GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 28, 2023

Kory Feetham
AUGUST HAUS ASSISTED LIVING LLC
1201 Village Parkway
Gaylord, MI 49735

RE: License #: AL690392652
Investigation #: 2023A0009029
August Haus Assisted Living

Dear Kory Feetham:

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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame 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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL690392652
Investigation #:	2023A0009029
Complaint Receipt Date:	08/01/2023
Investigation Initiation Date:	08/02/2023
Report Due Date:	08/31/2023
Licensee Name:	AUGUST HAUS ASSISTED LIVING LLC
Licensee Address:	1201 Village Parkway Gaylord, MI 49735
Licensee Telephone #:	(989) 448-7094
Administrator:	Kory Feetham
Licensee Designee:	Kory Feetham
Name of Facility:	August Haus Assisted Living
Facility Address:	1201 Village Parkway Gaylord, MI 49735
Facility Telephone #:	(989) 448-7094
Original Issuance Date:	10/23/2018
License Status:	REGULAR
Effective Date:	03/14/2023
Expiration Date:	03/13/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED & AGED

II. ALLEGATION(S)

	Violation Established?
On July 25, 2023, Resident A was given another resident's melatonin.	No
On July 27, 2023, Resident B had dried feces on his buttocks, legs and genitals from being left in a soiled brief.	Yes
On July 27, 2023, Resident C fell and sustained an injury on the bridge of her nose from her glasses. It is unknown how long she had been on the floor after falling.	No
On July 25, 2023 and July 27, 2023, there were not enough staff working to meet the residents' needs.	No

III. METHODOLOGY

08/01/2023	Special Investigation Intake 2023A0009029
08/01/2023	APS Referral
08/02/2023	Special Investigation Initiated - On Site Interviews with lead supervisor Dani-Lin Marcinkowski and Resident A's Representative Face to face contact with Resident A, Resident B and Resident C
08/03/2023	Contact - Telephone call made to home manager Heather Reno
08/04/2023	Contact – Telephone call made to licensee designee/administrator Kory Feetham, left message
08/07/2023	Contact – Document (email) sent to home manager Heather Reno
08/07/2023	Contact – Document (email) received from home manager Heather Reno
08/09/2023	Contact – Telephone call made to licensee designee/administrator Kory Feetham and home manager Heather Reno
08/24/2023	Contact – Telephone call made to direct care worker Ron Forward
08/24/2023	Contact – Telephone call made to direct care worker Jadyn Reno
08/24/2023	Contact – Telephone call made to Resident B's Family Member, left message

08/24/2023	Contact – Telephone call made to Resident C's Representative, left message
08/25/2023	Inspection Completed – On Site Discussion with home manager Heather Reno Face to face contact with Resident B and Resident C
08/25/2023	Contact – Telephone call received from Resident B's Family Member
08/25/2023	Contact – Telephone call received from Resident C's Representative
08/25/2023	Exit conference with license designee/administrator Kory Feetham

ALLEGATION: On July 25, 2023, Resident A was given another resident's melatonin.

INVESTIGATION: I conducted an unannounced site visit at the August Haus Assisted Living adult foster care home on August 2, 2023. Lead supervisor Dani-Lin Marcinkowski was present at the time of my inspection. I spoke with her about the report that Resident A was given another person's melatonin supplement. Ms. Marcinkowski said that Resident A being given melatonin would happen on second shift and she did not have any direct knowledge of that. She said that it should be documented in the medication administration record if Resident A received melatonin. Ms. Marcinkowski was unclear whether I should have access to that information and called Resident A's Representative at that time. I spoke with Resident A's Representative at that time. He said that he did not know of his mother receiving melatonin. He said that he trusted that she would only be given something like that if she needed it. Resident A's Representative said that he did not feel that his mother would be able to tell me if she had received it or not or whether it was another resident's supplement. He said that this was due to his mother not being able to understand or remember those details. He stated he did not think it would be valuable for me to try to interview her.

