GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 14, 2024

Violet Bettig
Guardian Angel Homes LLC
725 N. Dettman Rd.
Jackson, MI 49201

RE: License #: AS380389381
Investigation #: 2024A0007007
Saint Gabriel

Dear Violet Bettig:

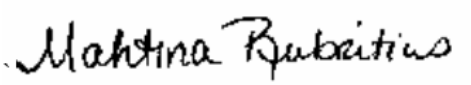
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AS380389381 |
| | |
| **Investigation #:** | 2024A0007007 |
| | |
| **Complaint Receipt Date:** | 12/18/2023 |
| | |
| **Investigation Initiation Date:** | 12/19/2023 |
| | |
| **Report Due Date:** | 02/16/2024 |
| | |
| **Licensee Name:** | Guardian Angel Homes LLC |
| | |
| **Licensee Address:** | 725 N. Dettman Rd.<br>Jackson, MI 49201 |
| **Licensee Telephone #:** | (517) 914-1039 |
| | |
| **Administrator:** | Ray Patino |
| | |
| **Licensee Designee:** | Violet Bettig |
| | |
| **Name of Facility:** | Saint Gabriel |
| | |
| **Facility Address:** | 1038 Woodbridge<br>Jackson, MI 49202 |
| **Facility Telephone #:** | (517) 914-1039 |
| | |
| **Original Issuance Date:** | 02/23/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/07/2022 |
| | |
| **Expiration Date:** | 08/06/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED<br>TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A disclosed that Ray Patino, Administrator, is inappropriately touching her. | No |
| Rey Patino twists Resident B's hand when he is not following directions, then will direct him into his bedroom. | No |
| Ray Patino slept through third shift instead of providing support and supervision to the home. | Yes |
| The facility runs low on food. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 12/18/2023 | Special Investigation Intake - 2024A0007007 |
| 12/18/2023 | APS Referral – Received. |
| 12/19/2023 | Contact - Telephone call made to APS Worker #1. |
| 12/19/2023 | Special Investigation Initiated - On Site- Unannounced - Face to face contact with Resident A, Resident B, Resident C, Resident D and two direct care staff. |
| 12/20/2023 | Contact - Telephone call made to Jackson County Guardian (Guardian A), case discussion. |
| 12/20/2023 | Contact - Telephone call made to APS Worker #1. |
| 12/20/2023 | Contact - Document Sent - Email to APS Worker #1. |
| 12/21/2023 | Contact - Telephone call made to APS Worker #1. |
| 01/02/2024 | Contact - Document Received - Subsequent Allegations Received. |
| 01/03/2024 | Inspection Completed On-site - Unannounced - Face to face contact with Ray Patino, Administrator, Home Manager #1, Resident B and Resident D. |
| 01/03/2024 | Contact - Telephone call made to APS Worker #1. |

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| 01/04/2024 | Inspection Completed On-site - Face to face contact with APS Worker #1, Ray Patino, Resident B, and Home Manager #1. |
| 01/08/2024 | Contact - Telephone call made to Violet Bettig, Licensee Designee. |
| 01/09/2024 | Contact - Telephone call received from ORR Worker #1. Case discussion. |
| 01/10/2024 | Contact - Telephone call received - APS Worker #2. Case discussion. Staff feel like they are being retaliated against. Appointment scheduled. |
| 01/11/2024 | Inspection Completed On-site - Unannounced - Face to face contact with APS Worker #2. No answer at facility. APS Worker #2 contacted Ray Patino and he stated all residents were on outings. APS Worker #2 stated she would return to the facility later that day and follow up. |
| 01/11/2024 | Corrective Action Plan Received from ORR Worker #1. Case discussion. |
| 01/12/2024 | Contact - Telephone call received from APS Worker #1. Case discussion. |
| 01/25/2024 | Contact - Face to Face - Case conference with ORR Worker #1, APS Worker #1 and APS Worker #2. |
| 01/25/2024 | Contact - Face to Face with Complainant - Subsequent Allegations received. |
| 01/31/2024 | Contact - Face to Face - contact with APS Worker #2. She went to the home to check the food. There was an adequate amount of food. She also will be substantiating the allegations regarding Resident B. |
| 01/31/2024 | Contact - Telephone call made to Violet Bettig, Licensee Designee. |
| 02/05/2024 | Contact - Face to Face with APS Worker #1. |
| 02/05/2024 | Contact - Face to Face with APS Worker #2. Case discussion. |
| 02/06/2024 | Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1, Resident B, Resident C, Resident D, Employee #5 and Employee #6. |

