GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2023

Tamika Ruth
514 S. Ortman Street
Saginaw, MI 48601

RE: License #: AS730377214
Investigation #: 2023A0580024
Annie's Home Care

Dear Ms. Ruth:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730377214
Investigation #:	2023A0580024
Complaint Receipt Date:	02/28/2023
Investigation Initiation Date:	03/02/2023
Report Due Date:	04/29/2023
Licensee Name:	Tamika Ruth
Licensee Address:	514 S. Ortman Street Saginaw, MI 48601
Licensee Telephone #:	(989) 714-1271
Administrator:	Tamika Ruth
Licensee Designee:	N/A
Name of Facility:	Annie's Home Care
Facility Address:	514 N. Warren Avenue Saginaw, MI 48607
Facility Telephone #:	(989) 401-7835
Original Issuance Date:	11/16/2015
License Status:	REGULAR
Effective Date:	05/16/2022
Expiration Date:	05/15/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
There is a male staff, Mr. Terry Bulger that drinks alcohol while on duty.	No
Resident A is yelled at and treated bad by staff, Mr. Terry Bulger.	No
The home has feces in the upstairs bathroom that staff will not clean.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/28/2023	Special Investigation Intake 2023A0580024
02/28/2023	APS Referral This referral was denied by APS for investigation.
03/02/2023	Special Investigation Initiated - On Site An onsite inspection was conducted.
03/09/2023	Contact - Telephone call made A call was made to Witness 1
03/14/2023	Inspection Completed On-site An onsite inspection was conducted. Contact made with the licensee, Ms. T. Ruth.
03/14/2023	Contact - Telephone call made Call made to the licensee, Ms. T. Ruth.
03/14/2023	Contact - Face to Face Spoke with staff, Mr. Terry Bulger.
03/14/2023	Contact - Face to Face Interview with Resident B.
03/14/2023	Contact - Face to Face Interview with Resident C.
03/17/2023	Contact - Document Sent Email to the licensee requesting documents.

03/27/2023	Contact - Telephone call made Spoke with Ms. Ruth regarding the lack of response to the email requesting documents.
03/27/2023	Contact - Document Sent Resent the email to the licensee requesting documents.
04/07/2023	Contact - Document Sent Non-cooperation email sent to the licensee due to lack of receipt of docs.
04/07/2023	Contact - Telephone call made Call to Mr. Anthony Humphrey, AFC Consultant assigned to this home.
04/11/2023	Contact - Document Received Faxed copy of documents requested from the licensee.
04/18/2023	Inspection Completed On-site An interview was attempted with Resident A.
04/18/2023	Contact - Face to Face A follow-up interview with Resident B.
04/18/2023	Contact - Face to Face Spoke with Ms. Summer McGee of Elara Caring.
04/18/2023	Contact - Face to Face Interview with staff, Mr. Bulger.
04/19/2023	Exit Conference An exit conference was held with the licensee designee, Ms. Tamika Ruth.

ALLEGATION:

There is a male staff, Mr. Terry Bulger, that drinks alcohol while on duty.

INVESTIGATION:

On 02/28/2023, I received a complaint via BCAL Online Complaints. This complaint was denied by APS for investigation.

On 03/02/2023, I conducted an unannounced onsite inspection at Annie's Home. There was no answer at the door.

On 03/09/2023, I spoke with Witness 1. Witness 1 stated that on 02/24/2023, she went to the facility to pick Resident A up from the AFC and he asked her to come inside. Upon entering she observed 1 male staff in the home, name unknown, sitting at the front desk. It was her first visit to the home. It was at this time that Resident A expressed that staff, Mr. Terry Bulger, drinks alcohol while on duty. Witness 1 stated that Resident A is currently at an inpatient hospitalization at Healthsource. It is unknown when he will be released.

On 03/14/2023, I conducted a follow-up onsite inspection at Annie Home. There was no answer at the door.

On 03/14/2023, I placed a call to the licensee, Ms. Tamika Ruth, informing her that a complaint had been received. She agreed to come allow me inside the facility. Upon entering the facility, live in-staff, Mr. Terry Bulger was observed sitting on a bed located in the dining room area of the home. When asked why he did not answer the door, he showed me a pair of ear buds that had been in his ear.