Ms. Marcinkowski then provided me with Resident A's medication administration record. It showed that Resident A had been given melatonin on July 5, July 11, July 12 and July 22, 2023. It was given "as-needed" and the reason for it being given was "sleeplessness". I asked if there was any record of it having been administered on July 25, 2023. She said that it did not show that it had but they had been having some difficulties with the system around that time. Ms. Marcinkowski said that residents are only given medication, vitamins and/or supplements that are prescribed to them. She did not know of any time that a resident was given something that was not prescribed to them.

I spoke with home manager Heather Reno by telephone on August 3, 2023. I asked her about the report of Resident A being given another resident's melatonin. She said that Resident A would not have been given another resident's melatonin, but they do have a "backstock" of some vitamins that they sometimes give residents if they run out of their own vitamins. Resident A receives 5 mg. of melatonin, as needed. They would have only given her 5 mg. of melatonin from the backstock if she ran out of her own. I asked Ms. Reno if she would provide me with the doctor's order or prescription that allowed Resident A to be administered the melatonin.

I spoke with licensee designee/administrator Kory Feetham and home manager Heather Reno by phone on August 9, 2023. Ms. Reno reiterated much of what she had told me during my earlier phone call with her.

I spoke with direct care worker Ron Forward by telephone on August 24, 2023. I asked him what he knew about Resident A receiving another resident's melatonin. He replied that he did not know anything about that. Mr. Forward had not given Resident A melatonin and she has not experienced sleeplessness during the times he was there. They only give medication as prescribed and only when there is a prescription for the medication. The administration of the medication is then recorded in the resident's medication administration record. He was unaware of any resident ever being given another resident's medication or supplement. They each have their own which is labeled for their use.

I then spoke with direct care worker Jadyn Reno by telephone on August 24, 2023. Ms. Reno said that she had been new when the issue of the melatonin came up with Resident A. The melatonin was listed as an "as needed" medication. Resident A had always gone to bed just fine when she was there during the evening shift. She did not seem to need the melatonin at those times. Resident A never asked about it. She did look through Resident A's as needed medications on-hand and did not see melatonin. Ms. Reno did not know anything about Resident A being given another resident's melatonin. Ms. Reno has been trained to administer medication and they are told that they can only administer medication that is prescribed to a specific resident. It must be listed in the medication administration record for them to be able to give it to the resident. This includes vitamins and supplements. If the bottle does not have the resident's name on it and/or it is not in the system, the resident does not get it.

On August 25, 2023, home manager Heather Reno provided me with a copy of Resident A's "E-Rx New Prescription" dated April 19, 2022. It prescribed that Resident A receive "Melatonin 5 mg oral tablet, One HS prn for sleep". Written in was "One at bedtime".

APPLICABLE RULE	
R 400.15312	**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:	It was confirmed through this investigation that Resident A has been prescribed melatonin 5 mg. at bedtime as needed. There was a record that she had been given melatonin 5 mg. during some days in July of 2023. I was provided with the physician's prescription for the supplement. There was no evidence that it was given improperly.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On July 27, 2023, Resident B had dried feces on his buttocks, legs and genitals from being left in a soiled brief.

INVESTIGATION: During my unannounced site visit at the August Haus Assisted Living facility, I was speaking with Ms. Marcinkowski about the concerns that had been reported. At one point, she reported that it was time for the residents' medication administration and that she needed to assist with that. I waited for her in a fenced-in recreational area. While I waited, a resident initiated a conversation with me. I was able to determine that it was Resident B with whom I spoke. He showed me a large drink container and told me that he drank large quantities of tea each day. I asked Resident B what he thought about his care at August Haus. He said that it is very good and that it is much better than it was a year or so ago. Resident B said that a year or more ago, there were not enough staff but now there are more staff. I asked him about the call buttons they use. He said that a staff person always comes if he needs assistance. Resident B said that it usually takes about 1 or 2 minutes for a staff person to arrive after he asks for help. Sometimes it is longer if they are busy with another resident. Resident B said that he does need help with toileting. He said that the staff are good about helping him with that. Resident B said that they check him all the time. I asked him if there was a time when he was left in a soiled brief for too long. He said one time he had to wait fifteen minutes but that was the only time he could remember. I asked him if he could recall when that happened. He said that it had just happened recently but that he could not

remember the exact day. Resident B denied that he was harmed in any way from that. He said that he knew that they got to him as soon as they could. He did not have any concerns about the facility or any specific staff and liked living there.

