GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 28, 2023

Karen Laseck
Pathway Home of Elsie, LLC
133 W. Main Street
Elsie, MI 48831

RE: License #: AM190394424
Investigation #: 2024A1029010
Pathway Home Of Elsie

Dear Ms. Laseck:

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190394424
Investigation #:	2024A1029010
Complaint Receipt Date:	11/03/2023
Investigation Initiation Date:	11/07/2023
Report Due Date:	01/02/2024
Licensee Name:	Pathway Home of Elsie, LLC
Licensee Address:	133 W. Main Street Elsie, MI 48831
Licensee Telephone #:	(517) 281-2729
Administrator:	Karen Laseck
Licensee Designee:	Karen Laseck
Name of Facility:	Pathway Home Of Elsie
Facility Address:	133 W Main Street Elsie, MI 48831
Facility Telephone #:	(517) 281-2729
Original Issuance Date:	10/31/2018
License Status:	REGULAR
Effective Date:	04/30/2023
Expiration Date:	04/29/2025
Capacity:	11
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was administered tuberculin serum injection instead of her insulin.	Yes
Resident B eloped on October 28, 2023 and was gone for one hour without her coat or cane.	Yes
Direct care staff members only receive one hour of training.	No
New employees do not have a test for communicable tuberculosis read within 48 hours and licensee designee Karen Laseck still allowed them to work with residents.	Yes
Licensee designee Ms. Laseck comes to work under the influence of alcohol and is mean to the residents and the direct care staff members.	No

III. METHODOLOGY

11/03/2023	Special Investigation Intake 2024A1029010
11/07/2023	Special Investigation Initiated – Sent email to complainant.
11/28/2023	Inspection Completed On-site – face to face with Licensee designee Karen Laseck, direct care staff members Lanette Frost, Christina Melvin, Resident A, Resident B at Pathway Home of Elsie
11/29/2023	APS Referral Made to Centralized Intake
12/20/2023	Contact - Telephone call made to direct care staff member Christina Melvin, Lanette Frost (Left message), Lisa (unavailable), Mindy Burgess, Makayla Brown-Burgess, Jana Lipps
12/21/2023	Contact – Telephone call to Lanette Frost (Left message), Jana Lipps
12/21/2023	Exit conference with licensee designee Karen Laseck

ALLEGATION: Resident A was administered a tuberculin serum injection instead of her insulin.

INVESTIGATION:

On November 3, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Resident A received an injection of tuberculin instead of her prescribed insulin injection.

On November 28, 2023, I completed an unannounced on-site investigation at Pathway Home of Elsie and met with direct care staff member Christina Melvin and licensee designee Karen Laseck. Ms. Laseck stated Resident A received tuberculin serum instead of receiving her insulin injection. Ms. Laseck stated Resident A did not experience any adverse effects from receiving this and she did contact Resident A's physician and Quality Plus Pharmacy for guidance after learning of this medication error. Ms. Laseck stated the tuberculin serum and insulin vials looked similar and although they were labeled, direct care staff member Lanetta Frost administered the wrong one. Ms. Laseck stated direct care staff member Lanetta Frost was shown the difference between the vials and should not have administered the wrong one. I observed the insulin and tuberculin vials, which were stored in a small, unlocked refrigerator sitting next to each other, in licensee designee Karen Laseck's office. Ms. Laseck stated she wrote on the Tupperware containing the vials which one was which. I advised Ms. Laseck they should not be stored close together since they look so similar and that a locked box was also required. Ms. Laseck stated Resident A's blood sugar level is checked two times per day after which it is determined how much, if any, insulin to dispense. Ms. Laseck stated direct care staff member Lanetta Frost has never had a medication error in the past. Ms. Laseck stated she has tuberculin serum at the facility because she is an RN and administers the tuberculin tests for her employees.

I reviewed the *Medication Incident Report Form* completed on September 19, 2023, by Ms. Laseck which documented direct care staff member Lanetta Frost administered the wrong medication and Ms. Frost was educated regarding medication passes and the '5 Rights' and was then observed administering medications again. According to the report:

> *"This writer entered Pathway Home at approximately 11AM on this date. Ms. Frost was on duty and she was having difficulty with the blood glucose machine. This writer assisted her in completing the BS check on Resident A and the result required insulin coverage. This writer assisted Ms. Frost into the medication room so she could draw up the required insulin per Doctors orders. This writer noted that Ms. Frost obtained a small plastic container out of the fridge that contained a vial of Tubersol. This writer asked what she was doing with that and she said she was getting the insulin. This writer asked Ms. Frost again what she was doing and she said "Dorothy" told her to use the vial in the Tupperware before opening a new one. This writer educated Ms. Frost*

on the spot on insulin administration, gave her the correct vial of Darlene's insulin, told her about the medication comparison, and confiscated the empty Tubersol vial.

