GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Connie Clauson
Assured Care Assisted Living, LLC
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

March 27, 2024

RE: License #: AL110283722
Investigation #: 2024A0579019
The Willows Assisted Living #2

Dear Connie Clauson:

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 (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110283722
Investigation #:	2024A0579019
Complaint Receipt Date:	01/30/2024
Investigation Initiation Date:	01/31/2024
Report Due Date:	03/30/2024
Licensee Name:	Assured Care Assisted Living, LLC
Licensee Address:	Suite 203, 3196 Kraft Ave SE, Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Nora Ramirez
Licensee Designee:	Connie Clauson
Name of Facility:	The Willows Assisted Living #2
Facility Address:	3507 Hollywood Road, St. Joseph, MI 49085
Facility Telephone #:	(269) 428-0715
Original Issuance Date:	11/14/2007
License Status:	REGULAR
Effective Date:	09/18/2022
Expiration Date:	09/17/2024
Capacity:	20
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive appropriate follow up treatment.	Yes
The home has had bedbugs.	No
Records were not provided as requested.	No

III. METHODOLOGY

01/30/2024	Special Investigation Intake 2024A0579019
01/31/2024	Special Investigation Initiated - Letter Complainant
02/15/2024	Contact – Telephone Call Received Relative A1
02/15/2024	Contact - Document Sent Karen Hodge, Baruch Senior Ministries
02/16/2024	Contact - Telephone Call Received Nora Ramirez, Administrator
02/16/2024	Contact - Document Sent Relative A1
02/19/2024	Contact - Document Sent Guardian A
02/20/2024	Contact - Face to Face Resident A Nora Ramirez, Administrator
02/26/2024	Contact - Document Received Nora Ramirez, Administrator
03/01/2024	Contact - Document Received Nora Ramirez, Administrator
03/11/2024	Contact - Document Sent

	Cindy McLaughlin, Lincoln Senior Center
03/13/2024	Contact - Document Received Guardian A
03/14/2024	Contact - Face to Face Alyssa Sass, DCW
03/18/2024	Contact- Document Sent Nora Ramirez, Administrator
03/21/2024	Contact- Document Received Guardian A
03/21/2024	Contact- Document Sent Nora Ramirez, Administrator
03/22/2024	Contact- Document Received Nora Ramirez, Administrator
03/22/2024	Contact- Telephone Call Made Jennifer Thierbach, DCW Alyssa Sass, DCW
03/22/2024	Contact- Telephone Call Made Jennifer Thierbach, DCW
03/22/2024	Contact- Telephone Call Made Alyssa Sass, DCW
03/22/2024	Contact- Telephone Call Made Kyra Purnell, DCW
03/22/2024	Contact- Telephone Call Made Amari Crumbly, DCW
03/22/2024	Contact- Telephone Call Made Ayanna Hunter, DCW
03/22/2024	Contact- Telephone Call Made Guardian A
03/22/2024	Contact- Telephone Call Made Kyra Purnell, DCW
03/22/2024	APS Referral

	John Wheeler, Adult Protective Services
03/22/2024	Contact- Document Received Guardian A
03/24/2024	Contact- Document Received Guardian A
03/25/2024	Contact- Face to Face Nora Ramirez, Administrator Kyra Purnell, DCW
03/26/2024	Contact- Telephone Call Made Jennifer Thierbach, DCW
03/27/2024	Exit Conference Nora Ramirez, Administrator

ALLEGATION:

Resident A did not receive appropriate follow up treatment.

INVESTIGATION:

On 1/30/24, I received this referral which alleged that on 1/22/24, Guardian A received a phone call from staff notifying her that Resident A had a bruise to her left eye that could not be explained, Resident A was complaining of chest pain, and Resident A was resistant to being touched or dressed. Guardian A was unable to visit the home until the evening of 1/24/24 and after visiting, she sent an email to administrator Nora Ramirez asking that Resident A's physician observe the injury. Guardian A was told the visiting physician would be at the home on 1/25/24. The visiting physician was called about Resident A, but Relative A1 learned on 1/25/24 that Resident A was not seen by the physician on 1/25/24. Relative A1 then requested Resident A taken to the Emergency Department where a CAT scan and x-rays were taken. It was discovered Resident A had two broken ribs. Resident A returned to the home with a spirometer to prevent pneumonia. On 1/27/24, the direct care worker (DCW) observing Resident A's use of the spirometer was witnessed by relatives of Resident A "using it the opposite way" and not providing it to Resident A correctly. Relatives had to show the DCW how to use the device correctly.

