GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 17, 2024

LeeAnn Pennington
Mercy Services for Aging
873 W Avon Rd.
Rochester Hills, MI 48307

RE: License #: AL630299636
Investigation #: 2024A0605006
Mercy Bellbrook/Frances Warde

Dear LeeAnn Pennington:

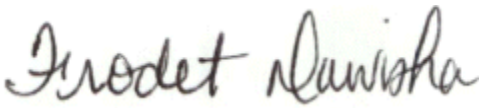
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630299636
Investigation #:	2024A0605006
Complaint Receipt Date:	11/17/2023
Investigation Initiation Date:	11/20/2023
Report Due Date:	01/16/2024
Licensee Name:	Mercy Services for Aging
Licensee Address:	873 W Avon Rd. Rochester Hills, MI 48307
Licensee Telephone #:	(248) 656-6300
Administrator/Licensee Designee:	LeeAnn Pennington
Name of Facility:	Mercy Bellbrook/Frances Warde
Facility Address:	873 W. Avon Road Rochester Hills, MI 48307
Facility Telephone #:	(248) 656-6306
Original Issuance Date:	02/18/2010
License Status:	REGULAR
Effective Date:	08/18/2022
Expiration Date:	08/17/2024
Capacity:	17
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The home is short staffed and cannot do all the work with the staff they have. The staff complained to LeeAnn Pennington, but she does not do anything about it.	Yes

III. METHODOLOGY

11/17/2023	Special Investigation Intake 2024A0605006
11/20/2023	Special Investigation Initiated - Letter Emailed complaint to Adult Protective Services (APS)
11/20/2023	APS Referral Adult Protective Services (APS) referral made
11/20/2023	Contact - Document Received Email stating APS worker Sara Peoples has been assigned the investigation
11/21/2023	Inspection Completed On-site Conducted unannounced on-site investigation in collaboration with APS worker Sarah Peoples
11/21/2023	Contact - Document Received Email from registered nurse (RN)/Executive Director Diane Alexander
12/05/2023	Contact - Face to Face Conducted surprise fire drill in collaboration with Bureau of Fire Safety (BFS) Don Collick
12/06/2023	Contact - Document Received Email from licensee designee LeeAnn Pennington
12/11/2023	Contact - Telephone call received Discussed concerns with BFS Don Collick and Larry DeWachter
12/20/2023	Contact - Document Received Email from APS Sara Peoples

12/20/2023	Contact - Telephone call made BFS Don Collick recommended another surprise fire drill
12/21/2023	Contact - Telephone call made Discussed allegations with direct care staff (DCS) Kamya Kelsey, Sheree Shorter, and Kyjuana Cantrell. Left message for DCS Catherine Woods.
01/08/2024	Contact - Telephone call made Discussed allegations with DCS Mitzi Briggs. Left message for DCS Dora Moran and made attempted to call DCS Tyisha Joyner but received a busy signal and attempted to call DCS Tracey Ireland but was unsuccessful as someone answers the phone but does not speak.
01/08/2024	Contact - Telephone call made Discussed allegations with durable medical power of attorney (DPOA) A, DPOA B, and DPOA C. Left message for DPOA D.
01/10/2024	Contact - Face to Face Conducted a surprise fire drill with BFS Fire Marshal Don Collick
01/11/2024	Contact - Telephone call made Left message for BFS Fire Marshal Supervisor
01/11/2024	Contact - Telephone call received Followed with BFS Fire Marshal Supervisor
01/11/2024	Exit Conference Conducted exit conference via telephone with licensee designee LeeAnn Pennington with my findings

ALLEGATION:

The home is short staffed and cannot do all the work with the staff they have. The staff complained to LeeAnn Pennington, but she does not do anything about it.

INVESTIGATION:

On 11/17/2023, intake #198544 was assigned for investigation regarding Mercy Bellbrook/Frances Warde is short staffed and there are not enough direct care staff (DCS) to provide for the care of all the residents.

On 11/20/2023, I initiated the special investigation by making a referral to Adult Protective Services (APS). The referral was assigned to APS worker Sara Peoples. Ms. Peoples agreed to conduct an unannounced on-site investigation on 11/21/2023.

On 11/21/2023, I along with APS worker Sara Peoples conducted an unannounced on-site investigation at Mercy Bellbrook/Frances Warde. Present were the licensee designee LeeAnn Pennington, Executive Director/Register Nurse (RN) Diane Alexander, DCS Julia Slowiczek and DCS Dajanique Smith and 15 residents.

