GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2024

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007095
Investigation #: 2024A1024026
Park Place Living Centre #D

Dear Mrs. 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,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390007095
Investigation #:	2024A1024026
Complaint Receipt Date:	04/09/2024
Investigation Initiation Date:	04/10/2024
Report Due Date:	06/08/2024
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Janet White
Licensee Designee:	Connie Clauson
Name of Facility:	Park Place Living Centre #D
Facility Address:	4222 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	09/21/1989
License Status:	REGULAR
Effective Date:	07/30/2022
Expiration Date:	07/29/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Michael Cuff is inappropriate with other staff members and sells pills to staff members.	No
Direct care staff member #1 and Rebecca Mackinaw do not have required employee trainings.	Yes
Direct care staff member #1 and Rebecca Mackinaw have not completed required employee health physicals.	Yes
Staff Member #1 and Rebecca Mackinaw have not been tested for communicable tuberculosis (TB).	Yes
Staff does not assist Resident A with her catheter bag as required.	No
Staff member Lynette Gabbidon mistreats Resident A and staff member Michael Cuff has made Resident A feel uncomfortable.	No
Staff members accepts money from Resident D.	Yes
The maintenance on the property is not well maintained. The kitchen pipes and toilets have been broken and not addressed.	No

III. METHODOLOGY

04/09/2024	Special Investigation Intake 2024A1024026
04/10/2024	Special Investigation Initiated – Telephone with Staff Member #1
04/12/2024	Contact - Telephone call made Rebecca Mackinaw
04/15/2024	Inspection Completed On-site with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd
04/25/2024	Contact - Telephone call made Michael Cuff
04/25/2024	Inspection Completed On-site with direct care staff member Christine Brown, administrator Janet White, Residents A, B, C
05/27/2024	Exit Conference with licensee designee Connie Clauson
05/27/2024	Inspection Completed-BCAL Sub. Compliance
05/27/2024	Corrective Action Plan Requested and Due on 06/06/2024
05/27/2024	APS Referral-does not meet criteria

ALLEGATION: Direct care staff member Michael Cuff is inappropriate with other staff members and sells pills to staff members.

INVESTIGATION:

On 4/9/2024, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged direct care staff member Michael Cuff is inappropriate with other staff members and sells pills to staff members.

On 4/10/2024, I conducted an interview with Staff Member #1 who stated that direct care staff member Michael Cuff is a former employee and prior to him terminating his employment she witnessed him brag about selling "pills" to other staff members while working and heard rumors that he has been romantically involved with staff members while working as he has been seen coming out of the activity room with another female staff member. Staff Member #1 stated she has no direct knowledge if Michael Cuff is inappropriate and has not witnessed anything herself.

On 4/12/2024, I conducted an interview with direct care staff member Rebecca Mackinaw who stated that she has no knowledge that Michael Cuff is inappropriate with other staff members, nor has she ever heard that he has sold pills to anyone. Rebecca Mackinaw stated Staff Member #1 is upset with Michael Cuff because he ended their romantic relationship and Rebecca Mackinaw believes this complaint was made in retaliation. Rebecca Mackinaw stated to her knowledge Michael Cuff has appropriate interactions with other staff members.

On 4/15/2024, I conducted an onsite investigation at the facility with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd who all stated that they have no knowledge that Michael Cuff has been inappropriate with other staff members, nor have they ever heard about Michael Cuff selling pills to other staff members.

While at the facility, I reviewed Michael Cuff's *Michigan's Workforce Background Check* letter dated 8/23/2023 that stated Michael Cuff is eligible for employment in a job that involves direct access or provides direct services to a resident in an adult foster care setting.

On 4/25/2024, I conducted an interview with direct care staff member Michael Cuff who denied these allegations and stated that he believes he is being harassed because false complaints have been made against him and he no longer works for the facility however continues to get phone calls from previous co-workers. Michael Cuff ended the interview and stated that he did not have anything else to say regarding the issue.

On 4/25/2024, I conducted an onsite investigation at the facility with direct care staff member Christine Brown who stated that she is also the life enrichment director and has never heard or seen any inappropriate behaviors conducted by Michael Cuff. Christine Brown also stated she has never received any complaints made by residents regarding this staff member.