On 1/31/24, I contacted the complainant via email confirming my receipt of the allegations for investigation.

On 2/15/24, I spoke with Relative A1 regarding the allegations. She confirmed the allegations were true as reported.

On 2/20/24, I completed an unannounced on-site investigation. An interview was completed with Ms. Ramirez. I met and spoke to Resident A, but she would not speak to me and could not engage for interviewing.

Ms. Ramirez stated she became aware of Resident A's bruise near her eye on 1/22/24. Ms. Ramirez stated she asked third shift DCWs if Resident A had a fall, if they witnessed Resident A on the floor in her room, or if they had any knowledge of how Resident A obtained this injury. She stated they told her they did not have any knowledge of how Resident A obtained the injury or concern that she had a fall overnight. She stated Resident A does not have a history of falls but tends to sleep with half of her body on her bed and half hanging off her bed during the night, so she believes Resident A likely did have some type of unwitnessed fall. She stated the same day, Resident A began saying her chest hurt and she was in pain, however Resident A is often confused, and she would say the pain was in her arm, then her hand, and then her leg when asked. She stated without knowing what happened or where Resident A was feeling pain, it was difficult to know how to treat her. She stated Guardian A requested Resident A be monitored for 24-hours before seeking additional treatment.

Ms. Ramirez stated DCW Jennifer Thierbach checked Resident A's vitals and assessed her for signs of a stroke. She stated they called Resident A's physician, and they were advised to test Resident A for COVID-19 and if the test was negative,

to send Resident A to the Emergency Department for further evaluation. She stated Resident A was tested and her results were negative so DCWs requested permission from Guardian A to send Resident A to the hospital. She stated Guardian A reported she wanted to see Resident A prior to agreeing to have her sent to the hospital, but she was not feeling well and could not see Resident A that day. She stated on 1/24/24, Guardian A visited and would not agree to Resident A being taken to the hospital which Ms. Ramirez reminded her was against medical advice. She stated on 1/25/24, Resident A was not seen by visiting physicians as her physician was already aware of her condition and medical advice was not being followed by Guardian A. She stated Relative A1 and Relative A2 visited on 1/25/24 and requested Resident A be evaluated at the hospital so she was taken in. She stated she was notified Resident A was found to have fractured ribs and would be returning to the home with medication and a spirometer.

Ms. Ramirez stated she was advised by the hospital that due to Resident A's confusion she struggled to cooperate with the spirometer, and she was not to use it overnight. She stated she does not have direct knowledge of a DCW using the device incorrectly, but she believes the staff passing medication that day would know how to use the device correctly. Ms. Ramirez stated she could not confirm that the worker assigned to assist Resident A with using the device was ever trained on using the device correctly though. She agreed to provide the contact information for the staff passing medication on 1/27/24.

On 3/4/24, I received and reviewed Resident A's Care Notes which noted on 1/22/24, Resident A was found to have a small bruise on the right side of her left eye and she was complaining of chest pain. It was also noted on 1/22/24, Guardian A declined medical treatment for Resident A and requested she be monitored for 24 hours. I also received an *Incident/Accident Report* form noting Resident A had a fall at 3:00 a.m. on 2/21/24. After that fall, Resident A's physician was contacted, and it was agreed she would be sent to the Emergency Department for evaluation.

On 3/22/24, I attempted a telephone interview with Ms. Thierbach and DCW Alyssa Sass at The Willows. It was reported they both were not present today.

On 3/22/24, I attempted a telephone interview with Ms. Thierbach at her personal number. An automated message played stating the number was no longer in service.

On 3/22/24, I completed a telephone interview with Ms. Sass who reported she did not directly witness the injury to Resident A in January 2024, because she was not providing direct care at that home at that time. She stated in working on the campus, in preparation to be working at this home more regularly, DCWs did tell her they believe Resident A had fallen out of her bed and struck her face on her nightstand which led to her eye injury. She stated Guardian A would not allow anyone to move Resident A's furniture after her first injury even though they expressed concerns she was injured by her furniture while falling out of bed. She stated Resident A fell out of

her bed overnight a second time in February which she responded to. She stated after the second fall, she and DCW Amanda Welch insisted Guardian A allow Resident A's furniture to be moved for her safety and Guardian A then agreed.