Quality Plus Pharmacy called back and stated that after research no ill effects should have occurred with the small dose that was administered."

I reviewed Resident A's medication administration records for September and October 2023 which included documentation of her blood sugar levels being checked and what dosage of insulin she required, if any. The initials are difficult to decipher on the MARs to see which direct care staff member completed each injection however it appears Ms. Frost gave the insulin on one or two occasions the week during the week of September 14, 2023.

On December 20, 2023, I interviewed direct care staff member Mindy Burgess. Ms. Burgess stated she was aware that Resident A received tuberculin serum instead of insulin. Ms. Burgess stated Resident A was given medication in error one time by Ms. Frost. Ms. Burgess stated it was not an ongoing issue. Ms. Burgess stated after this incident the tuberculin has been removed. Ms. Burgess stated the refrigerator is in a locked room but she does not think there is a lock on the refrigerator.

On December 20, 2023, I interviewed direct care staff member Christina Melvin. Ms. Melvin stated Ms. Laseck noticed Ms. Frost attempting to give the tuberculin injection and called to inform her about the error. Ms. Melvin stated she did not train Ms. Frost but a previous manager did. Ms. Melvin stated she does not know of Ms. Frost to have any other medication errors other than this and the last time she worked, there was both tuberculin and insulin in the refrigerator. Ms. Melvin stated the refrigerator is not locked and there was no lock box in the refrigerator. Ms. Melvin stated Ms. Frost started working there in May 2023 so it is unknown how many times she gave her tuberculin instead of insulin but it was likely more than a one-time incident.

On December 20, 2023, I interviewed direct care staff member Makayla Brown-Burgess who stated she is fairly new but mostly works third shift and has only administered medications twice. Ms. Brown-Burgess stated she was not working when Resident A was given the wrong medication but she was told during her training to watch for the two similar bottles because there was a mistake in the past. Ms. Brown-Burgess stated both vials are in the refrigerator together and one is in a plastic container and the insulin is in the medication box so they are separated now. Ms. Brown-Burgess stated the refrigerator does not have a lock on it however it is in a locked office.

During my on-site investigation, I completed my interviews in the office and I did observe the medication refrigerator located in the office. Ms. Laseck confirmed the office is always locked when not in use and Ms. Lipps confirmed this to be true during her on-site investigation on December 21, 2023.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A did not receive her insulin injection as prescribed. Rather Resident A received tuberculin serum instead on at least one occasion. According to an incident report form completed by licensee designee Karen Laseck, direct care staff member Lanetta Frost confused the vial of tuberculin serum for insulin and consequently gave Resident A this instead of insulin as prescribed. Ms. Laseck stated Resident A did not experience any adverse effects from receiving this and she also contacted Resident A's physician and Quality Plus Pharmacy for guidance. During my on-site investigation, I observed the two vials in an unlocked refrigerator in Ms. Laseck's locked office kept next to each other.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B eloped on October 28, 2023 and was gone for one hour without her coat or cane.

INVESTIGATION:

On November 3, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Resident B left the facility without supervision and was found 1.5 blocks away without her coat and cane.

On November 28, 2023, I completed an unannounced on-site investigation at Pathway Home of Elsie and interviewed licensee designee Karen Laseck. Ms. Laseck stated Resident B eloped from the facility on October 28, 2023 because direct care staff were trying to figure out how to shut off the fire panel. Ms. Laseck stated Resident B was sitting on the couch and was bothered by the noise because she was covering her ears. Ms. Laseck stated during this timeframe Resident B went outside without direct care staff noticing she was gone. Ms. Laseck stated when they realized she was not in the facility, they called EMS and law enforcement who searched for her. Ms. Laseck stated Resident B was missing from the facility from 5:13 PM-6:30 PM. Ms. Laseck stated direct care staff member Ms. Melvin found Resident B by a white van 1.5 blocks from the home. Ms. Laseck stated Resident B has eloped from the facility before but she usually heads south away from the facility. Ms. Laseck stated Resident B has eloped from the facility on average once per year in the four years she has resided at Pathway Home of Elsie. Ms. Laseck stated she was so worried about Resident B because it gets dark so early now and they were worried they would not find her before it was dark outside. Ms. Laseck stated once she was found, she did contact Relative B1 and

Resident B was examined by EMS but did not have any injuries. Ms. Laseck stated Resident B did not take her cane or her coat before leaving the facility.