I also conducted an interview with administrator Janet White who stated that Michael Cuff no longer works for the facility, and she has not heard of any complaints regarding Mchael Cuff selling pills to other staff members or being inappropriate with other staff members.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Staff Member #1, Rebecca Mackinaw, Darnesha Singleton, Michael Cuff, Christine Brown, Aleah Shepherd, Lynette Gabbidon, administrator Janet White and review of Michael Cuff's *Workforce Background Check* eligibility letter there was no evidence to support the allegation staff member Michael Cuff is inappropriate with other staff members and sells pills to staff members. No staff member interviewed had any direct knowledge of Michael Cuff being inappropriate with other staff members or selling pills to other staff members. In addition, Michael denies these allegations. I also reviewed Michael Cuff's background check letter which shows that Michael Cuff is eligible to work directly with residents therefore Michael Cuff is suitable to meet the needs of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff member #1 and Rebecca Mackinaw do not have required employee trainings.

INVESTIGATION:

This complaint also alleged direct care staff member #1 and Rebecca Mackinaw do not have required employee trainings.

On 4/10/2024, I conducted an interview with Staff Member #1 who stated that she is not happy with how staff are treated at the facility by management and believes staff members are hired without getting the proper training. Staff Member #1 stated she

does not believe she has completed all her employee training and also believes Rebecca Mackinaw has not completed her required trainings. Staff Member #1 stated she has prior experience and knows for certain she never completed CPR and First Aid training.

On 4/12/2024, I conducted an interview with direct care staff member Rebecca Mackinaw who stated that she has completed all required employee training and completed these trainings when she was hired. Rebecca Mackinaw stated after each of her training sessions she had to sign a piece paper that verified her competency in the specific training. Rebecca Mackinaw stated she has no knowledge of any staff members who has not completed employee trainings.

On 4/15/2024, I conducted an onsite investigation at the facility with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd who all stated that they have completed all required trainings upon hire and have no knowledge of any direct care staff members who have not received employee trainings.

On 4/25/2024, I conducted an onsite investigation at the facility with direct care staff member Christine Brown who stated she completed all required trainings upon hire, and she has no knowledge of any staff members that has not completed employee training.

I conducted an interview with administrator Janet White who stated all direct care staff members have completed training however Staff Member #`1 still needs to complete First Aid/CPR training. Janet White further stated she is unsure what happened to Aleah Shepherd employee training records however is certain that she completed all her trainings when she was hired.

While at facility, I reviewed employee files for Staff Member #1, Rebecca Mackinaw, Michael Cuff, and Aleah Shepherd. According to these employee records Staff Member #1 did not complete First Aid/CPR training and there were no training records to review for Aleah Shepherd. All other training records were verified for these staff members.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.**

	(f) Safety and fire prevention. **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Staff Member #1, Rebecca Mackinaw, Darnesha Singleton, Christine Brown, Aleah Shepherd, Lynette Gabbidon, administrator Janet White and review of employee trainings there is evidence to support the allegation staff members do not have required employee trainings. Janet White stated all staff members have completed training however Staff Member #`1 still needs to complete First Aid/CPR training. Janet White further stated she is unsure what happened to Aleah Shepherd employee training records however was certain that she completed all her trainings when she was hired. I reviewed employee files for Staff Member #1, Rebecca Mackinaw, Michael Cuff, and Aleah Shepherd and according to these employee records Staff Member #1 did not complete First Aid/CPR training and there were no training records to review for Aleah Shepherd. All other training records were verified for these staff members therefore Staff Member #1 and Aleah Shepherd have not had required trainings.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff member #1 and Rebecca Mackinaw have not completed required employee health physicals.

INVESTIGATION:

This complaint also alleged direct care staff member #1 and Rebecca Mackinaw have not completed required employee health physicals.

On 4/10/2024, I conducted an interview with Staff Member #1 who stated that she and Rebecca Mackinaw were recently asked to complete a health physical because they never completed their physical when they were hired a few months ago. Staff Member #1 stated she completed her health physical this month but was hired back in November 2023.

On 4/12/2024, I conducted an interview with direct care staff member Rebecca Mackinaw who stated that she completed a health physical when she was hired for employment and has no knowledge of any staff member who has not completed a health physical.

On 4/15/2024, I conducted an onsite investigation at the facility with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd who all stated they completed health physicals upon hire and thereafter since they have been

employed at the facility and have no knowledge of any staff members who have not completed health physicals.

On 4/25/2024, I conducted an onsite investigation at the facility with direct care staff member Christine Brown who stated that she completed a health physical upon hire for employment. Christine Brown further stated she has no knowledge of any staff member who has not completed their health physicals.