Ms. Sass stated she recalls working on 1/27/24 and assisting Resident A with her spirometer. She explained when using a spirometer, the tube goes into Resident A's mouth, and Resident A inhales which holds a plastic piece on the device at a certain level. She stated she has used spirometers with other residents, so she is certain she did it correctly. She stated she believes, since DCWs who pass medications receive additional medication training outside of standard DCW medication training, all DCWs who pass medications would know how to use the spirometer with Resident A and that the spirometer is pictured on Resident A's discharge paperwork which shows how to use it correctly. She denied knowing if Resident A's family was present when she assisted Resident A with using the spirometer on 1/27/24.

On 3/22/24, I attempted a telephone interview with DCW Kyra Purnell who was reported to be the person who assisted Resident A with her spirometer on 1/27/24 during second shift. The individual who answered reported I had an incorrect phone number, and they did not know anyone named Kyra.

On 3/22/24, I attempted a telephone interview with DCW Amari Crumbly, as it was reported she was working overnight on 1/22/24. An automated message played stating the number was no longer in service.

On 3/22/24, I completed a telephone interview with DCW Ayanna Hunter who reported she was working overnight into 1/22/24 and witnessed Resident A with a bruised eye while in bed prior to ending her shift. She stated she is unsure when Resident A obtained the injury because she did not hear Resident A fall or witness Resident A out of her bed at all that evening and she initially thought it happened on another shift, so she did not report it, assuming it was already reported. She stated since that injury, Resident A has fallen out of bed overnight on one or two occasions, so she now believes the injury occurred from a fall overnight. She stated Resident A's bed is low to the ground and there is a mat on the floor to prevent injury, so she is not certain how Resident A was injured during the fall as there are measures in place to keep her safe should she fall from the bed.

On 3/22/24, I completed a telephone interview with Guardian A who stated she was informed on 1/22/24 at around 12:30-12:40 p.m. that Resident A had what was described as a minor bruise near her eye and it was unknown how it was obtained. She stated she was an hour away from the home and asked Ms. Thierbach what to do and whether she should come to the home. She stated Ms. Thierbach did not express the severity of the bruise or any urgency and reported Resident A was "joyful" and that although Resident A appeared resistant to getting dressed or having her chest touched, she was awake, walking, and had eaten breakfast and lunch. She stated Ms. Thierbach told her that Resident A was given a COVID test and that Resident A's physician was notified of the injury, but she was not advised that if the

COVID test was negative Resident A should be taken to the hospital. She stated she was not told, until this conversation, that if Resident A's COVID test was negative she should be taken to the hospital or that not sending her to the hospital was against medical advice. She stated she would have supported Resident A being taken to the hospital sooner had she been made aware of the severity of her injury and/or that it was the recommendation of her physician. She stated she trusted Ms. Thierbach's assessment of Resident A and agreed to come to the home the next day but became ill and could not go to the home that day. She stated she was able to visit the following day and found Resident A with significant bruising to her eye, cheek, and swelling to her cheekbone. She stated it looked like Resident A was "punched in the face." She stated it was her understanding Resident A's physician would be at the home the following day and Resident A would be seen. She stated based on how upsetting and severe she found the injury to Resident A to be, and because she does not believe it could have occurred from a fall or accidental injury, she and Relative A2 decided Resident A should be taken to the Emergency Department. She stated it was when arriving to take her to the Emergency Department that she learned Resident A's physician did not see her while he was at the home as planned.

She stated Resident A has had two to three falls from her bed since the unexplained injury in January, but this decline happened after the unexplained injury, which she feels came from an assault, to Resident A, so she is not certain the injury in January came from a fall. She agreed to send photographs of the injury that she had taken because she believes the injuries are consistent with someone who was punched. She stated the bruise to Resident A's eye was also on the opposite side of her fractured ribs and she does not understand how that would happen during a fall. She stated Resident A's nightstand was near her bed at the time of the unexplained injury in January and no one recommended it be moved or she would have agreed to that. She stated it was only after a confirmed fall in February that DCWs rearranged her furniture and added a mat beside her bed which she was grateful for. She stated she wishes DCWs would have asked to move Resident A's furniture sooner, as she supports any measures to keep Resident A safe.

