GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 26, 2024

Destiny Saucedo-Al Jallad
Turning Leaf Res Rehab Svcs., Inc.
P.O. Box 23218
Lansing, MI 48909

RE: License #: AS330092644
Investigation #: 2024A1033020
Cedar Cottage

Dear Ms. Saucedo-Al Jallad:

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

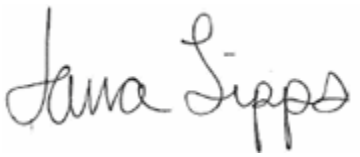
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once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

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330092644
Investigation #:	2024A1033020
Complaint Receipt Date:	01/03/2024
Investigation Initiation Date:	01/08/2024
Report Due Date:	03/03/2024
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Destiny Saucedo-Al Jallad
Licensee Designee:	Destiny Saucedo-Al Jallad
Name of Facility:	Cedar Cottage
Facility Address:	621 E. Jolly Road Lansing, MI 48910
Facility Telephone #:	(517) 393-5203
Original Issuance Date:	05/09/2000
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident Care Agreements are not being updated annually.	No
Resident A was taken to Detroit for a physician's appointment and left alone in a restaurant for multiple hours by direct care staff. The direct care staff member could not locate Resident A when she returned to the restaurant. Resident A's mother, Citizen 1, had to drive to the restaurant to locate Resident A.	Yes

III. METHODOLOGY

01/03/2024	Special Investigation Intake 2024A1033020
01/08/2024	Special Investigation Initiated - On Site- Interview with Program Director/Direct care staff, Amber Ely-Costa, licensee designee, Destiny Al-Jallad, direct care staff/Assistant Program Director, Quantella Hamilton, Resident A, and Citizen 1. Review of Resident A resident record and Resident Care Agreements for all residents.
01/08/2024	Contact - Telephone call made- Attempt to interview direct care staff, Sierra Thomas. Voicemail box was "full", text message sent.
01/08/2024	Contact - Telephone call received- Interview with Sierra Thomas, via telephone.
01/08/2024	APS Referral- APS referral made per protocol.
02/22/2024	Contact – Document Sent Email correspondence with licensee designee, Destiny Al-Jallad.
02/23/2024	Contact – Document Received Email correspondence and documentation received from Program Manager, Amber Ely-Costa.
02/23/2024	Contact – Document Received Email correspondence and employee training files received from Julianne Platz, Business Services Specialist.
02/27/2024	Exit Conference Conducted via telephone with licensee designee, Destiny Al-Jallad.

ALLEGATION: Resident Care Agreements are not being updated annually.

INVESTIGATION:

On 1/3/24 I received an online complaint regarding the Cedar Cottage, adult foster care facility (the facility). The complaint alleged *Resident Care Agreement* (RCA) forms for current residents are not being updated annually by direct care staff or the licensee designee, Destiny Al-Jallad. On 1/8/24 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/Program Director, Amber Ely-Costa, on this date. Ms. Ely-Costa reported that the facility currently has five residents. She provided the resident records for these five residents. I reviewed all the resident records and discovered that all the RCA forms were updated annually. There were no RCA forms that were not updated annually.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Based upon observations made during the on-site investigation and review of current resident records, the *Resident Care Agreement* forms for current residents have been updated annually.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was taken to Detroit for a physician's appointment and left alone in a restaurant for multiple hours by direct care staff. The direct care staff member could not locate Resident A when she returned to the restaurant. Resident A's mother, Citizen 1, had to drive to the restaurant to locate Resident A.

INVESTIGATION:

On 1/3/24 I received an online complaint regarding the facility. The complaint alleged that Resident A was taken to Detroit for a physician's appointment by a direct care staff member and left alone in a restaurant for multiple hours by this direct care staff member. The complaint further alleged that Resident A's relative, Citizen 1, had to