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|---|---|
| 02/06/2024 | Contact - Telephone call made to (Previous) Employee #2. Phone number not in service. |
| 02/06/2024 | Contact - Telephone call made to Employee #3. Interview. |
| 02/06/2024 | Contact - Telephone call made to (Previous) Employee #4. Interview. |
| 02/06/2024 | Contact - Telephone call made to (Previous) Employee #1. Phone number not accepting calls. |
| 02/06/2024 | Contact - Telephone call made to APS Worker #1. Update regarding information from interviews. |
| 02/07/2024 | Contact - Telephone call made - APS Worker #1. Please contact LARA if there are changes and allegations are substantiated. |
| 02/07/2024 | Contact - Telephone call made to Ray Patino, Administrator. Interview. |
| 02/08/2024 | Contact - Telephone call (x3) made to Violet Bettig, Licensee Designee. I requested a returned phone call to conduct the exit conference. |
| 02/09/2024 | Exit Conference conducted with Violet Bettig, Licensee Designee. |
| 02/12/2024 | Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1, Employee #5, Resident B, Resident C, and Resident D. |

**ALLEGATION: Resident A disclosed that Ray Patino, Administrator, is inappropriately touching her.**

**INVESTIGATION:**

On December 19, 2023, I interviewed APS Worker #1. He informed me that Resident A's case manager, Donna (Howard) Potter, has been aware of the allegations. APS Worker #1 informed me that they don't know if Resident A is being sexually abused in the home because there are concerns regarding the creditability of the referral source. APS Worker #1 stated he will contact ORR Worker #1 to try and set up a meeting with Complainant. APS Worker #1 further stated Resident A has a history of sexual abuse including an incident, unrelated to this AFC facility, that occurred about five years ago and is currently proceeding through the court system.

According to APS Worker #1, Resident A is employed, and she is independent. Donna Potter has attended several medical appointments with Resident A, and Resident A has never disclosed that anything was happening in the home to Donna Potter. APS Worker stated a referral has been made to law enforcement about the allegation. He will be meeting with Resident A and Donna Potter.

On December 19, 2023, I conducted an unannounced on-site investigation, and made face to face contact with Resident A, Resident B, Resident C, Resident D and two direct care staff.

I interviewed Resident A. Resident A reported that things were going well in the home, she has a job, and she spends a lot of time in the community. We talked about the outings she enjoys in the community, such as bowling and going to the Jackson Crossing. She reported to get along with the staff and had no concerns to report. When asked specific questions, Resident A informed that nothing inappropriate was happening. She informed me that she had no idea why someone would say that she was being inappropriately touched. She also stated she knew who she could tell if something happened that she did not agree with.

Resident B was not interviewed, as staff on duty reported that due to his diagnosis and limited cognitive abilities, he would not be able to provide information to confirm or refute the allegations.

I interviewed Resident C, who reported that things were going good in the home, and that he got along with staff. Resident C did not voice any concerns.

I also interviewed Resident D who did not report any concerns about how she was treated by staff. It was also noted that Resident D had limited cognitive abilities.

On December 20, 2023, I spoke with Guardian A1. She stated that Resident A was sexually abused in the past, which is currently going through the court process, and Resident A wants court to be over. According to Guardian A1, Resident A told an individual (Individual A1) that she did not want to be her friend. Guardian A1 stated now Individual A1 is alleging that Ray Patino is abusing Resident A. Guardian A1 stated that Resident A never said anything to her, Donna Potter, or Home Manager #1, about anything inappropriate occurring between she and Ray Patino. Guardian A1 stated that these are very serious allegations, and she thinks that if something happened, Resident A would say something to her or Donna Potter. Guardian A1 stated Resident A's medical providers have not reported any concerns to her either.

On December 21, 2023, I spoke to APS Worker #1. He informed me that he interviewed Resident A, and she did not disclose any information, confirming the allegations. APS Worker #1 stated that at that point, he did not plan to substantiate this allegation.

On January 3, 2024, I spoke with APS Worker #1. He stated that he still had not heard back from case management regarding contact information for Individual A1.