She stated she witnessed DCW Kyra Purnell unable to use Resident A's spirometer correctly. She stated Ms. Purnell is a good worker and she does not want Ms. Purnell to get in trouble but she does not think Ms. Purnell was adequately trained at this home to use the device correctly which is not her fault.

On 3/22/24, I attempted a telephone interview with Kyra Purnell at The Willows. It was reported she was not present today.

On 3/22/24, I contacted Adult Protective Services worker John Wheeler inquiring the findings of his investigation as Guardian A reported he was involved and had completed his investigation. Mr. Wheeler responded that neither he, nor law enforcement, substantiated allegations of abuse or neglect to Resident A during their investigations.

On 3/22/24, Guardian A forwarded communication she had with Ms. Ramirez. In an email dated 1/27/24, she expressed concern that relatives were “never urged” by Ms. Thierbach to take Resident A to the hospital for evaluation and had they been she would have requested Resident A be taken to the hospital on 1/22/24. She also discusses her conversation with Ms. Thierbach on 1/22/24 in that email which is consistent with how she reported the conversation to me.

Guardian A also provided an email from 1/31/24 to Ms. Ramirez where she expresses concern that DCWs do not know how to use Resident A’s spirometer correctly and reported a DCW was witnessed on 1/27/24 having Resident A exhale into the device instead of inhaling to inflate the valve as required to use the device correctly.

On 3/22/24, I reviewed Resident A’s “After Discharge Summary” from 1/25/24 which noted Resident A needed to continue to use the spirometer every hour for a week. There was no photo of the spirometer nor instructions on how to use it on this document.

On 3/24/24, I observed a photo of Resident A that Guardian A reported was from 1/24/24. The outer corner of Resident A’s eye down her cheekbone presented with deep purple bruising.

On 3/25/24, I interviewed Ms. Purnell at the home. She denied involvement with Resident A’s injury on 1/22/24 and reported she only observed Resident A with bruising near her eye in the days following the injury. She stated since that incident, she has worked overnight and was present when Resident A had a documented fall in February. She stated Resident A likes to sleep in an odd position with her head, and times her upper body, off the side of her bed. She stated while it was not known in January 2024, because Resident A had not fallen previously, she now believes that Resident A obtained the injury from falling out of bed due to the position she sleeps in and that she has since had a pattern of falls overnight. She denied concerns that any DCW would assault Resident A or witnessing anyone being physically aggressive with Resident A.

Ms. Purnell stated she was not trained and there were no instructions on how to provide the spirometer to Resident A. She stated Resident A was not very cooperative with using the device. She stated she believed Resident A had to exhale into the device, but relatives of Resident A saw this and corrected her that Resident A was to inhale while holding the tubing from the device in her mouth. She stated this was a misunderstanding on her part since she was not formally trained and just assumed how to use it.

On 3/26/24, I completed a telephone interview with Ms. Thierbach. She stated she was working on the morning of 1/22/24 and observed Resident A in bed with a small bruise on the side of her eye. She stated she immediately contacted the DCWs

working the night before to ask what occurred. She stated they reported there was nothing atypical that happened that night and it was assumed Resident A must have had an unwitnessed fall, although she did not have a pattern of falls at that time. She stated Resident A sleeps with her head, and times her upper body, hanging off the side of the bed so it was easy to assume she may have fallen, face or upper body first, from her bed due to her preferred sleeping position.

She stated that morning she took Resident A's vitals and did a skin assessment on Resident A, since she presented with an unexplained injury. She stated at that time, the bruise was small. She stated later in the morning, Resident A told another DCW she was having chest pain and the DCW expressed to Ms. Welch that Ms. Thierbach "wasn't doing enough" so she went to see Resident A and to take her vitals again. She stated Resident A could not express to her where her pain was so Ms. Thierbach would place her had on Resident A's arm, hand, and leg and ask, "Does that hurt?" to which Resident A responded, "Yes" to each body part. She stated if you asked Resident A, "May I touch you?" and you touched and moved her hand or arm, she did not express pain though. She stated she contacted Resident A's physician who stated to test her for COVID-19 since she had atypical behavior with this unexplained injury, was expressing chest pain, and there were recent positive cases in the home. She stated he advised that if Resident A was not positive for COVID-19, the hospital would be better fit to evaluate her, and she should go there.