come pick up Resident A from the restaurant as she was abandoned there by the direct care staff member. On 1/8/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Ely-Costa regarding the allegations. Ms. Ely-Costa reported that on 10/19/23 former direct care staff, Sierra Thomas, had taken Resident A to a physician's appointment in the Detroit area. Ms. Ely-Costa reported that the appointment was at noon. She reported that after the physician's appointment Resident A had requested to use the bathroom, so Sierra Thomas stopped at a local diner for Resident A to use the restroom. Ms. Ely-Costa reported Sierra Thomas explained that Resident A had an upset stomach and requested medication. Sierra Thomas did not have medication with her, so she left Resident A on the toilet in the diner and drove to the local Walmart store to purchase an over-the-counter medication for Resident A. Ms. Ely-Costa reported Sierra Thomas reported that when she returned to the diner with the medication, Resident A was gone. Ms. Ely-Costa reported Assistant Program Manager/direct care staff, Quantella Hamilton, was informed of the situation and spoke with Sierra Thomas. Ms. Ely-Costa reported it was decided that Sierra Thomas should drive around the local area looking for Resident A as they assumed she may have eloped from the restaurant. Ms. Ely-Costa reported Resident A is from the Detroit area, so direct care staff were wondering if she had prearranged to have someone pick her up from the diner on this date. Ms. Ely-Costa reported that the facility vehicle Sierra Thomas was driving has a GPS unit installed and they were able to pull up the records from the GPS unit and noted that Sierra Thomas had driven around the Detroit area for a period of about three hours on 10/19/23, looking for Resident A. Ms. Ely-Costa reported that she was not sure about the timeline of events on the date of the alleged incident but knew that at some point in the evening she spoke with Citizen 1 and updated her that direct care staff member Sierra Thomas could not find Resident A. Ms. Ely-Costa reported Resident A had made contact with Ms. Hamilton and Citizen 1 at some point during the day. She reported that Citizen 1, ultimately, went to the diner and picked up Resident A, where she had been left by Sierra Thomas. Ms. Ely-Costa reported that around 10pm on 10/19/23, Sierra Thomas returned to the facility with the facility vehicle, alone. She reported that she had not been able to locate Resident A and decided to return to the facility. Ms. Ely-Costa was not clear about whether the police were called during this period when Resident A was not able to be located. Ms. Ely-Costa reported direct care staff, Gloria Ramirez, was sent to Citizen 1's home to pick up Resident A on 10/19/23 around 11pm and returned to the facility with Resident A around 3am on 10/20/23.

During on-site investigation on 1/8/24 I interviewed Ms. Hamilton regarding the allegation. Ms. Hamilton reported that on 10/19/23 Sierra Thomas had attempted to reach her on her cell phone. She reported that she did not answer the call as Ms. Hamilton was attending a funeral when the call occurred. Ms. Hamilton reported that she asked, via text message, if Sierra Thomas was okay. Ms. Hamilton stated that this text exchange occurred around 5:08pm (as she looked at her text history to confirm this time). She reported that Sierra Thomas stated, "no worries." Ms. Hamilton reported that a while later Resident A sent a text to Ms. Hamilton from a number that was not hers. Ms. Hamilton reported the text message from Resident A

stated that she had sent Sierra Thomas to the local store to pick up some medication for her upset stomach and Sierra Thomas never returned to the restaurant where she left Resident A. Ms. Hamilton reported at this time she made a telephone call to Sierra Thomas who then explained that she had left Resident A at a restaurant, on the toilet, and got herself lost on the way back to the restaurant and could not find the restaurant where she left Resident A. Ms. Hamilton reported that after she heard from Resident A, she made a telephone call to Ms. Ely-Costa around 540pm. Ms. Hamilton reported that she was not working on this date and let Ms. Ely-Costa handle the situation moving forward. She reported that she was made aware that the employees at the restaurant, where Resident A was left in the restroom, had to call the paramedics to help get Resident A off from the toilet and back into her wheelchair. Ms. Hamilton reported that she did not have any contact with Citizen 1 on the date of the incident.