Ms. Ruth stated that there are currently only 2 residents in the home, with Resident A currently hospitalized. When asked for guardian contact information, she stated that both residents are their own guardians.

On 03/14/2023, while onsite, I interviewed Resident B in his room. Resident B was observed sitting in a wheelchair. He was appropriately dressed. Resident B stated that he has lived in the home for the past 3 months. He denied seeing Mr. Bulger drink in the home.

On 03/14/2023, while onsite, an interview was conducted with Resident C. Resident C stated that staff, Mr. Terry Bulger drinks what he believes is liquor in the home.

On 03/17/2023, I sent an email to the licensee requesting copies of the current AFC Assessment Plans and Health Care Appraisals for Residents B and C, as well as contact information for the physical therapist providing services to Resident B.

On 03/27/2023, I resent an email to the licensee requesting copies of the current AFC Assessment Plans and Health Care Appraisals for Residents B and C, as well as contact information for the physical therapist providing services to Resident B.

On 03/27/2023, I spoke with Ms. Ruth regarding the lack of response to the email. She indicated that she had not received the email, however, she would fax the items requested. Ms. Ruth confirmed that she received the resent email while on the phone.

On 04/07/2023, I sent a final email to Ms. Ruth requesting documents, or an additional finding of licensing rule R400.14103(3), due to her lack of cooperation.

On 04/07/2023, I sent an email to the homes' assigned AFC consultant, Mr. Anthony Humphrey, regarding Ms. Ruth's lack of cooperation. He followed up with a return phone call indicating that he'd recently received a complaint on the home and conducted on onsite inspection earlier today. Due to our allegations being the same, Mr. Humphrey dismissed his complaint and shared the information observed and obtained while he was onsite.

On 04/18/2023, I conducted a follow up onsite inspection at Annie's Home Care. In attempt to interview Resident A regarding the allegations, he expressed that he is not in the mood to answer any questions.

On 04/18/2023, staff, Mr. Bulger denied the allegations that he drinks liquor in the home.

On 04/19/2023, I spoke with the licensee, Ms. Tamika Ruth. The home has no policies and procedures on alcohol use.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Witness 1 stated that Resident A expressed that staff, Mr. Terry Bulger, drinks alcohol while on duty. Resident B denied seeing Mr. Bulger drink in the home. Resident C stated that staff, Mr. Terry Bulger drinks what he believes is liquor in the home. Staff, Mr. Bulger denied the allegations that he drinks liquor in the home. Based on the interviews conducted, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is yelled at and treated bad by staff, Mr. Terry Bulger.

INVESTIGATION:

On 03/09/2023, I spoke with Witness 1, who stated that Resident A has expressed that staff, Mr. Terry Bulger yells at him and treat him bad to control him.

On 03/14/2023, Resident B denied that staff, Mr. Bulger yells at him. He denied any mistreatment in the home.

On 03/14/2023, Resident C stated that staff, Mr. Terry Bulger yells and screams at him and the other residents all the time.

On 04/18/2023, I conducted a follow up onsite inspection at Annie's Home Care. In attempt to interview Resident A regarding the allegations, he expressed that he is not in the mood to answer any questions.

On 04/18/2023, staff, Mr. Bulger denied the allegations that he yells and screams in the home.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	Witness 1 stated that Resident A has expressed that staff, Mr. Terry Bulger yells at him and treat him bad to control him. Resident B denied that staff, Mr. Bulger yells at him. He denied any mistreatment in the home. Resident C stated that staff, Mr. Terry Bulger yells and screams at him and the other residents all the time.

	Staff, Mr. Bulger denied the allegations that he yells and screams in the home. Based on the interviews conducted, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home has feces in the upstairs bathroom that staff will not clean.

INVESTIGATION:

On 03/09/2023, Witness 1 stated that on 02/24/2023, while visiting the facility, she observed the upstairs toilet as being broken, filled with feces and clothes. Resident A shares that the toilet has been broken for a while without being fixed. Residents continuously stuff shirts in the toilet to cover the smell.

On 03/14/2023, I conducted an onsite inspection. While onsite I observed both the upstairs and downstairs bathrooms. At the time of this visit, no feces was observed in either bathroom. Both toilets were able to properly flush.

On 03/14/2023, Resident C stated that there is usually feces smeared around in the upstairs bathroom. To his knowledge, the toilet has not been fixed and cannot flush.