On January 4, 2024, APS Worker #1 and I conducted an unannounced on-site investigation and made face to face contact with Ray Patino and Resident B. Home Manager #1 also arrived at the facility.

Ray Patino stated that he has standards and if staff are not doing their job, he would not have them work in the facility. He stated Employee #1 has made threats against him. Regarding Resident A, Ray Patino stated that she was the first resident placed in the home and his daughter and Resident A were friends. When his daughter passed away, it had an effect on Resident A. Ray Patino reported he treats Resident A like a daughter. Ray Patino stated that some of the residents don't get much money, so he will give them money and Resident A is one of the residents he has given money to for community activities, so she doesn't go without.

Ray Patino denied the allegations and stated nothing inappropriate was going on. He stated that Resident A was abused in the past and their home was a place where she felt safe. He stated that if Resident A felt uncomfortable about anything, she could report the information to him. Ray Patino denied the allegations and reported to be disappointed that someone would make these allegations about him.

On January 12, 2024, I spoke with APS Worker #1. He was at the home and made face to face contact with Ray Patino, another staff member, and Resident B.

On January 31, 2024, I interviewed Violet Bettig, Licensee Designee. She stated that Resident A looks up to Ray Patino, like a father figure. She stated that she has no concerns regarding anything inappropriate occurring. In addition, that she stated she asked Resident A herself and Resident A did not confirm that anything was happening. Violet Bettig stated that he would not harm Resident A, as he treats her like a daughter. She stated that Resident A is like family to them, and they care about her wellbeing.

On February 6, 2024, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #1, Resident B, Resident C, Resident D, Employee #5, and Employee #6.

On February 7, 2024, I spoke to APS Worker #1 who stated he did not find any evidence that Ray Patino was inappropriately touching Resident A and would be closing his case. He agreed to contact LARA if he receives any new information, and the allegations are substantiated.

On February 9, 2024, I conducted the exit conference with Violet Bettig, Licensee Designee. We discussed the investigation. Violet Bettig agreed with the conclusion of the investigation.

| APPLICABLE RULE | |
|---|---|
| **R 400.14305** | **Resident protection.** |
| | **(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.** |
| **ANALYSIS:** | Resident A denied that anything inappropriate was occurring, and she also knew who she could tell if something happened that she did not agree with. APS Worker #1 and Donna Potter, Case Manager, interviewed Resident A and she did not disclose any information. Guardian A1 informed me that Resident A never disclosed anything to her, Donna Potter, or Home Manager #1, about anything inappropriate occurring between she and Ray Patino. Guardian A1 stated that these are very serious allegations, and she thinks that if something happened, Resident A would say something to her or Donna Potter.<br><br>Ray Patino denied the allegations and reported to be disappointed that someone would make these allegations about him.<br><br>According to Violet Bettig, Licensee Designee, Resident A looks up to Ray Patino, like a father figure. She stated that she has no concerns regarding anything inappropriate occurring.<br><br>Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that Resident A is being inappropriately touched by Ray Patino, and that she is not being treated with dignity and her personal needs, including protection and safety, are not attended to at all times in accordance with the provisions of the act. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION: Rey Patino, Administrator, twists Resident B's hand when he is not following directions, then will direct him into his bedroom.**

**INVESTIGATION:**

During this investigation, subsequent allegations were received. It was alleged that Rey Patino, Administrator, twists Resident B's hand when he is not following directions, then will direct him into his bedroom.

On January 3, 2024, an unannounced on-site investigation was conducted, and I made face to face contact with Ray Patino, Administrator, Home Manager #1, Resident B, and Resident D.

While at the facility, I attempted to interview Resident B. It was noted that Resident B has limited cognitive abilities. When asked how he was treated by Ray Patino, Resident B replied “okay.” When specifically asked about his hands being bent, Resident B had a blank stare on his face. When asked if he as being treated badly or harmed, he replied “no.” Resident B reported that he would tell his mom if any staff members were treating him badly.

On January 4, 2024, APS Worker #1 and I conducted an unannounced on-site investigation and made face to face contact with Ray Patino and Resident B. Home Manager #1 also arrived at the facility.

During the interview with Ray Patino, I inquired about Resident B and how he was doing with following directions. Ray Patino stated that Resident B was doing pretty good, and they were trying different options. I inquired if he bends Resident B’s hand when he does not follow directions, and Ray Patino denied the allegations. He stated that Resident B can be very aggressive, and when this happens, they hold his wrist so he “can’t get wild.” Ray Patino stated this is what they teach in training. Ray Patino stated that he reads a lot to Resident B, and he will go in his room to talk to him. Ray Patino reported he cares about Resident B and denied harming him.