LeeAnn Pennington and Diane Alexander were interviewed regarding the allegations. There are 15 residents residing at Frances Warde. Four of the 15 residents are two-person assists. There are three shifts: day shift from 7AM-3PM, afternoon shift from 3PM-11PM and midnight shift from 11PM-7AM. During the day shift, there are two DCS staff and one RN. During the afternoon shift, there are three DCS from 3PM-8PM and only two DCS from 8PM to 11PM and then only two DCS during the midnight shift. There are two other RN's that assist during the day shifts: Cindy Shumaker and Ying Qi. Both Ms. Pennington and Ms. Alexander believe there are sufficient staff during each shift to meet the needs of all the residents including the four residents who are two-person assist with only two DCS on shift. Ms. Pennigton stated there is an open-door policy at Frances Warde and there has not been any staff member that complained about insufficient staff and not able to care for the residents. Ms. Alexander stated that during the morning shift, when there are two different two-person assist residents requiring assistance then she or another RN steps in to assist. She stated that during the midnight shift, the residents are sleeping and do not require much assistance including the two-person assist residents.

Resident A was in her bedroom along with her friend/DPOA (A) who was visiting with her. Resident A has dementia and is a two-person assist during transfers in and out of bed and her wheelchair. The DPOA (A) visits at different times including at night to ensure Resident A's needs are being met. There have been a couple of times when DPOA (A) visited with Resident A and "she was completely soiled." The response time for the staff was "slow," to change her. However, he brought this to the attention of Diane Alexander and the issue was addressed. Overall, DPOA (A) stated, "staff are usually good."

Residents B, C, and D who are all two-persons assists were not interviewed as they were in their wheelchairs in the living room doing activities. However, I did observe them, and they had good hygiene.

Resident E was interviewed in the dining room. She uses a walker to ambulate. She likes living here and stated, “I’m very pleased with what I have.” She was unable to provide any information on staffing. Resident E had good hygiene.

Resident F was not interviewed due to her diagnosis of Alzheimer’s and was unable to carry a conversation. However, her husband was visiting with her. Resident F’s husband lives right upstairs in the independent living apartments located in the same building. The husband visits with his wife multiple times daily and described her as “a wonderer.” She likes to wonder around the facility as she can ambulate but ambulates slow and the husband was standing closely by her as she was ambulating. The husband did not have any concerns but stated, “staff are pretty good, but this place can probably use more people.” He did not have any further details to add.

Resident G was interviewed but due to her dementia, she was unable to carry a conversation or answer questions. She did say, “I don’t like it here,” but then began talking about work.

Resident H was observed sleeping in her bed in her bedroom.

Resident I was interviewed in his bedroom. He has lived here for three months. He reported that there is staff, but he usually stays in his bedroom. Staff check on him usually, but he was unable to provide specifics regarding staff.

Resident J was interviewed in his bedroom along with his son/DPOA (J). Resident J ambulates but is also a wonderer and requires “extra supervision.” The staff seem to always know where Resident J is. DPOA (J) visits often including the weekends. He has no concerns with staffing and stated, “they are proactive in caring for his father.”

Resident K was observed sitting in the living room. He was not interviewed as he was participating in an activity. He was in his wheelchair.

DCS Julia Slowiczek was interviewed regarding the allegations. Ms. Slowiczek has been working here for five years. She works the day/morning shift from 7AM-3PM. There are always three staff members on shift including one RN. Ms. Slowiczek stated there are about four to five residents who are a two-person assist. If there are two two-person assist residents needing assistance simultaneously, then one resident will need to wait until another staff member is available before that person can assist. Ms. Slowiczek has no concerns of meeting the needs of all 15 residents with three staff members during her shift.

Ms. Slowiczek stated they do not have residents at Frances Warde who use commodes near bedside. She stated they have personal protective equipment (PPE) for staff available and have never had any issues with not having PPE.

Note: I observed staff and volunteers wearing PPE during this visit.

DCS Dajanique Smith was interviewed regarding these allegations. Ms. Smith has been with this corporation for four years. She too works the day/morning shift from 7AM-3PM. There are three staff members including an RN during both morning and afternoon shifts, but then two staff members during the midnight shift. There are five residents that are a two-person assist. Resident A, Resident B, Resident C, Resident D, and Resident K. Ms. Smith can attend to all the residents' needs during her shift including the two-person assist residents because Resident D is a hospice patient and has an aide that is at this facility Mondays and Thursdays. Ms. Smith stated that the two-person assist residents wake up different times so while she and another staff member are getting one resident up, the others may be still sleeping or in their beds.