On 04/07/2023, assigned AFC Licensing Consultant, Mr. Anthony Humphrey stated that he made an unannounced onsite at Annie's Home Care. Staff, Terry Bulger was present. The bathroom on the main floor was observed clean. The upstairs bathroom observed had feces was on the toilet, the bottom of the bathroom door, the floor tiles were peeling and in need of replacement and the toilet barely flushes. Mr. Bulger stated that one of their residents is blind and he leaves feces on the toilet. He could not explain how feces got on the bottom portion of the door.

Resident A stated that he has cleaned the toilet in the upstairs bathroom several times because it's always having feces on it.

Resident D stated that they do have feces on the toilet all the time and the toilet partially work. He is unsure why feces is being left on the toilet.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Witness 1 stated that on 02/24/2023, while visiting the facility, she observed the upstairs toilet as being broken, filled with feces and clothes. On 03/14/2023, I observed both the upstairs and downstairs bathrooms. No feces was observed in either bathroom. Both toilets were able to properly flush. AFC Licensing Consultant, Mr. Anthony Humphrey observed that the upstairs bathroom observed had feces was on the toilet, the bottom of the bathroom door, the floor tiles were peeling and in need of replacement and the toilet barely flushes. Staff, Mr. Bulger stated that one of their residents is blind and he leaves feces on the toilet. Resident A stated that he has cleaned the toilet in the upstairs bathroom several times because it's always having feces on it. Resident C stated that there is usually feces smeared around in the upstairs bathroom. To his knowledge, the toilet has not been fixed and cannot flush. Resident D stated that they do have feces on the toilet all the time and the toilet partially work. Based on Witness 1 and Mr. Humphrey's observation of feces in the upstairs bathroom, resident and staff interviews, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/14/2023, while onsite, I interviewed Resident B in his room. Resident B was observed sitting in a wheelchair.

On 03/14/2023, licensee, Ms. Tamika Ruth stated that Resident A uses his wheelchair he uses it from time to time due to a previous fall. She adds that he currently receives physical therapy.

On 04/11/2023 I received and reviewed an emailed copy of the AFC assessment plan for Resident B. The plan indicates that resident B requires the use of a cane as needed. The Health Care Appraisal completed for Resident B, dated 01/17/2023, states that Resident B uses a Walker. Ms. Ruth added a notation in the paperwork that Resident B is no longer receiving physical therapy services. She did not provide any contact information for the service provider.

On 04/18/2023, I conducted a follow-up onsite inspection at Annie's Home Care. Contact was made with both Resident B, who was sitting in a wheelchair, and Physical Therapist, Ms. Summer McGee of Elara Caring Home Health Care. She stated that Resident B receives physical therapy one time a week as a result of a stroke. Resident B stated that he uses the wheelchair when he gets tired. Both she and Resident B confirmed Resident B can walk and uses the assistance of both a walker and a cane.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Resident B was observed sitting in a wheelchair. Resident B's written assessment plan, signed and dated 01/17/2023, indicates that Resident A requires the use of a cane as needed. Licensee, Ms. Tamika Ruth stated that Resident A uses his wheelchair he uses it from time to time due to a previous fall. There is evidence that the use of a wheelchair as an assistive device is not specified in Resident B's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 04/19/2023, the licensee designee, Ms. Tamika Ruth stated that Resident B was provided with a wheelchair due to being 80 years old and tired at times. She does not have a prescription for the wheelchair.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Licensee does not have a prescription for Resident A's current use of a wheelchair. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/09/2023, Witness 1 stated that while in the home on 02/24/2023, she observed the med cart, located in a pantry area of the kitchen. This area has no door. She observed pill bottles all over the counter. She also observed exposed pill packs and about 50 loose medications. Resident A suddenly went in the med area, asked if he could take his Tramadol. She informed him to ask staff, however, he popped the medication in his mouth. She is not sure if it was his prescribed medication.

On 03/14/2023 while onsite, I observed medication cart, which was locked, located in the kitchen pantry area. I also observed pill pack medication on top of the locked medication cart.

Consultant, Mr. Humphrey indicated that on 04/07/2023, he made an unannounced onsite at Annie's Home Care. Staff, Terry Bulger led him into the kitchen pantry where the medicine cart was located. The medicine cart was observed locked. However, on the shelf of one of the pantry cubbies, there were 15 scattered pill bottles that had 1 or 2 pills in the bottle. In another cubby he observed pill packs that still had pills in them.