On 1/8/24, during on-site investigation, I interviewed Resident A. Resident A reported that on 10/19/23 she had been driven to a physician's appointment in the Detroit area by Sierra Thomas. She reported that Citizen 1 met them at the appointment and gave her money and food. She reported that after the appointment she had to use the restroom and asked Sierra Thomas to stop somewhere so she could use the restroom as she had an upset stomach. Resident A reported that once Sierra Thomas got her situated on the toilet in the restroom, she asked Sierra Thomas to go to the local store and purchase her some Pepto Bismol for her upset stomach. Resident A reported that Sierra Thomas then left her in the restroom of the restaurant, on the toilet, and went to the local store for medication. Resident A reported that she was sitting on the toilet for an extremely long period of time when an employee of the restaurant came into the restroom and asked if she needed assistance as she had been in the restroom for about 1.5 hours. Resident A reported that she could not transfer herself back to her wheelchair as it was not within reach and the employees of the restaurant ended up calling for paramedics to assist in getting Resident A back to her wheelchair. Resident A reported that once she was in her wheelchair, she remained in the entryway of the restaurant waiting for Sierra Thomas to return for her. She reported that she spent hours waiting and was worried the restaurant would close. She reported that around 9:45pm Citizen 1 arrived and picked her up and took her to her home. She reported that Citizen 1's home is not barrier free, and they were challenged to be able to get Resident A's wheelchair into the home. Resident A reported that she also requires a straight catheter for her urinary care every couple of hours and she ran out of straight catheter supplies due to the prolonged period she was left alone by Sierra Thomas. Resident A reported that she was forced to use a straw from a restaurant to straight catheterize herself. Resident A reported that she did not have her own cell phone on her on this date and had borrowed someone else's cell phone. She reported that this cell phone only had a 3% charge, and she had no way to recharge the cell phone. She reported that she did contact Ms. Hamilton, using this cell phone and gave her the address of the restaurant. Resident A reports that the restaurant she was left at, by Sierra Thomas, was called M1 Grill. She reported that Sierra Thomas did not leave her a telephone number to contact her at when she left her at the restaurant. Resident A reported

that she was picked up by direct care staff at Citizen 1's home and transported back to the facility on 10/19/23. She reported she arrived back at the facility around 2am on 10/20/23.

On 1/8/24 I interviewed Citizen 1, via telephone. Citizen 1 reported that on 10/19/23 she received a voicemail message from Ms. Ely-Costa, noting that Resident A was missing. Citizen 1 reported that later Ms. Ely-Costa gave her the address of the M1 Grill location as to where Resident A was located. She reported that she then went to the restaurant and picked up Resident A around 8:30pm. She reported that she took Resident A to her home, which she noted is not barrier free. She reported that her neighbor had to assist them in getting Resident A inside, with her wheelchair. Citizen 1 reported that a direct care staff member came to her home and picked up Resident A later that evening, after 10:30pm. Citizen 1 reported that she spoke with the employees at the restaurant and was told that when they found Resident A, alone in the restroom, her wheelchair was placed too far away from her for her to be able to transfer herself safely from the toilet to the wheelchair.

On 1/8/24 I interviewed Sierra Thomas via telephone. Sierra Thomas reported that she is no longer employed by the facility. She reported that her employment had been terminated. Sierra Thomas reported that she had been a new direct care staff member and on the date of 10/19/23 she was placed on the schedule as a "float". She reported that this meant she was to be available to go between the "cottages" and help where needed. She reported that the facility is housed on a campus with multiple other licensed adult foster care facilities. Sierra Thomas reported that on this date she was asked by a manager, Dave (last name unknown to Sierra Thomas), to transport Resident A to Detroit for a medical appointment. Sierra Thomas reported that she felt uneasy about the request to transport Resident A as she was a new direct care staff and did not feel she had been adequately trained to provide transportation such a long distance from the facility without another direct care staff also in attendance. Sierra Thomas reported that she did transport Resident A to her medical appointment, where Citizen 1 met them to help get Resident A out of the vehicle. She reported that the appointment was at noon and it took about two hours. Sierra Thomas reported that after the appointment, Citizen 1 left and she started to head back to the facility with Resident A. Sierra Thomas reported that Resident A had requested to use the restroom, so Sierra Thomas stopped at a local restaurant and took Resident A inside to use the restroom. Sierra Thomas reported that while Resident A was on the toilet, she asked Sierra Thomas to go to the local store and purchase her some Pepto Bismol. Sierra Thomas reported that she left Resident A at a "Hispanic family restaurant" and went to Walmart to get her some Pepto Bismol. She stated that she had given Resident A her telephone number to use in case of an emergency. She reported that when she returned to the same restaurant, Resident A was not there. Sierra Thomas reported that she spoke with Ms. Hamilton regarding the situation and drove around the Detroit area looking for Resident A for a period of five hours. Sierra Thomas reported that Ms. Hamilton gave her the location of Resident A and it was 45 minutes away from where Sierra Thomas states she left Resident A. Sierra Thomas reported that

she is unsure how Resident A was able to move 45 minutes away from the original location. Sierra Thomas reported that she spoke with Ms. Ely-Costa who stated to Sierra Thomas that she should keep driving around looking for Resident A and that she would contact the police. Sierra Thomas reported that she is unsure whether Ms. Ely-Costa called the police. She reported that she started to become fearful for her safety and decided to drive back to the facility. Sierra Thomas reported that she arrived back at the facility around 10:30pm without Resident A.