Ms. Thierbach stated she then contacted Guardian A and spent 15 minutes on the phone with her. She stated she is certain she told Guardian A a minimum of three times that Resident A's physician said she should be taken to the hospital for further evaluation. She stated while she cannot speak to the urgency in the tone of her voice, she is certain she advised Guardian A of the physician's instructions at least three times. She stated Guardian A asked her what she would do if it was her relative and she advised she could not tell Guardian A what to do, but that she recommends following the physician's instructions. She stated Guardian A could not come to the home that day and requested to see Resident A before sending Resident A to the hospital. She stated Guardian A requested she continue taking Resident A's vitals, which she agreed to do while she was working, but reported to Resident A she would not be working on 1/23/24. She stated due to a pattern of "exaggeration" by Guardian A, she made sure to note in Resident A's Care Notes that day that Guardian A chose not to send Resident A to the hospital because she "just had a feeling" Guardian A would blame her for why it took so long to send Resident A to the hospital.

She stated Guardian A came to the home on 1/24/24 and due to how bruises heal, especially in elderly residents, Resident A's bruise was significantly larger than at the time of the injury. She stated Guardian A "went ballistic" as she had anticipated and became upset with her for not taking Resident A's vitals on 1/23/24, which she told her she could not do because she was not working. She stated although Guardian A was upset, Resident A was not taken to the hospital for evaluation until

Relative A1 and Relative A2 brought her on 1/25/24 and it was then learned she had two fractured ribs.

Ms. Thierbach stated Guardian A insisted Resident A was assaulted by a DCW. She stated she explained that with residents with advanced dementia, it is not uncommon for them to begin falling as they decline. She stated she assumed Resident A had a fall overnight from her bed in January but exactly a month later, she had a witnessed fall out of bed overnight. She stated she has also worked overnight recently and found that Resident A is very agitated throughout the night and will bounce her body on her bed in agitation so she is at times alert at night even if a DCW may not see it. She stated she is certain Resident A was not assaulted and believes this incident was the start of a pattern of overnight falls due to Resident A declining due to dementia.

Ms. Thierbach provided an image of Resident A dated 1/22/24 at 7:05 a.m.. There was deep purple bruising observed on the upper, outer corner of Resident A's eye between her brow bone and eye socket.

APPLICABLE RULE	
R 400.15305	**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:	Ms. Hunter confirmed an unexplained bruise was found on Resident A's face while she was working overnight on 1/22/24. Ms. Ramirez, Guardian A, and Ms. Thierbach reported Resident A presented with an unexplained bruise and chest pain on 1/22/24. Ms. Ramirez, Guardian A, and Ms. Thierbach reported Resident A did not receive medical treatment following her unexplained injury and reported pain until relatives brought her to the hospital on 1/25/24 where it was found she had two fractured ribs. Ms. Ramirez and Ms. Thierbach reported Guardian A declined to allow Resident A to be sent to the hospital for evaluation after the unexplained injury. Guardian A denies she refused Resident A being sent to the hospital and reported the severity of Resident A's injury and alleged doctor's recommendations regarding Resident A going to the hospital were not accurately shared with her.

	Guardian A and Ms. Purnell reported Ms. Purnell was assigned to assist Resident A with using the spirometer she discharged from the hospital with in January 2024. Ms. Purnell acknowledges she was not trained to use the device. Guardian A and Ms. Purnell confirm Resident A's relatives had to instruct Ms. Purnell on how to use the device because she was initially using it incorrectly. Ms. Ramirez denied direct knowledge of DCWs incorrectly using Resident A's spirometer but reported she could not confirm the worker assigned to assist Resident A with using the device was formally trained to use it correctly. Based on the interviews completed, there is sufficient evidence Resident A's protection and safety were not attended to at all times when medical treatment was not immediately sought following an unexplained injury to Resident A and her complaining of pain, as well as, when the DCW assigned to assist Resident A with her spirometer was not trained on how to correctly use the device.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The home has had bedbugs.

INVESTIGATION:

On 1/31/24, I was completing a telephone interview with a former DCW who inquired if I was aware that the home had bedbugs. I agreed to investigate these allegations.

On 2/16/24, Relative A1 reported there are bedbugs in the home and that information was not shared with relatives so that they were made aware.