Mr. Bulger stated that the pills are from previous residents that are no longer in the home.

On 04/07/2023, Resident A informed consultant, Mr. Humphrey that stated that staff administers his medication. He denied ever taking his own medications.

On 04/07/2023, Resident D informed consultant, Mr. Humphrey that he does not get his own and he does not have access to his meds because they are kept locked in a med cart.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Witness 1 observed pill bottles all over the counter, exposed pill packs and about 50 loose medications. I observed pill pack medication on top of the locked medication cart. Consultant, Mr. Humphrey observed 15 scattered pill bottles that had 1 or 2 pills in the bottle and pill packs that still had pills in them. Based on the observation of the medication being unlocked, there is sufficient evidence to support this licensing rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Consultant, Mr. Humphrey indicated that on 04/07/2023, he made an unannounced onsite at Annie's Home Care. Staff, Terry Bulger led him into the kitchen pantry where the medicine cart was located. The medicine cart was observed locked. However, on the shelf of one of the pantry cubbies, there were 15 scattered pill bottles that had 1 or 2 pills in the bottle. In another cubby he observed pill packs that still had pills in them.

On 04/07/2023, staff, Mr. Bulger stated that scattered pill bottles and pill packs observed in the medication area are from previous residents that are no longer in the home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Staff, Mr. Bulger stated the scattered pill bottles and pill packs observed are from previous residents that are no longer in the home. Prescription medication from previous residents has not been disposed. There is enough evidence to support this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/09/2023, Witness 1 stated that while in the home on 02/24/2023, she did not observe any bugs, however, she observed a white powdery substance strewn on the floors all throughout the facility, as if there is some sort of bug infestation.

On 03/14/2023, while onsite, I observed a white powdery substance on the floor baseboards throughout the home. No bugs were seen. Staff, Mr. Bulger stated to me that there were any bed bugs in the home.

On 04/07/2023, Mr. Bulger informed consultant, Mr. Humphrey that the home had roaches, but they are about gone now. When asked if they had bedbugs as well, he stated that he “thinks so”.

On 04/07/2023, Resident A informed Mr. Humphrey that the home had bedbugs at one time, but they are gone now. The home still has roaches, and they are seen at night when they turn on the lights, which is why his mattress was wrapped up in tape.

On 04/07/2023, Resident D informed Mr. Humphrey that the home has bedbugs and roaches.

04/19/2023, I spoke with the licensee, Ms. Ruth, regarding current pest control program used at the home. She stated that she cleans up and sprays for bugs weekly. Ms. Ruth was advised that a professional statement indicating that there is no current infestation in the home is needed.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	Witness 1 stated that while in the home on 02/24/2023, she did not observe any bugs, however, she observed a white powdery substance strewn on the floors all throughout the facility, as if there is some sort of bug infestation. On 03/14/2023, while onsite, I observed a white powdery substance on the floor baseboards throughout the home. No bugs were seen. Staff, Mr. Bulger stated to me that there were any bed bugs in the home. On 04/07/2023, Mr. Bulger informed consultant, Mr. Humphrey that the home had roaches, but they are about gone now. When asked if they had bedbugs as well, he stated that he “thinks so”. Resident A informed Mr. Humphrey that the home had bedbugs at one time, but they are gone now. The home still has roaches, and they are seen at night when they turn on the lights, which is why his mattress was wrapped up in tape. Resident D informed Mr. Humphrey that the home has bedbugs and roaches. Licensee, Ms. Ruth, stated that she cleans up and sprays for bugs weekly. Based on the observation of the white powdery substance on the floors and interviews with residents and staff, there is enough evidence to support the violation that there continues to be an infestation in the home, despite the current pest control being maintained**.**
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/09/2023, Witness 1 stated that while onsite on 02/24/2023, she observed the stove in the kitchen with a lot of dirt, grime, and caked grease.