During on-site investigation on 1/8/24 I reviewed the following documents:

- *AFC-Resident Care Agreement* for Resident A, dated 11/1/23. On page one of this document under the area, *The basic fee includes the following basic services,* it states, "All utilities including water, electric, heat, and 3 balanced meals per day plus 2 snacks. Transportation to and from necessary medical appointments as well as legal appointments. Basic hygiene supplies."
- *Assessment Plan for AFC Residents,* dated 11/1/23, under section, *Moves Independently in Community*, it states, "No" with the following narrative, "Residential staff support client in the community with questions, providing verbal prompts, assistance, health and safety, guidance and decision making, support, and transportation. [Resident A] has multiple sclerosis and has very limited mobility from the waist down. [Resident A] benefits from physical assistance and support during transfers from her wheelchair to another flat service at the same level. She additionally benefits from a sliding board a support to her with weight baring during transfers as she is unable to bare weight on her legs. [Resident A] benefits from staff verbal cues and physical presence with hands on assist during certain transfers specifically when her M.S. symptoms increase." Under the section, *Toileting*, the narrative reads, "At the time of this assessment, [Resident A] catheterizes herself. Staff support [Resident A] by bring purchased supplies which are mailed to Turning Leaf on a regularly scheduled basis. [Resident A] frequently gets UTIs to which she is prescribed preventative antibiotics. [Resident A] is incontinent of bowel at times and during periods when her MS symptoms flair she benefits from staff support for verbal cues, reminders, and also physical assist to clean her peri area and buttocks." Under the section, *Physical Limitations*, the narrative reads, "At the time of this assessment, per staff report, [Resident A] is paralyzed in her lower extremities and therefore utilizes a manual and electric wheelchair."
- *Michigan Department of Community Health Recipient Rights Complaint*, dated 10/20/23, completed by Ms. Ely-Costa. The narrative on this document noted, "This writer was informed that while [Resident A] was with a DSP, [Sierra Thomas], on a doctor visit a few hours away they were on their way back (GPS tracks they went the wrong way). The two stopped at a diner so [Resident A] could use the bathroom. When [Resident A] was in there she started having diarrhea and ask [Sierra Thomas] to get her Imodium and gave her money and [Sierra Thomas] left [Resident A] sitting on the toilet to go to Walmart (20miles away) and never came back to the diner to get [Resident A]. [Sierra Thomas] returned to Turning Leaf without [Resident A] and said

she couldn't find her saying she went back to the diner but [Resident A] was gone (GPS tracker indicates she never returned to the diner to begin with) after talking with [Resident A] she stated that she had to cath herself with a straw which made her bleed and hurt. [Resident A] stated she was able to call her mom and her mom was able to come get her and EMS was called to get [Resident A] into the car. [Resident A] stayed at her moms until another Turning Leaf employee was able to pick her up and bring her back to Turning Leaf which occurred around 3am. [Resident A] told this writer that she never got her amodium so the DSP [Sierra Thomas] took her money as well. [Resident A] told this writer that [Sierra Thomas] was on her phone the whole drive to the dr. app (a 3 hour drive) yelling/fighting with her boyfriend over their living situation because [Sierra Thomas] and her boyfriend live with [Sierra Thomas's] mom and dad and the boyfriend doesn't like that. So [Sierra Thomas] was also not driving safe and was distracted by her personal things."

- *Turning Leaf Payroll Change Form*, for Ms. Thomas, dated 10/20/23. This document noted, "2 critical policy violations" for the *Reason for Separation*, as well as the following statement, "Both critical violations involved leaving residents unattended. One at hospital and twice at a diner in Rochester, MI." This document was initialed by Ms. Ely-Costa, on 10/20/23.
- *Incident/Accident Report* (IR). I reviewed the IRs on record for Resident A for the past six months. On the following dates it was documented, by way of an IR, that Resident A had issues with incontinence of either bowel or urine; 7/21/23, 9/6/23, 9/27/23, 10/25/23, 11/15/23, 11/17/23, 11/20/23, 11/23/23.

