactions with community members. They also support him to help him not take food or belongings from others. Resident A had a Behavioral Support Plan because he has eloped, and he has had physical aggressiveness. Even though he can feed himself he required constant supervision from staff while eating to prevent choking as well as taking other residents' foods. He will forget to change his adult protection or will report that he is soiled when he is not. He needed staff's help with showering and washing his hair. He needed partial physical assistance including prompting to complete his grooming and hygiene tasks. He needed help with brushing his teeth, total help to trim his nails and with his shaving. He can do the majority of his dressing, but he needed full assistance with his shoes and socks. He can ambulate and transfer independently but due to his Tardive Dyskinesia he appears to shuffle slowly. He has tremors in his hands and in his jaw. One of his diagnoses is Dysphagia, pharyngoesophageal phase. He struggles with sleeping and with insomnia. Staff provided continual checks on him throughout the night to help ensure he is sleeping on his side to help prevent him from chocking. He had times of agitation and aggression at least once per week that sometimes resulted in property destruction or harm to staff. He has a history of assaulting others and he primary targets females. He will wrestle people to the floor, punch, kick and pull hair. He has a history of destroying property while he is escalated. He has verbal outbursts that are aggressive in nature. He will yell, cuss, make racially derogatory comments, or sexually explicit remarks and this occurs on a weekly basis. He has tried to elope multiple times. He has run into the street, dropping his pants and urinating on the street.

On 01/19/2023, I reviewed Resident B's AFC assessment plan. Resident B is an elopement risk and lacks safety skills. The doors are alarmed. He is non-verbal. He lets staff know in gestures if he is hungry, tired, or otherwise uncomfortable. He can understand 1-2 step directives with cues from others. When he is upset, he may become agitated and then he jumps up and down and bites his hand. He can feed himself but requires supervision to slow down, not stuff his food in his mouth, or steal from others. His food has to be cut in bite size pieces. His diet is dysphasia 2, mechanical soft with thin liquids. He requires full assistance with bathing, dressing, grooming and personal hygiene. He wears adult protection, and he requires full assistance with changing and toileting as well as monitoring him, so he does ingest anything. He will put his hands into his adult protection and will remove fecal material which he will ingest. He needs staff to do hand-over-hand to make sure his hands are clean. Resident B has hearing loss and visual deficits. He also has a diagnosis of Pica. He will put anything into his mouth. He understands the words 'stop' and 'spit it out.' He has toys that he can chew on and hold onto. In the has exposed himself to others in the home or he stands in front of a window.

On 01/19/2023, I reviewed Resident C's AFC assessment plan and his IPOS. He uses a wheelchair, and he needs assistance in navigating his wheelchair. He has no safety skills. He is difficult to understand. He understands simple phrases, but he needs time to process and respond. Resident C is able to feed himself with a spoon and he receives food that has been puree and honey thick liquids. He requires supervision while eating to prevent choking or to assist him if he is tired or ill. He receives the supplement of Boost and honey thickened liquids. He is at risk for aspirating. He wears adult protection, and he needs assistance to use the toilet. He requires full assistance for bathing, grooming, dressing and personal hygiene. Resident C needs full assistance for all transfers. He is able to crawl or scoot, short distances. He uses a hospital bed, and he tires very easily. Resident C has a seizure disorder and potential for skin breakdown. His IPOS states that the staff are to reposition in bed side-to-side and in his wheelchair frequently at least every 2 hours during the night and 4 hours during the night. The staff makes sure he receives hourly checks throughout the night to monitor and ensure his health and safety. It can take up to 30+ minutes for Resident C to take his medications. He can give staff a hard time when it comes to taking/accepting his meds. He requires 24-hour supervision, to provide personal care and protection. He needs staff assistance in transferring. His fine and gross motor skills are impaired due to cerebral palsy. He has an oxygen machine that he requires ongoing support and assistance, and he is on oxygen 24-7. His health is very fragile, and he requires a lot of staff time. He has had several spells of pneumonia. He recently developed a skin break down on his bottom and he struggles with constipation and weight loss. He has attempted to elope. He was diagnosed with dementia in 2002. He cannot call for assistance and his communication skills are currently demonstrated at the 2-year, 6-month level. At the time of this inspection Ms. Williams reported he was in the hospital.