Ms. Smith stated that none of the residents use commodes, and they have enough PPE for all staff. There have never been any issues with not getting PPE when needed.
I reviewed Resident A's, Resident B's, Resident C's, and Resident D's assessment plans that were provided by Diane Alexander.

- Resident A's assessment plan was completed and signed by DPOA (A) on 12/06/2022. Her assessment plan was updated on 02/03/2023 when Resident A became a two-person assist; however, the signatures were never updated by the DPOA (A) and licensee designee, Ms. Pennington.
- Resident B's assessment plan was completed on 03/27/2023. Her assessment plan reflected that she is a two-person assist for all transfers with a Hoyer lift.
- Resident C's assessment plan was completed on 08/04/2023. Her assessment plan reflected she is a two-person assist with a Hoyer lift.
- Resident D's assessment plan was completed on 05/04/2023. Her assessment plan reflected she is a two-person assist for all transfers with a Hoyer lift.

I also reviewed the daily staffing schedule from 10/01/2023-11/11/2023. According to the daily staffing schedule there are only two DCS working during the afternoon shift from 3PM-9PM and during the midnight shift from 11PM-7AM.

On 11/21/2023, I emailed Diane Alexander requesting fire drills from the last six-months for Frances Warde. Ms. Alexander emailed the following fire drills for Frances Warde/McAuley:

- On 01/20/2023 at 9:10AM a fire drill was conducted at Frances Warde. No evacuation time noted. Comments section, "Activation occurred at same times as McAuley alarm. Staff responded in swift decisive action removing residents from harm's way. (if there was any danger). RACE and PASS were discussed following event. Good unplanned event." Brad Bernett signed off on drill. (I requested this drill, and it was emailed to me on 01/10/2024)
- On 03/07/2023, at 3:55PM a fire drill was conducted at Frances Warde. No evacuation time noted. Comments section, "Frances Warde did very well consider they had a few people (staff) off the hall. They moved very well and performed the fire plan very well. RACE and PASS were discussed." Brad

Bernett signed off on drill. (I requested this drill, and it was emailed to me on 01/10/2024)

- On 03/20/2023 at 2:10AM a “simulated,” fire drill was conducted without the alarm being pulled for both McAuley and Frances Warde. There is no indication on the log how long the evacuation time was for either building. Comment section stated, “Staff was aware of proper procedures.” Ron Young observed this drill and signed off.
- On 04/26/2023, a drill was conducted at 1:08PM. Location was “second floor AL exit door.” In the comments section it stated, “Staff on assisted living and skilled nursing were prompt in their actions.” Evacuation time was not documented on the log. Dwayne Maxwell observed this drill and signed off. (This drill was not completed for Frances Warde)
- On 05/24/2023, a drill was conducted but there is not time stated on the log other than “noon,” handwritten on the top of the log. It is also unclear which building this drill was conducted because location of drill is blank. “Memory Care Independent Living,” is handwritten on top of drill. There is no evacuation time documented on the log and nothing noted in the comment section. This log was signed by Dwayne Maxwell.
- On 06/19/2023, “education,” was conducted at 3:50AM, not a fire drill. On the top of the log, it is handwritten, “Memory Care, Assisted Living, and Skilled Nursing.” In the comment section it stated, “Staff was educated on fire safety.” (No drill conducted at Frances Warde)
- On 07/31/2023 a fire drill was conducted at 7:32AM. The location was “Assisted/Apt.” No evacuation time on log. The comment section stated, “Staff removed residents from hallway. Placed them in rooms or secure areas to be monitored.” Dwayne Maxwell observed this drill and signed off.
- On 08/30/2023, a fire drill was conducted at 6:09PM “facility wide.” No evacuation time noted on log. No notes in the comment section. Drill observed by Dwayne and William but signed off by Dwayne Maxwell.
- On 09/21/2023, “education,” was provided to staff at 12:30AM. Location was “Bellbrook.” In comments section, “Staff was reeducated on fire safety evacuation.” Signed off by Dwayne Maxwell. (No drill conducted at Frances Warde)
- On 10/11/2023, a fire drill was conducted at 10:37AM. Location was “Memory Care Apartments.” No evacuation time noted. No comments noted. Dwayne Maxwell signed off on drill. (This drill was not conducted at Frances Warde)

*__Note__: During the second quarter, an evacuation fire drill was not conducted during the evening and sleeping hours and in the third quarter an evacuation fire drill was not conducted during sleeping hours.