On 2/22/24 I corresponded with licensee designee, Destiny Al-Jallad, via email regarding the allegations. Ms. Al-Jallad reported that on the date, 10/19/23, Resident A was transported by Ms. Thomas in a Toyota Camry. She reported that the vehicle was equipped with a GPS tracking system called, Azuga. Ms. Al-Jallad reported that she was able to pull what is called a *Breadcrumb Report* from the Azuga system to track where the vehicle had driven on 10/19/23. Ms. Al-Jallad reported the Azuga system does have the capability for "real time" tracking of the vehicle, but due to "non Communication from the staff and mis-communication and confusion, staff not directly reporting what was happening", the system was not used in "real time" on 10/19/23. Ms. Al-Jallad reported that after reviewing the *Breadcrumb Report* for this vehicle she was able to determine that the vehicle appeared to have arrived at Resident A's medical appointment at 1:14pm and remained in this location until 3:42pm. She further reported it appears, based on this report, that the vehicle arrived at the M1 Grill (50501 Woodward Av. Pontiac, MI) at 4:01pm on 10/19/23. Ms. Al-Jallad reported that this is the location where Resident A was located. Ms. Al-Jallad was asked about the training protocol in place prior to a direct care staff member being able to provide transportation to a resident. Ms. Al-Jallad responded that direct care staff members complete a transportation/driving emergencies module training. Transportation shifts are discussed at new hire orientation. Human Resources checks all direct care staff driving records before they have been an approved driver and placed on a transport shift. The day of a resident transport the direct care staff meet with a manager who provides instructions and paperwork

regarding the transport. During this meeting the direct care staff has the opportunity to ask questions regarding the assignment. The direct care staff providing the transportation is instructed to contact their manager in case of an emergency. Attached to the email correspondence from Ms. Al-Jallad were the following documents:

- *[Resident A] to Dr. Rossi 12:15pm – Meeting-Clinical Calendar AEC TEST*. The location of the appointment was documented as, 633 South Blvd E, Rochester Hills, MI 48307. This document was dated for 10/19/23 and contained the following instructions:
    - 1. [Resident A] to Dr. Rossi
    - 2. Take Red Folder
    - 3. DO NOT make the next appointment.
    - 4. Document ON THIS APPOINTMENT CARD when the next appointment needs to be scheduled.
    - 5. REMEMBER TO SIGN appointment card.
    - 6. RETURN ALL APPOINTMENT INFO TO THE OFFICE
- *Breadcrumb Report,* dated 10/19/23. This report identifies the vehicle at the following locations on 10/19/23:
    - 10/19/23 @ 11:12AM EDT, *Ignition On*, 621 E. Jolly Rd. Lansing, MI 48910 (the facility).
    - 10/19/23 @ 1:14PM EDT, *Ignition Off*, 633 E. South Blvd, Rochester Hills, MI 48307 (Dr. Rossi's Office).
    - 10/19/23 between the time 1:58pm and 3:42pm there are 41 entries where the vehicle is either, *Idling, GPS Tracking, Ignition On, or Ignition Off*. The vehicle does not appear to leave Dr. Rossi's office during these instances.
    - 10/19/23 @ 3:42PM EDT, *GPS Tracking*, 271-499 E. South Blvd. Rochester Hills, MI 48307.
    - 10/19/23 @ 4:01PM EDT, *Ignition Off*, 50501 Woodward Ave. Pontiac, MI 48342 (M1 Grill Family Restaurant).
    - 10/19/23 @ 4:11PM EDT, *Ignition On*, M1 Grill Family Restaurant.
    - 10/19/23 @ 4:33PM EDT, *Ignition Off*, 2500 S. Adams Rd Rochester Hills, MI 48309 (Walmart Supercenter).
    - 10/19/23 @ 4:39PM EDT, *Ignition On*, Walmart Supercenter.
    - 10/19/23, the vehicle is recorded as remaining in *GPS Tracking* mode from 4:39PM until 7:26PM. No stops were recorded during this timeframe.
    - 10/19/23 @ 7:26PM EDT, *Ignition Off*, 2005 Walton Blvd, Abuburn Hills, MI 48326 (Marathon Gas).
    - 10/19/23 @ 7:31PM EDT, *Ignition On*, Marathon Gas.
    - 10/19/23@ 7:33PM EDT, *GPS Tracking* begins and continues until 9:23PM EDT.
    - 10/19/23 @ 9:23PM EDT, *Ignition Off*, the vehicle reaches the facility.