I spoke with Ms. Marcinkowski regarding the concern of Resident B not having his brief changed in a timely manner recently. She said that she did not know of any specific time that he had not been changed. The staff are instructed to check him and change him regularly, at least once every two hours. Resident B often refuses to be changed. She said that he likes to sit in the outside area at the table where I spoke with him and doesn't like to move from there sometimes. Resident B does not have a guardian and they cannot force him to be changed when he refuses. When he refuses, they will keep going back to him to try to encourage him. He will eventually agree to be changed in those instances. We spoke about the fact that I observed him with the large container of tea and Ms. Marcinkowski agreed that he does drink a lot of tea. She said that sometimes Resident B does get rashes in his groin area but she has only observed or been aware of him having light rashes. He has a rash cream in his room that they often use on him that corrects the issue.

On August 3, 2023, I asked home manager Ms. Heather Reno about the report of Resident B being left in a soiled brief. She said that he had been left in urine for an hour and a half when he napped in the afternoon one day. She replied that Resident B does sometimes refuse to be changed. When this occurs, they "reapproach" him and try to encourage him to comply with being changed. He will then comply when he is ready. Ms. Reno said that she could not believe that he would have been left in his own feces for very long if that had happened. She said that he has had diarrhea lately which does complicate the process a bit. Resident B usually refuses during the day because he does not want to move from his table outside where he likes to sit. Ms. Reno said that he did have a slight rash from the diarrhea but that it cleared up after the regular application of rash cream.

On August 24, 2023, I spoke with direct care worker Ron Forward about the report of Resident B being left in a soiled brief. He said that he remembered the day it happened near the end of July 2023. Mr. Forward said that he was at the facility volunteering his time. He went into Resident B's room at around 3:00 p.m. to speak with him. Resident B said that he was wet and asked to be changed. Mr. Forward said that he knew that he shouldn't change Resident B himself since he was not "on the clock". He told direct care worker Brie Baker at that time that Resident B was saying he was wet and had asked to be changed. She said okay, but never came back to change him. After some time, he asked Ms. Baker if she had changed Resident B. She said she had not but that "it will be okay". Mr. Forward said that he started his own shift at 4:00 p.m. and that another worker and he checked on Resident B at around 4:20 or 4:30 p.m. He said that they found that Resident B had soiled himself extensively and that it was "caked" all over him and that he was "quite the mess". Some of the feces had already dried on him and it took quite a while to clean him up. Mr. Forward said that he was upset about it because it was something that could have been avoided and the other staff person he was working with was so

upset about the incident that she quit. Mr. Forward said that it was the only time that he had ever known that to happen to Resident B or any other resident at the facility.

On August 24, 2023, I asked direct care worker Jadyn Reno about Resident B having a soiled brief. She stated that she was aware of the incident I was asking about. She said that she came in for her shift in the afternoon and another direct care worker was changing Resident B. She assisted the other staff with cleaning him up. There were a lot of feces and it looked like it had been there a while. They didn't know for a fact that it had been there for a long time but suspected it had. The feces was stuck to his skin in places. She didn't notice that it was necessarily dried to him but was difficult to clean up. They were upset that the staff on the shift before hadn't taken care of him. Ms. Reno said that she would have taken care of him before her shift ended if it had been her. She said that she did complain to a supervisor about the incident and that Ms. Baker was "written up" because of it. I asked her why Ms. Baker was written up. She said that it was because she had left Resident B in his own feces. She said that they are required to check each resident every two hours and check specifically if each resident is wet or soiled if they wear briefs. She said that they do need to change Resident B a lot since he drinks a lot of liquids. He will let them know if he is soiled and that he needs to be changed.