On 2/20/24, Ms. Ramirez reported there have been bedbugs in the home previously, but the home has a contract with Rentokil for pest control maintenance, the bedbugs were eliminated, and Resident A's room was not impacted. She stated Guardian A was made aware when there were bedbugs in the home.

On 3/13/24, I received an email from Guardian A which was a forwarded exchange between her and Ms. Ramirez on 2/9/24 discussing bedbugs at The Willows. Ms. Ramirez acknowledges the home previously had bedbugs, but reported they were resolved.

On 3/20/24, Ms. Ramirez stated there has not been sightings of bedbugs in this home since November 2023, but the campus is under contract with Rose Pest Solutions now so if they were to reoccur, Rose Pest Solutions will be contacted for service. She stated their maintenance person, Jon Thierbach, was also trained on how to manage bedbugs following the recommendations of Rose Pest Solutions, including bagging items, washing and drying in high heat, steaming, using a pest control powder, and putting protective coverings on mattresses in rooms that have had bedbugs. She stated he has not had to use those measures at this home recently because there have not been bedbugs in this home since it was treated in November 2023.

On 3/21/24, I received a statement from Ehrlich Pest Control from Ms. Ramirez. It was noted an extra maintenance service was completed on 11/13/23 in this home. Five rooms were inspected and found “without activity” and four rooms were treated. The rooms near Resident A’s room were treated but Resident A’s room was not. There were no areas noted “with activity” in this home at that time. I also received a statement from Rose Pest Solutions dated 3/11/24 stating they were in contract with The Willows.

On 3/22/24, Ms. Ramirez and I exchanged emails and she stated there are disgruntled staff falsely reporting bedbugs in the homes and now if a bug is seen in the home all DCWs report them as bedbugs. She stated if a bug is reported by DCWs, she and Mr. Thierbach immediately inspect the area. She stated they have not witnessed a bedbug in this home since it was treated in November 2023.

On 3/22/24, Ms. Sass stated there were bedbugs in this home several months ago, although she could not recall which month, but they were treated by a professional company and were eliminated. She stated the home has now switched to Rose Pest Solutions should they need treatment of the home in the future.

On 3/22/24, Ms. Hunter stated she has heard rumors of bedbugs in the home, but she only saw one herself “a while ago” in a resident’s room. She stated it was not Resident A’s room. She stated she did not recall specifically when this occurred. She denied knowledge of bedbug treatment, noting she works overnight, and stated she does not have direct knowledge of there regularly being bedbugs in the home because she only saw one once. She denied seeing evidence of bedbugs such as bite marks on residents, blood stains on mattresses, or bedbug feces in the home and only knows there were bedbugs from the one she saw and what she has heard from other DCWs.

On 3/22/24, Guardian A reported this home has been working to treat bedbugs since November 2022. She stated she would communicate with the former home administrator regarding the treatments and felt it was being managed but when Ms. Ramirez became administrator, she stopped responding so she is not certain what treatments, if any, are being done now. She stated bedbugs have been found in Resident A’s room off and on since November 2022. She stated she has observed

bedbugs in Resident A's room as recently as 1/31/24 and she photographed them. She stated she believes evidence of bedbugs was cleaned around the time this investigation began so she is not certain any evidence would be found in the home presently, but that bedbugs have not been fully eliminated in the home since they arrived in November 2022.

On 3/22/24, Guardian A forwarded pictures of debris in plastic bedbug interceptors beneath the casters of Resident A's bed. The photographs were not timestamped, but Guardian A reported they were taken on 2/21/24 and 1/31/24. I attempted to extract the files from the email to obtain the EXIF data to confirm the time and date the photo was taken but was unsuccessful. Due to the quality of the pictures, I did not see clear images of bedbugs in the photographs reported as taken on 1/31/24. I did see what appears to be some type of bug in the photographs reportedly taken on 2/21/24, however I could not conclude or exclude them as bedbugs from these photographs alone.

On 3/25/24, I completed an unannounced on-site investigation at the home. I observed Resident A's room and found one piece of debris that appeared to be some type of deceased bug with a narrow black body similar in shape to a grain of rice but smaller in size with no visible head or limbs. Although this bug appeared atypical to bedbugs I have observed previously, I could not conclude or exclude that it was a deceased bedbug. I observed a random sample of six rooms, including some rooms I was aware had been treated for bedbugs previously and others that had not, on all ends of the home, and did not find any evidence that is typically present when bedbugs are present, such as living bugs, feces, or blood spots on the tops or bottoms of mattresses. I did observe what appeared to be a deceased ant like bug in one resident's room with a torso like the debris I saw in Resident A's room.