I reviewed the Incident Report written by Ms. Laseck regarding this incident which included the following description of the event:

> *"Another female resident pulled the pull station on the DR wall. Fire panel went off sounding loudly. Residents covered their ears and [Resident B] went to the lobby beyond the closed double doors with her hands over her ears. This writer was on the phone with Summit attempting to reset the panel. Upon recognizing [Resident B] was gone, I called 911 to report her missing. I then called Mindy to come in early ASAP as I couldn't leave the building alone. I called Christina Melvin to see if she would help look. EMS and Mindy showed up. EMS, myself, and Christina all searched. This writer notified [Relative A1] that she was missing. Several law enforcement officers were present at the address. They sent out a three mile wide notice to the community. While driving around the streets several locals were searching for her. Christina finally located her at approximately 6:30 PM about three streets over from PWH. EMS checked her vitals and found no need to send her to the ER. Mindy served her supper and hot coffee. Her son was called and spoke to his Mom. Everything was back to normal. [Resident B] was examined and she had no bruises or marks. She denied falling or any injury."*

I reviewed Resident B's *Health Care Appraisal* which includes a diagnosis of Parkinson's disease, Macular Degeneration, and confusion. Under mental / physical status, the *Health Care Appraisal* listed: confused, difficult to redirect when angry, needs repeated reminders. Under mobility on Resident B's *Health Care Appraisal,* it listed Resident B was both "fully ambulatory and uses cane." Under the *Health Care Appraisal* section titled, 'hypothermia' it documented: "Yes, has eloped when angry, wants to go "home."

I reviewed Resident B's *Assessment Plan for AFC Residents* which stated she does not move independently in the community and Relative B1 transports her to appointments when needed. Under the section titled self-injurious behavior, Resident B's Assessment Plan for AFC Residents documented the following: "[Resident B] has eloped and crossed streets. She moves fast. When outside she can be difficult to get back inside."

I observed Resident B at the facility however due to her diagnosis of dementia, she was not able to answer questions regarding the allegation.

I interviewed Resident C who stated Resident B did leave the facility but she only knows of this happening one time and they found her "down the road." Resident C stated there were issues with the fire panel and all the direct care staff members were trying to figure out how to turn it off and all of a sudden Resident B was missing from the home and she

was found down the road. Resident C stated there were several law enforcement officers looking for her.

On December 20, 2023, I interviewed direct care staff member Mindy Burgess who confirmed Resident B eloped from the facility on October 28, 2023, while licensee designee Karen Laseck was working. Ms. Burgess stated she was called in to assist with locating Resident B who was found a few hours after she eloped. Ms. Burgess confirmed Resident B was located a few streets down from the facility. Ms. Burgess stated Resident B eloped a few other times during summer while Ms. Burgess was working but she was able to quickly catch up to her.

On December 20, 2023, I interviewed direct care staff member Christina Melvin. Ms. Melvin stated Resident B fell a couple days ago and broke her hip but she was not aware of another elopement since the incident on October 28, 2023. Ms. Melvin stated Resident B has eloped in the past and Ms. Laseck found her 1.5 blocks away at Dollar General. Ms. Melvin stated around 1-3 times per year Resident B leaves elopes from Pathway Home of Elsie.

APPLICABLE RULE	
R 400.14303	**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:	Resident B eloped from the facility on October 28, 2023, unbeknownst to licensee designee Karen Laseck who was working at that time. Resident B was gone for at least one hour before being located approximately 1.5 blocks from the facility. Although, licensee designee Karen Laseck contacted law enforcement immediately to assist with locating Resident B, Resident B has a pattern of eloping from the facility which has not been successfully addressed in her *Assessment Plan for AFC Residents.* Consequently, the licensee is not assuring Resident B's supervision, protection and personal care needs as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff members only receive one hour of training.

INVESTIGATION:

On November 3, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns direct care staff members only receive one hour of training before they are required to work with residents.

On November 28, 2023, I completed an unannounced on-site investigation at Pathway Home of Elsie and met with direct care staff member Christina Melvin and licensee designee Karen Laseck. Ms. Laseck stated after the employee completes their training, she has a shadowing program where they shadow for at least one 8 hour shift to make sure they are comfortable with the job duties.