On 12/05/2023, I along with BFS Fire Marshall Don Collick arrived at Frances Warde to conduct a surprise fire drill. Dwayne Maxwell, the maintenance personnel at Mercy Bellbrook met with us. Mr. Maxwell has worked for this company for about eight months.

He is responsible for conducting the fire drills at Frances Warde. Mr. Maxwell does not have the residents evacuate the building, but instead have all the residents evacuate to the lobby which is the center of both Frances Warde and McAuley. He pulls the fire alarm and one of the DCS goes on the PA announcing where the fire is which alerts the staff at McAuley. The staff at McAuley put all their residents in their bedrooms and come to Frances Warde to assist staff at Frances Warde to evacuate all the residents to the lobby. Mr. Maxwell stated that staff from their HFA building is also alerted and come to Frances Warde to assist. He stated that no one from those buildings are evacuating their residents. Those residents are only put in their rooms during the fire drills. Mr. Collick expressed significant concerns about the residents in both McAuley and at the HFA building not being evacuated and only placed in their bedrooms. Mr. Maxwell stated that there are only two DCS on shift during the midnight hours.

Mr. Collick advised Mr. Maxwell that a fire drill will be conducted today with only two DCS completing the drill without the assistance of any staff from McAuley. Inside Frances Warde were three staff members, RN Cindee Schumaker, DCS Dajanique Smith and DCS Deborah Gibbons and 16 residents. Ms. Smith and Ms. Gibbons were the DCS responsible for conducting this fire drill. Mr. Collick walked down the hallway and called “code red,” for a fire. We observed the fire drill. It took 3 minutes and 21 seconds for the staff member to pull the fire alarm and it took a total of 9 minutes and 15 seconds for the two staff members to evacuate all the residents into the lobby. Mr. Collick informed staff members and Mr. Maxwell that any time over 8 minutes is “impractical.”

I noted the following during the drill; staff appeared frantic, frustrated, and disorganized with the evacuation process. One of the DCS, I believe it was Ms. Smith made a comment stating, “We weren’t prepared for this.” During the fire drill, DCS Ms. Gibbons remained outside in the lobby with the residents that were taken out of the building first because “residents may wonder,” leaving Ms. Smith to evacuate the other residents by herself. Ms. Gibbons held the door wide open to assist Ms. Smith who was bringing the other residents to the door. All 16 residents were accounted for in the lobby. During this fire drill, no other residents from McAuley or the apartments upstairs or HFA evacuated during this simulated fire drill even when the fire alarm was sounded. Mr. Collick explained to Mr. Maxwell that even during simulated fire drills, all residents should be evacuating when hearing the fire alarm not just the building where the fire drill is being conducted.

Mr. Collick expressed concerns about the time it took staff to pull the fire alarm because if staff would have pulled it immediately, then that would alert the alarm system who then would alert the fire department who would have been notified immediately. Waiting to pull the file alarm increases the time it will take for the fire department to be notified and increases the arrival time to the facility. Mr. Collick advised staff that they cannot keep the door open because in a real fire, the lobby will then be filled with smoke since they were not completely evacuating residents out the building. Mr. Collick advised Mr. Maxwell that residents should be evacuating outside away from the building during fire drills, but that in inclement weather, residents may evacuate to the lobby during fire

drills. Mr. Collick also expressed concerns about the fire alarm lights that were not “synced,” but had a “strobing effect,” which is a significant concern for triggering seizures and epilepsy in some residents.

These concerns were discussed with licensee designee LeeAnn Pennigton. Ms. Pennington was advised that she cannot utilize any staff member from McAuley or any other building when conducting fire drills for Frances Warde. She was advised that the only staff she can count towards the promptness of evacuation capability is the two DCS she has scheduled during the afternoon shift from 3PM-9PM and during the midnight shift 11PM-7AM. Ms. Pennington was advised that due to the evacuation time being impractical of 9 minutes and 15 seconds, there is insufficient staff during the afternoon shift from 3PM-9PM and during the midnight shift from 11PM-7AM with only two DCS working those times. Ms. Pennington stated she will be reviewing these concerns during their meeting and will have Mr. Maxwell conduct additional fire safety education with all staff. Ms. Pennigton stated she will work closely with Mr. Maxwell to have the emergency evacuation procedures updated. Mr. Collick advised Ms. Pennington she will need to address the strobing alarm lights to ensure they are all synced properly with the alarm system.