I spoke with home manager Heather Reno on August 25, 2023 about direct care worker Brie Baker being "written up" for the incident with Resident B. She said that she did a "correction for her". This was not on paper but done verbally. This was done because Ms. Baker had put Resident B to bed without checking that he was wet or soiled. She said that she also made it mandatory that shift supervisors go behind all staff to make sure that two-hour checks are being done.

I spoke with Resident B's Family Member by telephone on August 25, 2023. She said that she believes that Resident B receives good care at August Haus. The staff there go out of their way to make sure he is happy. They seem to do everything they can to make him as comfortable as possible. He is lactose-intolerant and they make sure that he gets food that agrees with him. She has only known the staff there to change Resident B on a regular basis. He drinks a lot and it seems like they need to change him every five minutes at times. Resident B's Family Member denied that she had any concerns at all about August Haus.

I received Resident B's written assessment dated June 17, 2023. It indicated that Resident B "Needs Help" with toileting and that this required a "2 person assist transfer to toilet, 2 hr check/change, resident known to refuse".

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	It was confirmed through this investigation that Resident B had asked for assistance with toileting on one occasion near the end of July of 2023. It took approximately an hour and a half for him to receive assistance with toileting at that time. He was so soiled by that time that feces were stuck to his body and difficult to clean up. The staff who cleaned Resident B were upset that he had been left in that condition and the staff involved from the shift before was verbally reprimanded for not taking care of him. Resident B's written assessment indicates that he does need help with toileting.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On July 27, 2023, Resident C fell and sustained an injury on the bridge of her nose from her glasses. It is unknown how long she had been on the floor after falling.

INVESTIGATION: During my site visit on August 2, 2023, I observed Resident C in the outside area of the facility during my time there. I recognized Resident C from a previous facility and knew that she likes to walk. I noticed her around the office during those times as if she wanted to participate. During this visit, I noticed that Resident C was not getting around as easily as she had in the past but was able to get up from a couch without assistance and walk slowly around the facility. She seemed to enjoy the walking rather than her being disoriented and/or confused.

On August 2, 2023, I asked Ms. Marcinkowski about Resident C falling on July 27, 2023. She said that did happen and she was called by staff about it. Ms. Marcinkowski said that she lives close-by and that staff often call her for assistance. They called Resident C's Representative who did not want her going to the hospital unless she needed to go. Ms. Marcinkowski said that they looked Resident C over and that it seemed that she only had a small mark on the bridge of her nose from her glasses. She seemed unharmed otherwise. She was able to continue walking and did not exhibit any signs of being in pain. I asked Ms. Marcinkowski about the report that it was unknown how long Resident C had been on the floor after falling. She replied that she, herself, had left for the day at 4:30 p.m. and observed Resident C walking around at that time. She was called by staff at around 5:00 p.m. to say that Resident C had fallen. Ms. Marcinkowski said that she couldn't believe that it was for very long given that she had just left and that Resident C had fallen in a common area. Staff walk back and forth by this common area and would have observed her lying on the floor relatively quickly.

On August 3, 2023, I spoke with home manager Heather Reno regarding Resident C falling on or around July 27, 2023. She said that Resident C does walk around the facility a lot. She was a critical care nurse in her younger years and likes to feel useful. She will walk around, look out the windows in the common areas and tell

them that everything was fine around the facility. Sometimes, they will give her a clipboard to carry around. She said that she did not believe that Resident C had been on a floor for very long after she fell. Direct care worker Ron Forward found her and did not believe she had been there for long. Ms. Reno said that she did not know why it would have been reported that Resident C was on the floor for an unknown amount of time when Mr. Forward responded almost immediately. The staff got Resident C off the floor and checked her over for any possible injury. All they found was the mark on the bridge of her nose. She seemed fine otherwise. They called Resident C's Representative who did not feel it was necessary for her to go to the hospital if she did not seem injured in any way.