On 01/19/2023, I reviewed Resident D's AFC assessment plan and her IPOS dated 10/01/2021. She has a mild Intellectual Impairment. Her assessment plan stated she

has limited safety skills and she uses a wheeled walker for ambulation. She is unable to recognize danger which requires assistance from staff. She needs frequent prompts and reminders. Her skills to tell time are slowly diminishing and she is forgetful. The AFC assessment stated that her plan of service addresses concerns including verbal outburst, yelling, and crying due to anxiety. A times she uses offensive language in addressing others. She has a history of induced vomiting when her anxiety is high. Resident D is on a mechanical soft diet with ground meats, and she needs prompts to slow down and to finish her meals. Her BSP states, staff are required to put her food on two separate plates and assist her with eating bite by bite to ensure that she does not choke or throw up. She wears a pull up and she needs assistance with wiping especially after a bowel movement and after urination to avoid UTI (urinary tract infections). She needs reminders to use the bathroom and prompting to see if she had an accident, or she will not tell staff she needs new adult protection. She has urinary and bowel incontinence. She needs hands on assistance with bathing which includes hand over hand assistance and help with washing her hair and her body. She need assistance getting in and out of the tub and with drying. She needs prompts and assistance to complete grooming tasks, dressing and personal hygiene. She has clubbed feet and arthritis. She has braces on her legs and her feet and orthopedic shoes which staff have to assist her with all of these supports. She also has limited vision. She will be in “arm’s-length” of staff when she is in the community. Her IPOS read that they must manage her skin integrity, pain, prevention of falls and incontinence. Her Behavior Support Plan is to help her decrease her perseverating especially on time. She either yells or cries daily. Due to her arthritis her hands are being mostly nonfunctional. She has Rheumatoid Arthritis which has caused her more pain and Medication-induced acute akathisia.

On 01/19/2022, I reviewed Resident E’s AFC assessment plan and his network 180 IPOS. He has lived at Ridgebluff Home for more than 11 years. His plan indicated he uses a wheelchair for ambulation. He recently went on Hospice care. He has difficulty in feeding himself and is on a pureed diet. The IPOS has food guidelines which include many outlined steps how he is to eat and what is required of the staff during his meal and snack times. He has to be supported throughout the entire meal. He has shower chair for bathing, and he requires total assistance. He is incontinent and wears adult protection, but he has scheduled toileting times. He requires total care for dressing, grooming, and personal hygiene.

On 01/19/2022, I reviewed Resident F’s AFC assessment and her network 180 IPOS. Resident F is nonverbal and communicates through behaviors, facial gestures, and vocal utterances. She requires total care toileting and changing her adult protection, bathing, grooming, dressing, personal hygiene, and full assistance with taking her medication. She uses a wheelchair for ambulation, and she is not able to move her wheelchair. She uses a hospital bed. She uses a scoop plate and spoon to feed herself and she has a two-handed sippy cup. Her diet is mechanically soft. At times she needs hand to hand assistance. She has significant limitation in regard to her range of motion and therefore she requires full physical support for completing tasks. She is total care. The staff use a Hoyer to transfer into bed and out of bed into her

wheelchair. Her AFC assessment read that she has constipation, kidney stones and kidney stones with infections, UTI's, dysphasia, kyphosis, and hypertonia.

On 01/25/2023, I re-interviewed direct care staff, Ms. Parsley, by telephone. She stated that Mr. Mwee, the other third shifter, had just secured a new job two weeks ago, so he is going to part time hours. She reported that Mr. Zvirgzds, Administrator, had recently called her to ask about her training in fire safety and who from MOKA had trained her.

On 01/26/2023, I reviewed all of the fire drills for one-year 2022, including 1st. 2nd, and 3rd shift. I found that they were conducted within a safe time frame of fire drills and were under 8 minutes according to our 2012 Adult Foster Care Fire Safety Rules.

On 01/27/2022, I conducted a telephone interview with direct care staff, Florence Umutoni. I asked her how long she thought it would take her to Hoyer lift Resident F when she was sleeping, and she reported an estimate of 3 minutes. The staff has to put the support device under the resident before they can lift her up. I asked her about Resident E if he was sleeping. She stated it depends on the day. Some days he cannot balance himself and she said she has to ask another staff for help and reported that it takes two staff to put him in his wheelchair She reported it can take up to 5 minutes to transfer him. I asked her about Resident C, and she estimated about 2 to 3 minutes.