While at the home, I observed Resident B. He did not appear to be in any pain or uncomfortable. Resident B often asked if I had any dogs. He was also happy to show off the new gadget that his mother had purchased for him.

On January 9, 2024, I spoke with ORR Worker #1, and we discussed the complaints she had received and her investigations. ORR Worker #1 stated she requested Resident B have his finger examined at Urgent Care. ORR Worker #1 stated Resident B also had an x-ray and it was determined that Resident B’s finger was fractured, but it appeared that this may be an old injury. ORR Worker #1 stated Resident B was interviewed and stated, “He grabbed me.”, but stopped responding to ORR Worker #1 when additional questions were asked.

ORR Worker #1 stated a meeting is being planned with Violet Bettig, Licensee Designee, to address their concerns, as they needed a safety plan. ORR Worker #1 stated direct care staff described Ray Patino as a “monster.” According to ORR Worker #1, APS had also been notified about the concerns.

On January 12, 2024, I spoke with APS Worker #2. He was at the home and made face to face contact with Ray Patino, another staff member, and Resident B. He was there to speak with Resident A; however, she was at Violet Bettig’s house. APS Worker #1 called me later that day and stated that he went to Violet Bettig’s house but there was no answer at the door.

As a part of this investigation, I reviewed the information from Resident B's visit to the hospital. The following was noted from the *Emergency Department Notes*: on January 4, 2024, a 42- year-old male was seen for an evaluation of finger pain. Resident B had indicated to his caregivers that he was having pain in his finger. The AFC staff deny any obvious injury. Resident B's right ring finger was examined. Regarding musculoskeletal, there was no significant tenderness at the finger of concern. Resident B was able to flex and extend the finger without any difficulty. X-rays were also completed, and it was noted that there was "subtle irregularity seen involving tuft of the fourth distal phalanx, consistent with age indeterminant injury. Flexion deformity of the fourth digit at the PIP joint throughout the examination, correlate if fixed injury."

I reviewed *Office of Recipient Rights Report of Investigative Findings* authored by ORR Worker #1 and the following was noted:

- It was noted that during the interview with Resident B, ORR pointed to his finger and asked him "What happened?" Resident B replied, "He grabbed me." Resident B would not answer when asked who grabbed him. Resident B was asked if it was a man or woman, and he replied "Man." Resident B would not answer any additional questions.

- ORR Worker #1 interviewed Home Manager #1, who reported that nothing was wrong with Resident B's finger. She reported that a couple of disgruntled staff started unfounded rumors regarding the home. Home Manager #1 denied witnessing Ray Patino harm Resident B or using excessive force.

- It was also noted that several direct care staff were interviewed. The direct care staff reported being told they would be taken off the schedule if they spoke to ORR regarding their concerns.

- One staff member reported witnessing Ray Patino grab Resident B's hand and twist it, bending his fingers back. This had been witnessed multiple times. In addition, that Ray Patino pushes Resident B into his room and tells him to stay there. Resident B had reported to the staff member that his finger hurt and that his finger was bruised and bent awkwardly.

- Another direct care staff member reported to never witnessing Ray Patino assault Resident B, but that he used excessive force when restraining him.

- Another staff, who was visibly uncomfortable during the interview stated they needed their job and would not disclose any information, other than Ray Patino was the problem at the home.

- Another direct care staff reported that they witnessed Ray Patino grab Resident B's fingers and squeeze, then Resident B said "Ow."

- It was also noted that since the investigation started, the direct care staff were instructed by Ray Patino to say that Resident B broke his finger by taking out the garbage. Staff informed ORR that Resident B only takes out small bags of garbage, so this does not make sense. The direct care staff also reported that they were threatened for speaking with ORR. One direct care staff later reported that they were terminated four hours after their interview.

- It was also noted that APS Worker #2 and ORR Worker #1 interviewed Resident B. Resident B reported to be unsure as to what happened to his finger. Resident B was unable to answer any further questions.