Ms. Ramirez reported scheduling is being done with Rose Pest Control and the entire home will proactively be treated for bedbugs soon.

On 3/26/24, Ms. Thierbach reported she believes the home has been dealing with bedbugs off and on since 2022. She stated there were previously bedbugs in Resident A's room, prior to Ms. Ramirez becoming the administrator of this home. She stated it has been over six months, Resident A's room was treated, and the bedbugs were eliminated from her room. She stated each time a bedbug is seen, treatment is obtained. She stated she has partaken in each treatment because DCWs must bag resident belongings in preparation for either chemical or heat treatment to resident rooms. She denied that bedbugs have been in the home since the last professional treatment which was "a few months ago."

APPLICABLE RULE	
R 400.15401	**Environmental health.**

	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	Guardian A reported there have been bedbugs off and on in this home and in Resident A's room since November 2022 with her seeing bedbugs as recently as 2/21/24. Ms. Ramirez, Ms. Sass, and Ms. Hunter denied bedbugs in Resident A's room or seeing bedbugs in the home recently. Ms. Theirbach reported it has been over six months since Resident A had bedbugs in her room and they were treated. She stated there has not been bedbugs in the home since the home was last treated several months ago. Ms. Ramirez reported there has not been bedbugs since the home was last treated on 11/13/23. Ms. Ramirez provided a contract with Rose Pest Solutions dated 3/11/24 and reported scheduling is being done so the entire home will be treated soon. Records confirm bedbug treatment was completed in the home on 11/13/23 with "no activity found" and treatment was not completed in Resident A's room. Guardian A provide photographs of debris in the bedbug interceptors beneath Resident A's bed casters, that were not timestamped, but that she reported she took on 2/21/24 and 1/31/24. Due to the quality of the images, I could not conclude or exclude that the debris was bedbugs. I observed debris in an interceptor under Resident A's bed on 3/25/24 which appeared to be some type of bug material but was inconsistent with what I know as a bodies of bedbugs. I could not conclude or exclude that it was a bedbug. I did not see any additional evidence of bedbugs in the home and did observe a deceased ant-like bug in one resident's room, with a torso like what I observed in Resident A's interceptor. Based on the interviews completed, documentation reviewed, and observation made there is insufficient evidence to support allegations that a pest control program is not maintained in a manner that continually protects the health of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Records were not provided as requested.

INVESTIGATION:

On 2/15/24, Relative A1 requested my assistance with obtaining Resident A's records so a new placement could be sought for Resident A. Relative A1 stated a new placement was arranged but she feels false information was shared with the new placement because Resident A was not admitted. Relative A1 stated they have been waiting for Resident A's paperwork since 1/31/24. I explained the limitations of this licensing rule to Relative A1 and she expressed understanding.

On 2/15/24, I contacted Karen Hodge from Baruch Senior Ministries to obtain the contact information for Ms. Ramirez. Ms. Hodge reported she was aware that Resident A's relatives were looking for a new placement for Resident A as of 1/31/24. She stated she believes relatives requested the documentation be available within 24 hours which was not sufficient time. She stated Ms. Ramirez would be able to provide additional details and they would cooperate with providing any additional documentation requested.

On 2/16/24, I exchanged emails with Ms. Ramirez who reported when Resident A's relatives gave a 30-day discharge notice to them on 1/31/24, they did not request all Resident A's documentation. Rather, they requested a "health document" be completed for her new placement. Ms. Ramirez reported that document and the other necessary documents were sent to the potential new placement. She stated only recently did relatives request copies of Resident A's file which are available at the home and have been waiting for Guardian A to pick them up.

On 2/16/24, I exchanged emails with Relative A1 informing that Resident A's records were available for pick up by Guardian A at the home. Relative A1 reported a relative did go to the home previously to pick the records up but DCWs did not know where they were located, and Ms. Ramirez was not available, so the documents were not obtained at that time.