I also conducted an interview with administrator Janet White who stated Staff Member #1 did not complete a health physical when she was hired however a current health physical is now on file for Staff Member #1. Janet White further stated she believes Rebecca Mackinaw completed her physical however is not able to provide verification that she completed the physical. Janet White also stated Michael Cuff did not complete a health physical upon hire prior to him terminating his employment.

While at facility, I reviewed employee files for Staff Member #1, Rebecca Mackinaw, Michael Cuff, and Aleah Shepherd. According to these employee records Staff Member #1 was hired on 11/16/2023 and completed her health physical on 4/2/2024. I was not able to verify health physicals for Michael Cuff and Rebecca Mackinaw.

APPLICABLE RULE	
R 400.15205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Staff Member #1, Rebecca Mackinaw, Darnesha Singleton, Christine Brown, Aleah Shepherd, Lynette Gabbidon, administrator Janet White and review of employee records there is evidence Staff Member #1 and Rebecca Mackinaw have not completed required health physicals. Janet White stated Staff Member #1 did not complete a health physical when she was hired however a current health physical is now on file for Staff Member #1. Janet White further stated she believes Rebecca Mackinaw completed her physical however was not able to provide verification of a completed physical. Janet White also stated Michael Cuff did not complete a health physical upon hire prior to him terminating his employment. While at facility, I reviewed employee files for Staff Member #1, Rebecca Mackinaw, Michael Cuff, and Aleah Shepherd and according to these employee records Staff Member #1 was hired on 11/16/2023 and completed her health physical on 4/2/2024. In addition, I was not able to verify health physicals for Michael Cuff and Rebecca Mackinaw.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff Member #1 and Rebecca Mackinaw have not been tested for communicable tuberculosis (TB).

INVESTIGATION:

This complaint also alleged direct care staff Member #1 and Rebecca Mackinaw have not been tested for communicable tuberculosis (TB).

On 4/10/2024, I conducted an interview with Staff Member #1 who stated she does not remember taking a TB test and believes Rebecca Mackinaw also has not been tested for TB since she has been working at the facility.

On 4/12/2024, I conducted an interview with direct care staff member Rebecca Mackinaw who stated that she completed a TB test when she was hired for employment and has no knowledge of any staff member who has not completed a TB test.

On 4/15/2024, I conducted an onsite investigation at the facility with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd who all stated they completed a TB test when they were hired and every 3 years thereafter. These staff members also stated they have no knowledge of any staff member who has not completed a TB test.

On 4/25/2024, I conducted an onsite investigation at the facility with direct care staff member Christine Brown who stated that she completed a TB test when she was hired and has no knowledge of any other staff member who has not completed a TB test.

I also conducted an interview with administrator Janet White who stated that all staff members are current and have completed a TB test. Janet White stated Rebecca Mackinaw is the only staff member that she is not able to provide written evidence of her TB test.

While at facility, I reviewed employee files for Staff Member #1, Rebecca Mackinaw, Michael Cuff, and Aleah Shepherd. According to these employee records Staff Member #1, Rebecca Mackinaw, Michael Cuff and Aleah Shepherd all completed a TB upon hire. I was not able to review written evidence of a TB test completed for Rebecca Mackinaw.

APPLICABLE RULE	
R 400.15205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(4) A licensee shall provide the department with written evidence that he or she and the administrator have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken. The results of subsequent testing shall be verified every 3 years thereafter.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Staff Member #1, Rebecca Mackinaw, Darnesha Singleton, Christine Brown, Aleah Shepherd, Lynette Gabbidon, administrator Janet White and review of employee records there is evidence direct care staff member Rebecca Mackinaw has not been tested for communicable tuberculosis (TB). Janet White stated that all staff members are current and have completed a TB test however Rebecca Mackinaw is the only staff member that she is not able to provide written evidence of her TB test. While at facility, I reviewed employee files for Staff Member #1, Rebecca Mackinaw, Michael Cuff, and Aleah Shepherd and according to these employee records Staff Member #1, Michael Cuff, and Aleah Shepherd all completed a TB upon hire. I was not able to review written evidence of a TB test completed for Rebecca Mackinaw.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff does not assist Resident A with her catheter bag as required.

INVESTIGATION:

This complaint also alleged direct care staff does not assist Resident A with her catheter bag a required.