- ORR Worker #1 interviewed Ray Patino, who reported to have "no clue what happened" to Resident B's finger. He denied yelling at anyone. He reported that he has had to restrain Resident B by holding down his wrists but denied ever grabbing him by the wrists. Ray Patino reported that he never received any kind of physical management training. Ray Patino denied harming Resident B. ORR also noted that there were no Incident Reports written for physical management used on Resident B.

- ORR Worker #1 interviewed Violet Bettig, Licensee Designee. She reported that former staff were targeting Home Manager #1 and Ray Patino, and after they were terminated, the former staff have been "ganging up" on them. She reported that Ray Patino has a big heart, and he really cares about the residents. In addition, that his own children have received services, so he knows what it's like to be a guardian and a caregiver. Violet Bettig reported to observe Ray Patino interact well with the residents. She stated that she did not believe the allegations to be true.

Per the summary noted in the *Office of Recipient Rights Report of Investigative Findings*, ORR Worker #1 substantiated the allegations, Abuse, Class 1. In addition, it was recommended that disciplinary action be taken, and a corrective action plan was requested to address the established violation.

On January 31, 2024, I interviewed Violet Bettig, Licensee Designee. She stated that she had been contacted by ORR and could not believe what she was being told. She stated that she would be surprised if Ray Patino would be cruel to residents. She also stated that she has zero tolerance for staff mistreating the residents. Violet Bettig stated that they terminated Employee #1, as Ray Patino was doing her job for her. In addition, it was told to her that Employee #1 stated that she would not stop reporting until Ray Patino no longer had a job in the home. Violet Bettig stated that if the staff were concerned about Resident B's safety and care, why didn't they report during their employment.

On February 5, 2024, I spoke with APS Worker #2. She stated she interviewed Resident B's parents who were aware of the allegations. According to APS Worker #2, Resident B's parents stated Resident B messes with his hands, and they don't

think staff or Ray Patino would harm Resident B. According to APS Worker #2, Resident B's parents stated Resident B has been in the home for three years and this is the happiest he has been. Resident B's mother reported she Facetimes with him daily and feels like if something were wrong, he would tell them. Resident B's parents stated being unsure what happened but did not feel that staff harmed him.

APS Worker #2 stated that she substantiated this allegation for physical abuse.

On February 6, 2024, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #1, Resident B, Resident C, Resident D, Employee #5, and Employee #6.

I interviewed Home Manager #1 and inquired about Ray Patino bending or twisting Resident B's wrists. She stated that when Resident B is being aggressive, he will go for the staff's face or neck. She stated that Ray Patino does a wrist technique in which he holds both wrists; she also demonstrated the hold. She stated that Ray Patino is going to safety care training, along with the other staff.

I interviewed Employee #5. She reported to see Ray Patino redirect Resident B, but she has not observed him squeezing or holding his wrists.

I interviewed Employee #3, via telephone, who stated she has not witnessed Ray Patino squeezing or bending Resident B's fingers or wrists. She informed me that Resident B prefers to be around Ray Patino. I inquired about him redirecting when Resident B is aggressive, and she stated that Ray Patino will tell Resident B to sit down and rubs his arm. She stated that Resident B usually calms down. I inquired if she had observed anything concerning or thought there was anything else I needed to know, and she stated there was not.

On February 6, 2024, I interviewed (previous) Employee #4. She stated that she never witnessed Ray Patino squeeze Resident B's hands, but she did observe him put his hands around Resident B's neck and throw him on the bed. Employee #4 stated she said that was enough to Ray Patino, he told her to mind her business. After that incident, she informed that Ray Patino would nitpick and find a reason to yell at her.

On February 7, 2024, I spoke to APS Worker #1, who recalled that when he went to the home, Ray Patino asked Resident B to show him where he was hurt on his hand, and Resident B did not point to the fractured area.

On February 7, 2024, I interviewed Ray Patino and I inquired about him putting his hand's round Resident B's neck and throwing him on the bed. He stated that the incident never happened and that he would not do that to a resident. During the interview with Ray Patino, I also asked for clarification regarding when he told me he was trained to hold Resident B's wrists. He stated that another employee, who worked in a different home had brought a training manual from a different home. He

read the information in that training manual. I inquired if he had been trained in Safety Care or Physical Management and he stated he had not, but that he was scheduled for the class soon. He stated that other staff have been trained and the new staff are scheduled to be trained.