I reviewed the employee files for all seven employees and there was documentation each employee had completed all required licensing trainings including Reporting requirements, communicable diseases, personal care/ supervision, safety and fire prevention, resident rights, medication administration, CPI / Behavior intervention, and CPR / First Aid as well as at least one shift to shadow another direct care staff member.

On December 20, 2023 I interviewed direct care staff member Mindy Burgess. Ms. Burgess stated she has worked for CMH and is in the nursing program so she did not need additional training. Ms. Burgess stated after newly hired direct care staff members shadow a trained direct care staff member for a day, the newly hired direct care staff member is then able to work independently. Ms. Burgess also stated during staff meetings, a short scavenger hunt is conducted which is a helpful training tool as well. Ms. Burgess stated if they go over a topic at the monthly meeting, then they are getting more of the training.

On December 20, 2023, I interviewed direct care staff member Christina Melvin. Ms. Melvin stated training now is one day of shadowing before new direct care staff members work with residents. Ms. Melvin stated the most important training she gives is medication training, hygiene training, personal care, and transferring. Ms. Melvin stated she has never trained anyone on third shift duties because Ms. Laseck typically does that training. Ms. Melvin stated the duties mostly include cleaning, cooking, bed checks, and medications at 8 PM which she would show them during the day. Ms. Melvin stated there is a checklist and scavenger hunt that shows what areas they are trained in. Ms. Melvin stated she did cover Recipient Rights and reporting requirements and showed them how to report abuse and neglect. Ms. Melvin stated they go online and take a CPR / First Aid course. Ms. Melvin stated they talk about fire drills and where they are supposed to meet if there is an emergency.

On December 20, 2023, I interviewed direct care staff member Makayla Brown-Burgess. Ms. Brown-Burgess stated she trained with her mother in law who was very through and was mostly on third shift. Ms. Brown-Burgess stated she trained one day on second shift and three days of training on third shift. Ms. Brown-Burgess stated Ms. Burgess went through all personal care plans, cleaning, Resident Rights / Reporting requirements, medications, and fire safety. Ms. Brown-Burgess stated there is a list with a scavenger hunt and she also went over emergency procedures in case an ambulance had to be called. Ms. Brown-Burgess stated she felt she was adequately trained and is competent to work third shift.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	There is no indication direct care staff members only received one hour of training. I reviewed employee files for all seven employees and all seven employee files had documentation each had completed all required licensing trainings including: reporting requirements, communicable diseases, personal care/ supervision, safety and fire prevention, resident rights, medication administration, CPI / Behavior intervention, and CPR /First Aid as well as at least one shift to shadow another direct care staff member. Based on the interviews with Ms. Melvin, Ms. Brown-Burgess, and Ms. Burgess, direct care staff members are competent to perform their job duties.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: New employees do not have a test for communicable tuberculosis read within 48 hours and licensee designee Karen Laseck still allowed them to work with residents.

INVESTIGATION:

On November 3, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns licensee designee Karen Laseck gives her own communicable tuberculin (TB) tests and does not read the test within 72 hours as required. According to the allegations, direct care staff members are required to work with residents before this test is read.

On November 28, 2023, I completed an unannounced on-site investigation at Pathway Home of Elsie and met with direct care staff member Christina Melvin and licensee designee Karen Laseck. Ms. Laseck stated she has tuberculin serum at the facility and

will give the tuberculin tests when new employees begin their employment. Ms. Laseck stated she has been a registered nurse for 37 years and gives the tuberculin injection and also read the results within 72 hours. Ms. Laseck stated she buys the tuberculin serum at the pharmacy and is certified to perform these tests as an RN. Ms. Laseck stated she does not have employees start working until their test is read.

I reviewed the employee files for all seven employees and they all had a test for communicable tuberculosis on file that was read by Ms. Laseck within 72 hours except for Ms. Burgess who had her test completed but there was no record it was read. Ms. Laseck stated Ms. Burgess is also in the nursing program so she would have had a test through the school and she would get a copy.

On December 20, 2023, I interviewed direct care staff member Mindy Burgess who confirmed licensee designee Karen Laseck gives tuberculin tests for all the incoming direct care staff members and reads those test results as well. Ms. Burgess stated she had provided a TB test from school but it was not read so she redid one with Ms. Laseck. Ms. Burgess stated she does not know if she reads them before she puts people on the schedule or not.