On August 24, 2023, I spoke with direct care worker Ron Forward about Resident C falling. He said that he did know about that because he had been the one to find her that day. It had happened at around 5:00 p.m. He said that he was assisting another resident and when he went back through one of the common areas, he found Resident C on the floor. He called the other staff person who was present to help him. They then called a supervisor who lives nearby and Resident C's Representative. I asked Mr. Forward how long he believed Resident C had been on the floor. He said that it could not have been very long because he had just passed through that way and would have seen her. He had also just seen Resident C walking shortly before. Mr. Forward stated that he had been working at the facility for over six weeks and that she had never fallen any other time during his time there. He said that Resident C usually walks near the rail in the hallway and uses the rail when she needs it. Her husband is there every evening and spends a lot of time there. Her husband supports her being able to walk around the facility on her own. He is often in her room watching television while she is out walking. Mr. Forward did not feel that Resident C should be prevented from walking even though she had the one fall. She was not hurt by the fall except for a mark on the bridge of her nose from her glasses. Her husband did not want her to go to the hospital after they assessed that she was not injured.

I spoke with direct care worker Jadyn Reno by telephone on August 24, 2023. She said that she was also working on the day that Resident C fell. Another staff person found her on the floor in a common area. She had a small cut on the bridge of her nose from her glasses. They called a supervisor and Resident C's Representative. They asked Resident C's Representative if he wanted them to call 911. He said that he wanted them to check her out and see if she was injured before calling emergency services. They checked her out including taking her vitals and she seemed fine at that time. The supervisor showed up to assist them and Resident C's Representative also showed up shortly after to assess the situation. Ms. Reno said that she has not known Resident C to fall before. She likes to walk around the facility and does it all day long.

On August 25, 2023 I spoke with Resident C's Representative about her falling some weeks before. He said that he was aware of the incident. He said that he got there shortly after they contacted him and it looked like she had fallen into a chair or

a sofa. She was not hurt except for a mark on the bridge of her nose. He said that he has instructed the facility not to call emergency services unless Resident C is actually injured. We talked about the fact that Resident C walks around the facility on her own. He said that she was nurse for several years and then a pastor. She likes to feel like she is a part of what is happening there. Resident C's Representative said that he supports that she be allowed to walk unassisted there for now as it is important to her. He said that he is there every evening spending time with Resident C and sees a lot of what goes on. Resident C's Representative said that he feels that August Haus is a good place and denied that he has any complaints about the facility.

I received Resident C's written assessment dated November 11, 2022 on August 25, 2023. In regards to her Walking/Mobility, it indicated that she is "Independent in ambulation of facility".

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was confirmed through this investigation that Resident C fell at the facility near the end of July of 2023. There was no indication that she was left for any significant amount of time. Resident C does walk around the facility unassisted, and this is reflected in her written assessment. Her Representative supports that she be allowed to walk the facility unassisted at this time. He did not have any concerns about the incident or Resident C's supervision or care at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On July 25, 2023 and July 27, 2023, there were not enough staff working to meet the residents' needs.

INVESTIGATION: On August 2, 2023, I observed three staff working including lead supervisor Ms. Marcinkowski. I observed them caring for residents continuously during that time. This included responding to call alerts, checking on residents in common areas and providing care directly to residents in their rooms. Ms. Marcinkowski excused herself at one point during our discussion when it was time for her to administer medication to residents. I asked her about the report that there are only three staff working at the facility. She said that there are three staff present during the day and two or three during the evening shift. If there are two staff during the evening shift, it is usually after the residents have settled down for the night.

There are two staff during the midnight shift. This is the usual staffing pattern. Ms. Marcinkowski has worked at the facility for some time and believed that this was adequate staffing based on the number and needs of the residents. I asked her how long it usually takes them to respond to the call alerts from residents. She said that the goal is to respond to a call alert within 5 minutes but that it usually only takes them 2 or 3 minutes. The residents I observed seemed content and well-cared for during the time of the visit. Resident B had told me earlier during the visit that it only takes them 1 or 2 minutes to respond when he uses his call alert.