I inquired as to how Resident B's *Individual Plan of Service* (IPOS) instructed staff to address his aggression and he stated it was "vague," other than prompting him; he didn't recall all details of the plan. He stated that Resident B will scratch and dig at staff's face, so that is why they hold his wrists, when he's being aggressive.

Ray Patino stated that if he were hurting Resident B, why would he follow him around or want to be around him. He stated that when he (Ray Patino) is not in the home, he asks about him. He stated that he would not have a close relationship with Resident B if abuse were involved. He informed me that the previous staff got together and colluded to make this allegation. He questioned if things were happening, why they didn't say something or even tell Home Manager #1. He stated he would never harm a resident.

On February 9, 2024, I conducted the exit conference with Violet Bettig, Licensee Designee. She stated that Ray Patino had been removed from the schedule until further notice. However, that she did not think the allegations were true. She stated that Resident B walks around with his head down and the injury could have happened several ways (falling or running into things). Violet Bettig stated that Resident B had a hairline fracture under his fingernail.

She reported that ORR substantiated the allegations, and they want to know if Ray Patino returns. I informed her that she would need to communicate with ORR regarding those concerns. Violet Bettig agreed with the conclusion of the investigation.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | **(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.** |

| | |
|---|---|
| **ANALYSIS:** | When asked how he was treated by Ray Patino, Resident B replied “okay.” When specifically asked about his hands being bent, Resident B had a blank stare on his face. When asked if he was being treated badly or harmed, he replied “no.” Resident B reported that he would tell his mom if any staff members were treating him badly.<br><br>Ray Patino denied bending Resident B’s hands when he does not follow directions. He stated that Resident B can be very aggressive, and when this happens, they hold his wrist so he can’t get wild. Ray Patino informed that he would never harm a resident.<br><br>According to the ORR Report, it was noted that APS Worker #2 and ORR Worker #1 interviewed Resident B. Resident B reported to be unsure as to what happened to his finger. Resident B was unable to answer any further questions. ORR Worker #1 investigated the allegations, interviewed staff, a doctor, and other involved parties and substantiated the allegations, Abuse, Class 1.<br><br>According to the medical report, X-rays were also completed, and it was noted that there was “subtle irregularity seen involving tuft of the fourth distal phalanx, consistent with age indeterminant injury. Flexion deformity of the fourth digit at the PIP joint throughout the examination, correlate if fixed injury.”<br><br>While it should be noted that there is an injury to Resident B’s ring finger; it is unknown when it occurred, how it occurred and who was involved. There was no specific incident reported or documentation provided to support when the incident leading to the injury occurred and who was involved, if any direct care staff members.<br><br>Based on the information gathered during this investigation and provided above, it’s concluded that there is not a preponderance of the evidence to support the allegations that Ray Patino deliberately caused this injury to Resident B. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATIONS:**

**Ray Patino slept through third shift instead of providing support and supervision to the home.**

**INVESTIGATION:**

During this investigation, it was also alleged that on multiple unknown dates, Ray Patino slept through third shift instead of providing support and supervision to the home.

ORR Worker #1 documented the following in their *Office of Recipient Rights Report of Investigative Findings* report:

- The Anonymous Staff 1 reported that Ray Patino was often the only staff on schedule during third shift. When staff would arrive to the facility in the morning, Ray Patino was usually asleep on the couch. Different photos of Ray Patino sleeping on the couch were submitted to ORR.

- Home Manager #1 was interviewed by ORR Worker #1 and reported that Ray Patino usually works third shift, alone, and he covered any areas where staff were not scheduled to work. This usually occurred during third shift.

- ORR also reviewed staff schedules and noted that on at least two nights every week between June and August staff were not scheduled for third shift past 9:00 p.m. In addition, between September and October, at least five nights per week, staff were not scheduled past 9:00 p.m. In November and December, no staff were scheduled for third shift.

- Ray Patino reported that they recently terminated staff, who were not engaging well with the residents, and those staff are now causing problems. He denied falling asleep and reported to only be at the home to work. In addition, that he has not napped during breaks.

- One direct care staff member reported that Ray Patino showers at the home and stores his clothing there as well. It was also noted that four anonymous staff reported that Ray Patino slept during his third shifts.

- It was noted that per Lifeways Provider Liaison #1, three residents placed at St. Gabriel's AFC Home require a Specialized Residential level of care. In addition, all their contracts include awake staffing.

ORR Worker #1 substantiated the allegation Mental Health Services Suited to Condition.