On 12/06/2023, I received an email from LeeAnn Pennington regarding our simulated fire drill on 12/05/2023. Ms. Pennington completed worksheets for determining evacuation capability for each resident at Frances Warde during the midnight shift and submitted these documents via email. The level of evacuation capability for Frances Warde was a “slow,” when completed. However, the “slow,” was based on four staff (two from Frances Warde and two from McAuley) during their computation of evacuation capability. Ms. Pennington stated the following: “Based on this information, evacuation of the Mercy Bellbrook / Frances Warde or Mercy Bellbrook/ McAuley AFCs, would NEVER be left to just two people as the unit right next door (in this particular case McAuley AL630299637 is right next to Frances Warde), the staff assigned are trained to respond and would be notified as the alarm sounds in both units.”

On 12/11/2023, I emailed LeeAnn Pennington with my concerns after reviewing the worksheets for determining evacuation capability for each resident at Frances Warde during the midnight shift and their evacuation capability of “slow,” which is incorrect since they continue to utilize two DCS from McAuley during these fire drills. I also expressed concerns that the two DCS from McAuley are now leaving all their residents unsupervised when assisting with the evacuation procedure at Frances Warde. Ms. Pennington responded to my email stating that when the fire alarm goes off, it goes off at both Frances Warde and McAuley; therefore, a total of four DCS are evacuating all residents from both facilities. She stated that staff have been trained at both facilities to evacuate their residents first before assisting with the evacuation of the other building. Ms. Pennington stated she will be re-evaluating their evacuation capabilities with the BFS for clarification. In addition, Ms. Pennington stated that they will be utilizing wheelchairs and the use of a “bedsheet,” for evacuation in emergency situations.

On 12/11/2023, the fire marshal supervisor with BFS Larry DeWachter stated he spoke with Ms. Pennington and will be providing fire safety education to her staff. Mr. DeWachter is in agreement that staff from McAuley cannot be used during the evacuation procedures of France Warde and vice versa to get the accurate evacuation capabilities. Frances Warde and McAuley have different adult foster care (AFC) license numbers and are treated as separate buildings. Therefore, staff for McAuley cannot be counted for staff at Frances Warde.

On 12/20/2023, I received an email from APS Sara Peoples stating that she is substantiating her case for neglect due to DPOA (A) finding Resident A sitting in soiled clothing on multiple occasions and staff's slow response.

On 12/20/2023, I followed up with BFS Don Collick who agreed that another surprise drill at Frances Warde would be appropriate since Ms. Pennington advised that their evacuation procedures have been modified/updated.

On 12/21/2023, I interviewed DCS Kamya Kelsey via telephone regarding the allegations. Ms. Kelsey has worked for this company since 12/2022. She currently works the midnight shift from 11PM-7AM but will be transitioning to day shift beginning 01/07/2024. There are only two DCS working during midnight shift. Most of the residents are asleep except for a couple that stay awake during the night. There are five residents that are a two-person assist. Ms. Kelsey stated during the night, residents are sleeping so there have not been any problems caring for more than two of the two-person assists. She has never practiced a fire drill since she has worked at Frances Warde. She has been involved in discussions about conducting fire drills, but never practiced one. Ms. Kelsey was advised to assist the two-persons assist first, then residents with walkers and then the residents in wheelchairs during an evacuation. There was a fire drill during the day shift a couple of days ago, but a midnight shift has not had one yet. She is not sure if she and the other staff can get all 15 residents out safely because she has never conducted a drill.

Ms. Kelsey works with DCS Tracey Ireland and there have not been any concerns or complaints about residents not allowed to use commodes or concerns about no PPE's.

On 12/21/2023, I interviewed DCS Sheree Shorter via telephone regarding the allegations. Ms. Shorter began working for this company the end of April or May 2023. She is parttime and only works 30 hours. Her shift is midnight from 11PM-7AM. There are only two DCS during the midnight shift. There are about five residents who are a two-person assist. When she arrives to her shift, the residents are asleep. During the night, the residents do not require much care because they are sleeping. A fire drill was conducted a couple of days ago around 6AM which would be the sleep drill. Ms. Shorter participated in the drill. During the drill, she and DCS Kyjuana Cantrell began with the two-person assist residents. She took the first two-person assist resident out while Ms. Cantrell went to the second two-person assist resident. Ms. Shorter stated that another staff member (unknown who) assisted Ms. Cantrell with the other two-person assist

resident and the housekeeper held the door open. Ms. Shorter stated that housekeeping and maintenance do not work the midnight shift at Frances Warde, but during this drill, housekeeping, maintenance, and a RN assisted with the evacuation.