On August 3, 2023, I asked Ms. Reno about staffing at the facility. She said that she felt that staffing at the facility is adequate. She said that this is generally three staff when residents are active and two staff later in the day when residents are more settled. She said that they employ a full-time chef who does the food preparation so that direct care workers are only involved with resident care. Ms. Reno said that she also wanted me to know that there is always a supervisor on-call. The staff are encouraged to reach out to the on-call supervisor if they are ever feeling overwhelmed. The expectation is that the supervisor will assist staff when needed. Ms. Reno stated the current staffing is adequate based on the current needs of the residents. There is one resident who requires a two-person lift. There are always at least two staff present at the facility. I requested copies of the all the residents' resident care agreements and written assessments at that time.

On August 24, 2023, I asked direct care worker Ron Forward about staffing at the facility. He said that there are three direct care staff during the day and usually two at night. I asked him if he believed that was enough staffing. He said that it would be easier if there were three staff at night. He said that sometimes 2 or 3 call lights will go off at the same time. Mr. Forward explained that he can still handle everything but that it just gets somewhat hectic at times. When more than one call light goes off at once he will go to each resident, make sure the issue is not urgent and then tell them he will be right back if it is not urgent. He said that it is often just something simple like them requesting a glass of water or something. Mr. Forward went on to say that he is always able to respond in a timely manner to the calls. He said that at the most it will take him 3 or 4 minutes to respond even when he is busy. He said that he believed that all of the residents' needs are being met even when there are two staff and it is busy. He said that there is also an on-call supervisor available for them to call if they become overwhelmed. He said that he would call that if he needed to and felt that he receive assistance. He had contacted the on-call person before and gotten help in those instances.

On August 24, 2023, I asked direct care worker Jadyn Reno what she thought about staffing numbers at the facility. She said that it does get a bit hectic sometimes when they have only have two staff present but that they are able to "make it work". She said that she had talked to supervision about getting an extra staff during the evening shift. That would make it easier, but they are able to meet the needs of the residents with two staff. Ms. Reno said that she does not hesitate to call the on-call supervisor if they need help. She said that she will call if they get behind on

administering medication or providing showers. She said that it doesn't take long for someone to get there during those times. All of the supervisors live in town so it only takes 5 to 15 minutes depending on who it is. Ms. Reno said that she has been asked to come into the facility and work before when someone hasn't shown up for their shift and she has done that. She stated that she feels the residents' needs were being met.

I received all 20 resident care agreements and written assessments on August 25, 2023. I reviewed the resident care agreements and written assessments regarding specific care needs. Nine of the resident care agreements indicate that the resident requires, "medication management, 3 meals a day and assistance in dressing, bathing, washing, toileting and set up assistance". These residents' written assessments indicate that these residents require assistance or, more specifically, a "1 person assist", with toileting, bathing, grooming, dressing and personal hygiene. One resident requires a "2 person assist". The other eleven resident care agreements indicate more independent services including, "medication management, 3 meals a day, housekeeping, laundry and set up assistance". These residents have written assessments that reflect this independence indicating that these residents mostly do not require assistance with toileting, bathing, grooming, dressing and personal hygiene or that that they only need "minimal assistance".

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	It was confirmed through this investigation that the facility does have sufficient direct care staff on duty at all times. This includes three staff during busy times of the day and two during less busy times. Two direct care staff indicated that it does get "hectic" at times when there are only two staff on duty, however, they did feel that the residents' needs were being provided for during those times. The staff are able to respond to the residents' calls within minutes. They have an on-call supervisor available to contact when they feel they need assistance. It is the on-call supervisor's responsibility to provide additional staffing when needed. The residents' written assessments and resident care agreements indicated that there are nine residents who require help with all care needs and eleven who are more independent.

CONCLUSION:	VIOLATION NOT ESTABLISHED

I conducted an exit conference by telephone with licensee designee/administrator Kory Feetham on August 25, 2023. I told him the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

08/28/2023

Adam Robarge Date
Licensing Consultant

Approved By:

08/28/2023

Jerry Hendrick Date
Area Manager