As a part of the investigation, I also reviewed three photos, which appeared to be on different occasions, and observed Ray Patino to be sleeping on the facility couch. The photos were not date or time stamped. I was not able to verify who took these photo either during my investigation.

On February 6, 2024, I interviewed Home Manager #1, and inquired about Ray Patino sleeping at the facility. She stated that when the house was full of staff, he would take a nap. I inquired if he was getting paid during his naps and she reported that she did not know. She denied that he lived at the facility.

While at the facility, I also interviewed Employee #5, and she reported that she had observed Ray Patino sleeping on shift. Employee #5 did not provide any specific dates or times when she observed Ray Patino sleeping while caring for residents.

I also reviewed the files for Resident B, Resident C, and Resident D. They all required personal care, protection, and supervision.

I also reviewed the staff schedules and noted on multiple occasions that there was no staff scheduled after 9:00 p.m.

During my interview with Employee #3, who stated that she has not observed staff or Ray Patino sleeping on shift.

On February 7, 2024, I interviewed Ray Patino and inquired about him sleeping on the facility couch. I informed him that I had observed three different photos of him sleeping. He stated that he is usually the staff member who works at night, and there is no other staff there; he questioned how they would take the picture, when the house is locked etc. I inquired about him being observed sleeping when staff arrived for 1st shift, and he stated they have an issue with staff showing up late, so he is aware when they arrived. He also stated that his son resides in the home. Sometimes he will work third shift and then take him somewhere. If his son is not ready, he will sit on the couch and wait; and he might doze off. He stated that he does not sleep on shift.

I reviewed the Original Licensing Study Report which documented that staff are to be awake during sleeping hours.

During the exit conference with Violet Bettig, Licensee Designee, she stated that she did not think that Ray Patino was sleeping on the job. She stated that he locks the doors at night, due to issues with high crime in the area, so there was no way that staff could take pictures on third shift. In addition, he unlocks the door in the morning to allow staff to enter the home. She inquired if the photos were date and time stamped, and I informed they were not. Violet Bettig stated that Ray Patino was probably exhausted and was waiting for his son to get ready to leave. Violet Bettig inquired about installing cameras in the common areas of the home. She stated this would help to document what occurs in the home. We discussed the requirements regarding facility surveillance. I also informed her that Ray Patino should sleep at home and only be in the facility to work or visit with his son. This would help to clear up any confusion. She stated that he often worked extra hours because staff were not doing their jobs; he was picking up the slack for them. I informed her that I would be requesting a written corrective action plan to address the established violations.

| APPLICABLE RULE | |
|---|---|
| **R 400.14206** | **Staffing requirements.** |
| | **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.** |
| **ANALYSIS:** | It was documented in the ORR Report that per Lifeways Provider Liaison #1, three residents placed at St. Gabriel's AFC Home require a Specialized Residential level of care. In addition, all their contracts include awake staffing.<br><br>While it's unclear when or what time these photos were taken, what is clear is that Ray Patino was observed to be asleep on the facility couch on three separate occasions. The home requires staff to be awake to provide personal care, protection, and supervision to the residents.<br><br>Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that there was not sufficient staff on duty at all times to provide the supervision, personal care, and protection of residents. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATIONS:**

**The facility runs low on food.**

**INVESTIGATION:**

During this investigation, it was also alleged that the facility runs low on food.

On January 31, 2024, I made face to face contact with APS Worker #2. She informed me that she went to the facility to check the food, and there was an adequate amount of food in the home. She stated that she requested to see the menus and staff reported they did not have any.

On February 6, 2024, I checked the food in the home. The cabinets, refrigerator, and freezers were stocked with adequate amounts of food. There was additional food stored in the basement.

Home Manager #1 denied that the facility ran low on food or that staff had to utilize their own food stamps to purchase food for the home. I did not observe any menus in the home. I inquired about the menus and Home Manager #1 stated she did not like the menus, so she was not utilizing them. She was informed that she needed to post and utilize menus and document any changes.

Employee #5 reported there was plenty of food in the home and she had not observed them to run low on food.

Employee #6 informed me that she had not observed the facility to run low or run out of food.

Employee #3 stated that they shop for food on a regular basis, most times in bulk, and the facility has not run out of food.