On 2/23/24 I received email correspondence from Ms. Ely-Costa. Ms. Ely-Costa reported that when a direct care staff is providing transportation to a medical

appointment for a resident the direct care staff receive an appointment card and directions to the appointment. She reported direct care staff also take medications if the resident were to be away during a required medication administration time and for Resident A the direct care staff would have been providing catheters for her urinary incontinence care. Ms. Ely-Costa also provided in this email correspondence the following document:

- *Turning Leaf-Individual Plan of Service (IPOS) or Behavior Treatment Plan (BTP) Training Verification*, for Resident A. The document lists the effective date as 12/1/22 and the end date, 11/30/23. The document contains a list of direct care staff and their signatures attesting to having been trained in Resident A's IPOS. Ms. Thomas' signature was not on this document.
- *IPOS Meeting*, dated 12/1/22. On page 3, under section, *Safety*, it reads, "[Resident A] has a history in drug overdose in previous group home; group home will keep a close eye on [Resident A]. Home suspects drug use but [Resident A] denies. [Resident A] is meeting with therapist regularly to assess."

On 2/23/24 I received an email correspondence from Julianne Platz, Business Services Specialist, for the facility. The email contained the training transcript document for Ms. Thomas. Ms. Thomas is documented as completing all required adult foster care licensing trainings and in addition she completed a training titled, *Safe Driving Techniques and Driving Emergencies Module*, on 9/19/23.

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.

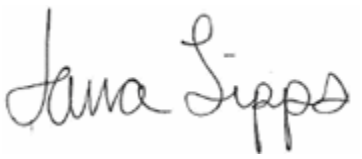
ANALYSIS:	Based upon interviews with Ms. Ely-Costa, Ms. Hamilton, Resident A, Citizen 1, and Sierra Thomas, as well as review of Resident A's resident record & Sierra Thomas' employee file, it can be determined that Resident A was left unattended in a vulnerable position, sitting on a toilet in a public restroom, by Sierra Thomas. Resident A's assessment plan indicates that she is not able to be independent in the community and requires assistance with transfers due to weakness/paralysis in her lower extremities. Sierra Thomas chose to leave Resident A sitting on a toilet in a public restroom, unattended, and drove to a local store to purchase medication for Resident A. Resident A was not only left alone in this position, but required the assistance of paramedics to be transferred off the toilet and back to her wheelchair as Sierra Thomas did not return to the restaurant which left Resident A unattended from approximately 4pm to 9:30pm on 10/19/23. She also left the wheelchair too far away from Resident A to reach if needed. Furthermore, Resident A requires straight catheter equipment to urinate and was left with no equipment to complete this task. Resident A and Citizen 1 noted that Resident A was forced to catheterize herself with a straw from the restaurant, which led to discomfort and unsanitary care. After review of the *Breadcrumb Report*, it is noted that Sierra Thomas never returned to the M1 Grill after she left Resident A at this location. As stated by Ms. Al-Jallad, the administration at the facility did have the capability of viewing the GPS tracking unit in the vehicle in "real time" but due to miscommunication and confusion, did not utilize this tool. By not utilizing all the tools at direct care staff members' disposal to assist Sierra Thomas in locating Resident A after Sierra Thomas became lost, Resident A's personal care, supervision and protection per her assessment plan were not provided. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(d) Personal care, supervision, and protection.**

ANALYSIS:	Based upon interviews with Ms. Ely-Costa, Ms. Hamilton, Resident A, Citizen 1, and Sierra Thomas, as well as review of Resident A's resident record, including her Individual Plan of Service Training Log, & Sierra Thomas' employee file, it can be determined Sierra Thomas was not documented as being competent or educated to Resident A's plan of care. It is evident that Sierra Thomas did not display competency in understanding Resident A's assessment plan, by leaving her unattended for multiple hours and not having adequate supplies for her care. By not being trained in Resident A's personal needs and plan of service, direct care staff member Sierra Thomas demonstrated incompetence placed Resident A in a situation of vulnerability where her supervision, protection, and personal care were compromised.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, a six-month provisional license is being recommended at this time.



02/26/24

_____

Jana Lipps Date
Licensing Consultant

Approved By:

02/26/2024

_____

Dawn N. Timm Date
Area Manager