On 01/27/2022, I conducted a telephone interview with direct care staff, Anna Repp. I asked her how long it would take to transfer Resident F to her wheelchair if she was sleeping and she stated 3 minutes. I asked her about transferring Resident E if he was asleep and she stated 2 minutes if she did alone and he maintain his balance and with 2 staff, it would take a little longer. I asked her about transferring Resident C to his wheelchair and she said 2 to 3 minutes. I asked her if she thought she could evacuate all the residents during sleeping in 2 ½ minutes and she said no.

Upon my review of residents, the following was determined. Resident F requires the use of a Hoyer Lift to transfer her to her wheelchair. Resident E is a one-person stand-by assist. Resident C requires full assistance with all transfers.

Upon review of MOKA's Fire Protection Plan states that your General Guidelines for evacuation is thee (3) minutes or less. As noted, your fire drills are 6 minutes 30 seconds, 2 minutes and 46 seconds with 3 residents up at the time of the drill, 6 minutes, and 7 minutes. Two for your times met your 3 minutes and two did not. The drills conducted on 3rd shift are to be done when all residents are sleeping. Even several of your other shift are over 3 minutes. On 06/29/2022, fire drill at 2 minutes and 46 seconds does not see possible with Resident F needing the use of a Hoyer lift requiring full physical support, and Resident C and E requiring assistance to transfer into a wheelchair and having to take them individually outside to the mailbox and return to the home for the next three residents.

On 01/27/2023, I conducted a telephone exit conference with the Licensee Designee, Ms. Hamlet, and she agreed with my findings.

APPLICABLE RULE	
R 400.14206	**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:	It was alleged that the home had inadequate staffing. I conducted interviews with six direct care staff, and they all denied that resident needs had not been met. Each staff knew all the needs of each resident. Ms. Williams, the Residential Coordinator, reported that she is in the home often and she has not been aware of any resident's needs not being met. She also stated that she has not received any complaints that the residents' needs had not been met. She confirmed that they have had adequate staffing on each shift. During the onsite inspection, the residents appeared to be receiving adequate care and supervision. Residents D and E both reported their needs are met. During the investigation I did not find any evidence that the home did not have sufficient care staff on duty at all times. Residents' needs related to their supervision, personal care and protection had been met. Fire drills were reviewed, and they were under the 8-minute time frame, therefore there is no violation to this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/19/2023, I called Ms. Williams and asked her to review with me on the phone the 3rd shift fire drills. (The home is fully sprinkled with an automatic shutting door to the hallway where all the residents are located.) She reported that they recently missed one 3rd shift fire drill. She was uncertain as to why it was missed. She stated

the last two third shift fire drills were both around 4 minutes, to have all the residents out of the home and at the meeting place. I explained to Ms. Williams that each direct care staff working on third shift needs to know how to do a fire drill and know how to safety evacuate each resident in a timely fashion. I also told her that they need to conduct a fire drill with each staff to see if they are capable of completing a required fire drill. I asked her to address my concerns immediately and have the staff do a fire drill. She stated she would be working on it.

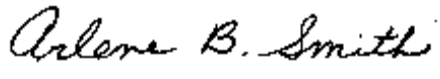
On 01/26/2023, I reviewed all of the fire drills for one-year 2022, including 1st. 2nd, and 3rd shift. There were no fire drill records for July 2022, September 2022, and for November 2022. Ms. Williams stated that the residents had COVID in July 2022. There were no make-up fire drills for the three months that were missed.

Exit conference with Licensee Designee, Tracey Hamlet, and she agreed with my findings.

APPLICABLE RULE	
R 400. 14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during the daytime, evening and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	Upon review of the homes fire drill there were three months, July, September, and November of 2022 where there were no fire drill records provided. Therefore, a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

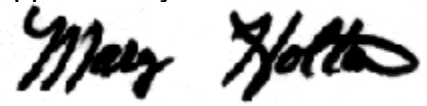
Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.



01/30/2023

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:



01/30/2023

Mary E. Holton Date
Area Manager