Ms. Shorter stated that there were six staff members during this drill. Ms. Shorter stated that she if it was not for the other four staff members assisting during this drill, she does not believe that she and Ms. Cantrell would get all the residents out of the building in eight minutes or less. There are too many two-person assist residents to get out first and then the walkers and then the ones in wheelchairs.

Ms. Shorter has never worked with DCS Tracey Ireland. She has never heard any concerns or complaints about Ms. Ireland not allowing residents to use commodes or any concerns about not enough PPE's.

On 12/21/2023, I interviewed DCS Kyjuana Cantrell regarding the allegations. Ms. Cantrell has been with this company since 05/2023. She is part-time and only works three days a week during the midnight shift from 11PM-7AM. There are only two DCS during the midnight shift. There are four-five residents that require two-person assists at Frances Warde. There have not been any concerns thus far during the midnight shift when two or more two-person assist residents required staff's assistance because they are usually sleeping. Ms. Cantrell stated that "I'm not too clear on evacuation procedures," but we get out the walkers first, then the two-person assist residents and then the wheelchair residents. Ms. Cantrell stated during the simulated fire drill that she participated in not too long ago, she and Ms. Shorter received help from staff working at McAuley. She does not know how long the evacuation took but had help. She is unsure if she and Ms. Shorter can evacuate all 15 residents eight minutes or less without any help from additional staff.

Ms. Cantrell has worked with DCS Tracey Ireland and stated there have not been any concerns about Ms. Ireland not allowing residents to use commodes or any concerns about not having enough PPE's.

On 01/08/2024, I interviewed DCS Mitzi Briggs via telephone regarding the allegations. Ms. Briggs has been working for this company over a year. She works the afternoon shift from 3PM-11PM. There are three from 9PM-11PM, but only two DCS from 3PM-9PM. There are a total of five residents who are a two-person assist. If she and another DCS is assisting in transferring a two-person resident and another two-person resident needs assistance, that third DCS will go to the two-person assist resident, but she must wait until Ms. Briggs or the other DCS with her is finished before attending to the other residents' needs. Ms. Briggs has never participated in a fire drill but reported that a fire drill was conducted a few weeks ago during the midnight shift, but she was not involved. Ms. Briggs has been working in this field for over 21 years and stated she is very familiar with evacuation procedures even though she is not familiar with Frances Warde. She stated, "If there is a fire, I know I have to get people out, because I've been working in nursing homes for a long time." Ms. Briggs stated that during her shift, almost all the

residents are up and, in their wheelchairs, or sitting in the living room, so she is confident she and the other DCS can get all 15 residents out safely.

Ms. Briggs has never worked with DCS Tracey Ireland and stated she has not heard any complaints or concerns about residents not being allowed to use commodes at night. She stated they have ample amount of PPE's and can access them.

On 01/08/2024, I interviewed DPOA (A) via telephone. Resident A is a two-person assist for transfers and all care. DPOA (A) visits regularly and does not announce he is visiting. The latest he has visited is 8PM. There were multiple occasions when he arrived, he observed Resident A sitting soiled in her undergarments. He could smell the urine as it was strong and saw her undergarments soiled through her clothes. He told staff and they changed her. He addressed this with Diane Alexander. Whenever he visits, there are two DCS for the residents and sometimes one or two RN's who assist when needed. He has no concerns.

On 01/08/2024, I interviewed DPOA (B) via telephone. Resident B cannot ambulate and is a two-person assist for all care. DPOA (B) visits twice weekly; however, her siblings also visit so there is someone visiting with Resident B daily. Occasionally, DPOA (B) has arrived and observed Resident B soiled. Resident B's undergarments are wet and can be observed through her clothes. DPOA (B) calls staff who advised her they are aware of it, but then take longer to show up to change Resident B. There is DCS every time she visits, but she is unsure if there is only two or three. She has no specific concerns but feels that staff are "sometimes overwhelmed," and DPOA (B) feels they are "understaffed." However, if these were consistence concerns, then DPOA (B) would report them to management. Management have been responsive whenever DPOA (B) has expressed concerns.