On 2/19/24, I exchanged emails with Guardian A who reported she was able to obtain Resident A's requested records, however she received only the partially completed Medication Administration Record (MAR) for February 2024, after 2/12/24, the MAR noted "went electronic." She stated no additional MAR sheets were received. Guardian A reported she requested records from March 2022 to the present. I agreed to address this at the home.

On 2/20/24, Ms. Ramirez stated the necessary paperwork was immediately prepared and given to Resident A's potential new placement when requested on 1/31/24. She stated paperwork was not the reason Resident A was not admitted to the new placement. She stated Resident A was evaluated twice at this home by staff

at the potential new placement. She stated it was determined based on the in-person assessments that the potential new placement did not have an opening for the level of care Resident A needed based on their in-person assessments. She stated the documentation relatives requested had been available in the home since 2/8/24 but Guardian A did not come to pick them up. She stated Ms. Welch called to inform Guardian A of where the records could be located if Ms. Ramirez was not available, but Guardian A did not respond. Ms. Welch was present at this time in the conversation and reported this was true.

On 3/4/24, I received Resident A's copies of the paperwork in Resident A's file which totaled to approximately 150 pages. Included was Resident A's assessment plan, *Health Care Appraisal,* physician contacts/'After Visit Summary" sheets, and MAR sheets from March 2022 to February 2024.

On 3/13/24, I met with the Licensee Designee for Resident A's former potential placement. He reported The Willows staff was timely with providing the requested documentation needed to consider Resident A for placement and that did not contribute to why Resident A was not placed in a home he oversees. He stated after his staff evaluated Resident A twice, it was determined her care needs were more significant than relatives expressed and there was not availability for placement with the level of care Resident A needs.

On 3/21/24, Guardian A reported Resident A was hospitalized with a Urinary Tract Infection, relatives informed Ms. Ramirez she would not be returning to this home as of 3/18/24 and requested Resident A's medical records be forwarded to her potential new placement as soon as possible. She requested assistance obtaining the records because they do not want Resident A returning to this home and she cannot be moved until the potential new placement receives her records.

On 3/21/24, Ms. Ramirez reported Resident A's records were requested on 3/18/24 and have already been sent to Resident A's new placement. She stated again, Guardian A wanted the records within less than 24-hours of requesting them. She stated Resident A's physician needed to sign the documentation, but he became ill and reported he would not be visiting the home. She stated, nevertheless, the records were signed, submitted to Resident A's new placement within 72 hours, and Resident A is ready to be admitted to her new placement.

On 3/22/24, I explained the limitations of this licensing rule to Guardian A and she expressed understanding.

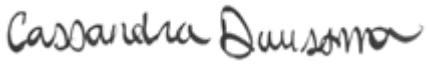
APPLICABLE RULE	
R 400.15302	**;provision of resident records at time of discharge.**
	(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost to the licensee of making the copies available.
ANALYSIS:	Guardian A and Relative A1 requested assistance with obtaining records for Resident A while arranging a new placement for her. Ms. Ramirez reported she cooperated immediately with the documentation needed for Resident A's potential placement on 1/31/24 and relatives did not request Resident A's full records for themselves then. She stated records were made available to relatives on 2/8/24 but were not picked up at that time. The Licensee Designee for Resident A's potential placement on 1/31/24, reported this home was "timely" with providing the documentation they requested. Ms. Ramirez reported records were requested for a second placement on 3/18/24, there was a delay with obtaining Resident A's physician's signature, but the documents were sent within 72 hours. Based on the interviews completed, there is insufficient evidence copies of records were not made available at the time of discharge, as requested, due to Resident A not discharging from the home. Rather, relatives were seeking potential new placements for Resident A. Furthermore, there is no timeframe noted in the rule for when these records must be provided and the records were reported to be provided "timely" to the first potential placement, within 72 hours for the second placement, and within approximately a week for relatives.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 3/27/24, I attempted a telephone exit conference with Ms. Ramirez. The call was not answered. An automated message played stating her mailbox was full. I sent an

email to her discussing my findings. A response was not received at the time of report disposition.

IV. RECOMMENDATION

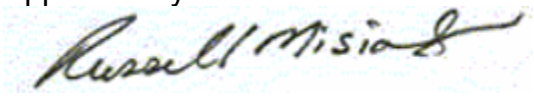
Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.



3/27/24

Cassandra Duursma — Date
Licensing Consultant

Approved By:



3/27/24

Russell B. Misiak — Date
Area Manager