Employee #4 stated that when she worked for the facility, the staff purchased food out of their own pockets. In addition, that Ray Patino would tell them they could only use or cook certain foods, mainly pertaining to the meats. They also purchased a separate creamer for Resident D because Ray Patino would get upset if they used the creamer for her coffee.

As a part of this investigation, I reviewed the weight records for Resident A, Resident B, Resident C and Resident D. In the past six months, and there was no significant weight loss for the residents. Their weights fluctuated between five and ten pounds.

During the exit conference with Violet Bettig, Licensee Designee, she stated that she spent thousands on groceries each month and she has receipts. In addition, that she purchases extra goodies, such as treats for Valentines Day and Easter. She agreed with the conclusion of this investigation.

| **APPLICABLE RULE** | |
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| **R 400.14313** | **Resident nutrition.** |
| | **(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.** |

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| **ANALYSIS:** | An adequate amount of food was observed in the home on two separate occasions.<br><br>Home Manager #1, Employee #3, Employee #5, Employee #6 did not confirm that the facility ran low on food.<br><br>Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that the facility ran low on food. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On February 6, 2024, I did not observe any menus in the home. Home Manager #1 informed me that she did not like the menus, so she was not utilizing them.

During the exit conference with Violet Bettig, she informed that she would fix this issue and agreed to submit a written corrective action plan.

| **APPLICABLE RULE** | |
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| **R 400.14313** | **Resident nutrition.** |
| | **(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.** |
| **ANALYSIS:** | The menus were not posted in the facility. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

During my January 4, 2024, and February 7, 2024, interviews with Ray Patino he stated he holds Resident B's wrists so Resident B cannot "get wild." Ray Patino also stated he read through information from a training manual brought from a different AFC and had not completed a formal training in physical management or crisis intervention.

On February 9, 2024, during the exit conference with Violet Bettig, she stated that ORR was not offering any courses during COVID and that's possibly why the training was not completed. She stated that Ray Patino is currently going through

the training. She agreed to submit a written corrective action plan to address the established violation.

On February 12, 2024, I conducted a follow-up investigation and made face to face contact with Home Manager #1, Employee #5, Resident B, Resident C, and Resident D. As a part of this investigation, I reviewed the *PCP and Treatment Plan* for Resident B. Regarding physical aggression, staff are to monitor him from a safe distance and not provide more attention. Based on my review of Resident B's Person-Centered Plan and Treatment Plan, there was no direction given for any direct care staff member to use any sort of physical intervention when Resident B is acting out aggressively.

I interviewed Home Manager #1 and requested to review Ray Patino's employee file. Home Manager #1 stated the employee file was with Violet Bettig, Licensee Designee, off site, for tax purposes. Consequently, I could not verify any employee training requirements for Ray Patino.

| **APPLICABLE RULE** | |
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| **R 400. 14307** | **Resident behavior interventions generally.** |
| | **(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.** |
| **ANALYSIS:** | Ray Patino stated he holds Resident B's wrists so Resident B cannot "get wild." Ray Patino also stated he read through information from a training manual brought from a different AFC and had not completed a formal training in physical management or crisis intervention.<br><br>Based on my review of Resident B's Person-Centered Plan and Treatment Plan, there was no direction given for any direct care staff member to use any sort of physical intervention when Resident B is acting out aggressively. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

During the course of this investigation, I also reviewed the staff schedules and noted on multiple occasions that there were no staff documented on the schedule after 9:00 p.m.

On February 12, 2024, I conducted a follow-up investigation and made face to face contact with Home Manager #1, Employee #5, Resident B, Resident C, and Resident D.

I spoke to Home Manager #1, and I inquired about why no staff were listed after 9:00 p.m., and she stated that those were the shifts that Ray Patino worked. I informed her that she and her staff must be listed on the schedule to cover all shifts.

| **APPLICABLE RULE** | |
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| **R 400. 14208 (3)(a)** | **Direct care staff and employee records.** |
| | (3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days.<br><br>The schedule shall include all of the following information:<br>(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.<br>(b) Job titles.<br>(c) Hours or shifts worked.<br>(d) Date of schedule.<br>(e) Any scheduling changes. |
| **ANALYSIS:** | I reviewed the staff schedules and noted on multiple occasions that there was no staff documented on the staff schedule after 9:00 p.m. The schedules did not include all the names of staff who were scheduled to work. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

2/9/2024

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

02/14/2024

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Dawn N. Timm Date
Area Manager