On 01/08/2024, I interviewed DPOA (C) via telephone. Resident C is non-ambulatory and requires two staff to care for all her needs. DPOA (C) visits daily during lunch time to ensure Resident C is eating and drinking. DPOA (C) cannot say she has been happy all the time with Resident C's care, but when she asks for help, she gets it. She is unsure what happens when she is not there which sometimes concerns her since Resident C depends on staff for all her care. A few years ago, a staff member was being obnoxious with providing care to Resident C when Resident C need to be toileted. DPOA (C) reported it to management and the staff was terminated. There have been a couple of times recently that DPOA (C) arrived and found that Resident C was slipping out of her Geri chair. Staff then inclined the Geri chair, and this addressed the issue. However, the DPOA (C) had to bring it to their attention. Resident C receives hospice care through Heart to Heart and has a nurse that comes to see her.

On 01/08/2024, I contacted Heart to Heart and spoke with Resident C's hospice nurse. The hospice nurse visits Resident C weekly and reported that Resident C always has good hygiene and staff or the DPOA (C) are feeding Resident C lunch. No concerns reported.

On 01/10/2024, I followed up with Diane Alexander regarding the staffing schedule. Ms. Alexander explained the staff schedule and stated that the staffing schedule per shift remains unchanged. There are only two DCS during the afternoon shifts from 3PM-9PM and only two DCS during the midnight shifts from 11PM-7AM.

On 01/10/2024, I along with BFS Don Collick conducted another surprise fire drill at Frances Warde. At arrival, we met with LeeAnn Pennington, Vice President of Operations Becky Lund, Dwayne Maxwell, and Diane Alexander. Ms. Alexander then left the lobby. Ms. Lund stated that since our last visit on 12/05/2023 when a surprise fire drill was conducted, she has spoken with BFS Fire Marshal Supervisor who advised her that staff from McAuley can be used at Frances Warde once McAuley has evacuated all their residents and that staff can be counted towards the evacuation time. Ms. Lund stated during this surprise fire drill, they will have both Frances Warde and McAuley evacuate their nine residents first and then a DCS from McAuley will assist staff from Frances Warde in evacuating their 15 residents. Again, I reiterated that according to our AFC licensing rules, only DCS that are working in Frances Warde can be counted towards the evacuation time; therefore, we can only have two DCS participate in this fire drill because there are only two DCS during the midnight shift and from 3PM-9PM in the afternoon.

Mr. Collick and I walked into Frances Warde, and I observed DCS bringing residents out of their bedrooms into the hallways in their wheelchairs. DCS were just standing in the hallways with residents, and I can hear DCS talking amongst themselves saying, “I’m tired of these surprise drills.” From my observation, DCS appeared to know a surprise fire drill was taking place. Ms. Alexander stated they did not know. She stated that residents were finishing up lunch and being toileted; therefore, they were in their wheelchairs and in the hallways. The two DCS who participated in the drill were DCS Dajanique Smith and DCS Karla Randall.

Dwayne Maxwell put a light in one of the bedrooms stating this is how they conduct their drills. Once a staff member sees the light, then the fire drill evacuation procedure begins. Ms. Alexander guided one of the DCS towards the hallway where the light was and then once the DCS saw the light, Mr. Collick began the timer. During this drill, the DCS pulled the pull station cover which sounded an alarm, so the staff began evacuation; however, Mr. Collick informed the staff that the fire alarm was not activated. It took 2 minutes and 30 seconds before staff pulled the fire alarm that sounded throughout the building including McAuley. It took a total of 6 minutes to evacuate 15 residents to the lobby.

I reviewed all the fire drills from 01/2023-10/2023 and they were completed however, they did not have the evacuation times. Mr. Maxwell and Ms. Lund stated that since the last fire drill on 12/05/2023, they have been putting the evacuation times on all their drills.

On 01/11/2024, I received a return call from BFS Fire Marshal Supervisor Larry DeWachter who stated that he never informed Becky Lund that they can count McAuley

staff when conducting a midnight drill evacuation at Frances Warde. Nor did he advise Ms. Lund that she can utilize staff from McAuley when determining the evacuation time of Frances Warde.

On 01/11/2024, I conducted the exit conference via telephone with licensee designee LeeAnn Pennington with my finds. Ms. Pennington stated she did not have any questions.