On 04/07/2023, while onsite, consultant, Mr. Humphrey, observed the kitchen stove with burnt food, grease and crud on top of the stove and around the burners.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(4) All food service equipment and utensils shall be constructed of material and that is nontoxic, easily cleaned and maintained in good repair. All food services equipment and eating and drinking utensils shall be thoroughly cleaned after each use.
ANALYSIS:	Witness 1 stated that on 02/24/2023, she observed the stove in the kitchen with a lot of dirt, grime, and caked grease. Consultant, Mr. Humphrey, observed the kitchen stove with burnt food, grease and crud on top of the stove and around the burners on 04/07/2023. Based on the observation of the stove there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/09/2023, Witness 1 stated that while onsite on 02/24/2023, she observed the back door exit to the home to be blocked and covered by furniture and trash.

On 04/07/2023, while onsite, consultant, Mr. Humphrey, observed a couch and some trash on the rear porch, towards the rear of the home. The couch was laid on its side, as if not in use. Mr. Bulger explained that the couch is going out to the trash. There was enough room to walk past to exit and enter the home, however; it appeared that the couch had been sitting there for quite some time. Mr. Bulger was informed that the porch must be cleaned and be free of debris as soon as possible.

While in Resident A's bedroom, Mr. Humphrey observed several cigarette butts on the floor, one of which was still partially lit, with smoke coming from it. Resident A admitted that he has been smoking in the home. Resident A was informed that he cannot smoke in the home, and he needs to clean up all the cigarette butts.

On 04/07/2023, Resident D admitted to consultant, Mr. Humphrey, that he smokes in the home. Resident D was informed that he can no longer smoke in the home and that he needs to smoke outside.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Witness 1 stated that she observed the back door exit to the home to be blocked and covered by furniture and trash. On 04/07/2023, consultant, Mr. Humphrey, observed a couch and some trash on the rear porch, towards the rear of the home. The couch was laid on its side, as if not in use. Mr. Humphrey also observed several cigarette butts on Resident A's floor, one of which was still partially lit, with smoke coming from it. Resident A admitted that he has been smoking in the home. Resident D admitted to consultant, Mr. Humphrey, that he smokes in the home. Based on the observation of old furniture and trash at the rear exit of the home, discarded cigarette butts and residents' admission of smoking in the home, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/14/2023, while onsite, I observed live-in staff, Mr. Terry Bulger, sitting on a bed located in the dining room area of the home.

On 04/18/2023, while onsite, I again observed the bed located in the dining area of the home. When interviewed, Mr. Bulger reported that he sleeps on the bed in the dining room in order to keep an eye on everything that goes on in the home.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.

ANALYSIS:	At the onsite inspection conducted on 03/14/2023 and 04/18/2023, I observed a bed located in the dining room area of the home. Staff, Mr. Terry Bulger reported that he sleeps on the bed in the dining room in order to keep an eye on everything that goes on in the home. Based on my observation of the bed in the dining room and staff, Mr. Bulger's admission that he sleeps on the bed in the dining room, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/09/2023, Witness 1 stated that while onsite on 02/24/2023, she observed few sheets on any beds.

On 03/14/2023, while onsite I observed resident bedrooms. Neither Resident A nor Resident C had sheets on their beds which are located upstairs. Other rooms upstairs were observed as unoccupied. An old torn and filthy mattress was observed in one of the unoccupied rooms.

On 04/07/2023, while onsite, consultant, Mr. Anthony Humphrey observed each resident bedroom, most of which were emptied. There was a mattress in one of the empty bedrooms. It appeared to be torn and filthy. Resident A's mattress was wrapped in plastic and tape. There was also a white powdery substance on the floors of each bedroom, alongside the walls.

On 04/18/2023, while onsite, I observed Resident D was lying in bed on a mattress with no sheet and on a pillow with no pillowcase. A photo was taken.

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.

ANALYSIS:	Witness 1 stated that while onsite on 02/24/2023, she observed few sheets on any beds. On 03/14/2023, Resident A and Resident C's beds were observed with no sheets on their beds. On 04/18/2023, Resident D was observed lying in bed on a mattress with no sheet and lying on a pillow with no pillowcase. Based on observations of Resident A and C's beds with no sheets on them and an observation of Resident D lying in bed with no sheets or pillowcase, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/19/2023, I conducted an exit conference with the licensee designee, Ms. Tamika Ruth, informing her of the violations established during the course of this investigation. Ms. Ruth was informed that a corrective action plan addressing the violations is due within 15 days.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

Sabrina McGowan April 19, 2023

_____

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton April 19, 2023

_____

Mary E. Holton Date
Area Manager