On December 20, 2023, I interviewed direct care staff member Christina Melvin. Ms. Melvin stated licensee designee Karen Laseck performs the tuberculin for incoming staff but she will have them take a picture and send it to her via text message and she does not actually feel their arm. Ms. Melvin stated she believes direct care staff members start working before the results are read.

On December 20, 2023, I interviewed direct care staff member Makayla Brown-Burgess. Ms. Brown-Burgess stated she went to Urgent Care to get her TB test but she knows that Ms. Laseck will also do them. Ms. Laseck will also read the tests within one day. Ms. Brown-Burgess stated she has never heard her taking a picture of the arm instead of coming in to have it read.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.

ANALYSIS:	There is no indication Ms. Laseck is not reading the tuberculin (TB) tests after she administers them to the employees. All current employees have had their TB tests read within the first week of their employment, except for Ms. Burgess who had completed a TB test but did not have the results documented. Although direct care staff member Ms. Burgess is not showing any signs of active TB, her TB test result is not complete without a final documented reading of the test result.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Licensee designee Ms. Laseck comes to work under the influence of alcohol and is mean to the residents and direct care staff members.

INVESTIGATION:

On November 3, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Ms. Laseck arrives to work under the influence of alcohol and is mean to the residents and direct care staff members.

On November 28, 2023, I completed an unannounced on-site investigation at Pathway Home of Elsie and interviewed licensee designee Ms. Laseck. Ms. Laseck stated she feels all direct care staff members come to work polite and respectful and she does not feel she has ever been mean to the residents. Ms. Laseck stated some of the residents are hard of hearing so she must talk louder than others, but she is not yelling at them or trying to be disrespectful to them. Ms. Laseck stated she has had employees who have told her they would “be reporting her to the state” because she had terminated their employment and felt these current allegations were in retaliation to that action.

Ms. Laseck stated she has never arrived to work under the influence of alcohol and stated there has never been any substance use on the property. Ms. Laseck stated she was arrested in 2014 for driving under the influence of alcohol and direct care staff members found this information online and brought it to her attention. Ms. Laseck stated if this was an issue for her, she would not still have her nursing license. Ms. Laseck stated there was never an issue that occurred at work which would make someone say she was under the influence.

I interviewed Resident C who stated the staff are great and she “gives them a hard time” but no one has been mean or rude to her including Ms. Laseck. Resident C stated she likes living at Pathway of Elsie. Resident C stated she has never had concerns regarding any direct care staff member or licensee designee Karen Laseck being drunk at work and has not observed anyone drinking. Resident C stated, “if they were drinking, I would have a drink with them!”

On December 20, 2023 I interviewed direct care staff member Mindy Burgess. Ms. Burgess stated Ms. Laseck has never been mean or aggressive with the residents. Ms. Burgess stated she has never had any concerns regarding substance abuse or Ms. Laseck coming to work after drinking. Ms. Burgess stated she has never smelled alcohol on Ms. Laseck or worried about her drinking.

On December 20, 2023, I interviewed direct care staff member Christina Melvin. Ms. Melvin stated she has not observed Ms. Laseck being mean directly to residents. Ms. Burgess has not observed licensee designee Karen Laseck using alcohol while working, slurring her words, stumbling or unable to perform her work duties.

On December 20, 2023, I interviewed direct care staff member Makayla Brown-Burgess. Ms. Brown-Burgess stated she has not had any concerns regarding Ms. Laseck being mean to residents. She seems to really care for the residents when she seems them. Ms. Brown-Burgess stated she has heard other direct care staff members say that she has been under the influence but she has never observed anything herself. Ms. Brown-Burgess stated Ms. Laseck has always been able to care for residents. Ms. Brown-Burgess stated she has never smelled alcohol on Ms. Laseck.

On December 21, 2023, an unannounced on-site investigation was completed by AFC Licensing consultant, Jana Lipps and Ms. Laseck was providing care to the residents and she was not under the influence of any substances.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Although there was an allegation of licensee designee Karen Laseck being under the influence of alcohol while working with residents, there was no observations from any direct care staff members interviewed of Karen Laseck using alcohol while working or exhibiting signs of alcohol intoxication such as slurring her words, stumbling or unable to perform her job duties. None of the direct care staff members interviewed had examples of how she was mean to residents or direct care staff members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

12/21/2023

Jennifer Browning
Licensing Consultant

Date

Approved By:

12/28/2023

Dawn N. Timm
Area Manager

Date