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:	Based on my investigation and information gathered, there is insufficient staff during the afternoon shift from 3PM-9PM and during the midnight shift from 11PM-7AM for the supervision, personal care, and protection of all 15 residents at Frances Warde. Residents A, B, C, D, and K are a two-person assist with transfers and all their personal care needs. There have been occasions when residents were observed by their DPOA's to be soiled in urine because they were not checked by staff. In addition, staff are unable to evacuate 15 residents safely from Frances Warde with only two DCS as they are relying on staff from another building to assist with the evacuation. DCS stated that if there was a fire during the midnight shift with only two DCS working that shift, they cannot evacuate all 15 residents' safety due to five of the residents being a two-person assist. On 12/05/2023, I along with BFS Fire Marshal Don Collick conducted a surprise fire drill at Frances Warde with only two DCS since there are only two DCS from 3PM-9PM in the afternoon and then during the midnight shift from 11PM-7AM. It took the two DCS participating in the fire drill 3 minutes and 21 seconds to pull the fire alarm and a total of 9 minutes and 15 seconds to evacuate all 15 residents to the lobby. The licensee designee LeeAnn Pennington was advised that evacuation time more than 8 minutes for a large AFC facility is "impractical." Therefore, there is either insufficient number of staff during these times or the individuals residing at Frances Warde may u7not need to be reevaluated since there are five two-person assist residents.

	Ms. Pennington completed the evacuation capability worksheet and determined that the level of evacuation capability for Frances Warde was “slow” because Ms. Pennington included a total of four DCS; two DCS from Frances Warde and two DCS from McAuley, also an AFC facility with nine residents, next door to Frances Warde and share a lobby. However, Ms. Pennington was advised that she cannot count DCS that are outside of Frances Warde in the level of evacuation capability to get the accurate category of evacuation for Frances Warde. I interviewed several midnight shift staff who stated they have never participated in a fire drill nor are they familiar with Frances Warde’s evacuation procedures. DCS also stated that if there was a fire during the midnight shift with only two DCS working that shift, they cannot evacuate all 15 residents’ safety due to five of the residents are a two-person assist. On 01/10/2024, I along with BFS Fire Marshal Don Collick conducted another surprise fire drill at Frances Warde. During this drill, the DCS pulled the pull station cover which sounded an alarm, so the staff began evacuation. Mr. Collick informed the staff that the fire alarm was not activated. It took 2 minutes and 30 seconds before staff pulled the fire alarm that sounded throughout the building including McAuley. It took a total of 6 minutes to evacuate 15 residents to the lobby. During both surprise fire drills, I observed the following, staff appeared frantic, frustrated, and disorganized with the evacuation process. One of the DCS made a comment stating, “We weren’t prepared for this.” However, it must be noted that the residents were in their wheelchairs and during the midnight shift, these residents will most likely be asleep in their bedrooms. Therefore, these times are not an accurate depiction of how long two DCS can safely evacuate 15 residents in less than 8 minutes when five of the residents require two-person assists.
CONCLUSION:	**VIOLATION ESTABLISHED**

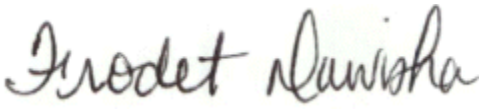
APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral

	and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on my investigation and information gathered, Resident A's and Resident B's personal hygiene was not met by staff at Frances Warde. On multiple occasions DPOA (A) observed Resident A soiled. DPOA (A) stated that they smelled urine coming from Resident A and her undergarments were soiled indicting she had been sitting soiled for long periods of time. DPOA (A) informed staff and Resident A was changed. DPOA (B) also reported observing Resident B soiled and their undergarments wet. They stated that it took longer than expected for staff to change Resident B after staff was notified, Resident B was soiled. DPOA (B) also reported that staff appear overwhelmed and DPOA (B) feels that Frances Warde is understaffed. During both my unannounced on-site visits, I did not observe any concerns with the residents' personal hygiene.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15318	**Emergency preparedness; evacuation plan; emergency transportation**
	(4) A licensee shall ensure that residents, all employees, volunteers under the direction of the licensee, and members of the household are familiar emergency and evacuation procedures.
ANALYSIS:	Based on my investigation and information gathered, DCS are not familiar with the emergency and evacuation procedures. I interviewed several midnight shift staff who stated they have never participated in a fire drill nor are they familiar with Frances Warde's evacuation procedures.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

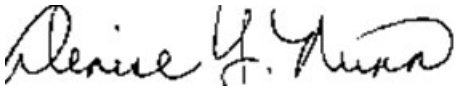
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



01/16/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



01/17/2024

Denise Y. Nunn Date
Area Manager