On 4/10/2024, I conducted an interview with Staff Member #1 who stated that Resident A has a catheter bag and direct care staff members allowed Resident A to have a ripped bag and did not assist her with replacing her bag. Staff Member #1 stated Resident A took matters in her own hands and tied a garbage bag around her catheter to prevent the bag from leaking on the floor. Staff Member #1 stated eventually Resident A was sent out by staff members to the hospital where she was able to get a new catheter bag.

On 4/12/2024, I conducted an interview with direct care staff member Rebecca Mackinaw who stated that Resident A can be very resistant to receiving assistance from direct care staff members and prefers to do most of activities of daily living on her own. Rebecca Mackinaw stated Resident A has a catheter bag that requires changing by direct care staff members when it gets full and cleaning as needed however if there are any issues with the bag such as rips or tears, Resident A is required to get assistance from her home help worker who monitors the care of the catheter and replaces the bag as needed. Rebecca Mackinaw stated a few months ago Resident A busted her catheter bag while she was in the process of changing home help agencies therefore, she did not have a supply company to come out to replace the bag for her during the time the bag ripped. Rebecca Mackinaw stated prior to this incident, Resident A was advised by her doctor to call the hospital during the transition period of switching home help providers if an emergency occurred with her bag and Resident A did not follow this instruction as she refused to initially to go to the hospital when her bag ripped. Rebecca Mackinaw stated direct care staff members routinely advised Resident A to go to the emergency room in order to receive assistance with her catheter bag however Resident A refused to go and instead tied a garbage bag around her catheter bag to avoid leakage on the floor. Rebecca Mackinaw stated Resident A used a garbage bag for about three days until staff members were eventually able to convince Resident A to be seen at the hospital to get her catheter bag replaced. Rebecca Mackinaw stated Resident A has a home help agency provider that comes out to see her and she does not like direct care staff members to be involved with her catheter bag care.

On 4/15/2024, I conducted an onsite investigation at the facility with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd. Lynette Gabbidon stated she has no knowledge of Resident A ever having issues with her catheter bag because she has a home help provider who assist with caring and replacing the catheter. Lynette Gabbidon further stated she monitors Resident A's

catheter bag to check if it needs cleaning or to be emptied however complex task for the catheter bag is conducted by the home help agency.

Darnesha Singleton stated she is familiar with an incident that took place involving Resident A refusing to go to the hospital upon staff's request to get her catheter bag replaced after it ripped and was not able to get it repaired by her home help agency. Darnesha Singleton stated she believes Resident A tied a garbage bag around her catheter for a couple of days before she agreed to go to the hospital to seek assistance to have the bag replaced. Darnesha Singleton stated that staff are not trained to replace Resident A's catheter bag which is why she has a home help agency to assist her with this task. Darnesha Singleton further stated she believes Resident A initially refused to be seen at the hospital because she does not like going to hospitals and was hoping her new home help agency would be able to assist her.

Aleah Shepherd stated direct care staff members are not required to handle complex matters involving Resident A's catheter and Resident A is required to contact her home help provider when there are issues such as when the bag rips or tears. Aleah Shepherd stated Resident A had a situation in the past where she was required to go to the hospital to seek replacement of her catheter bag due to switching home help providers. Aleah Shepherd stated during this time however Resident A refused to go the hospital as she attempted to correct the catheter issue on her own by wrapping a garbage bag around the ripped catheter bag. Aleah Shepherd stated after a couple of days of persistent requests from direct care staff members to seek assistance from the hospital, Resident A eventually agreed to go the hospital at which time she had her catheter bag replaced. Aleah Shepherd stated staff assist Resident A with changing her catheter bag and monitoring the bag for any issues however these are the only task direct care staff members are required to perform as it pertains to her catheter care.

On 4/25/2024, I conducted an onsite investigation at the facility with direct care staff member Christine Brown who stated that she has not observed any issues with staff not assisting Resident A as required. Christine Brown stated staff are not required to complete a complex task such as replacing Resident A's catheter bag therefore Resident A receives assistance from a home help agency. Christine Brown stated Resident A seems to work well with her home help provider and appears to be getting her complex care needs met. Christine Brown further stated she has not heard any concerns from Resident A regarding direct care staff not changing her catheter bag when it is full or making sure that the catheter is clean.

I also conducted an interview with administrator Janet White who stated that to her knowledge direct care staff members have provided adequate care to Resident A and performed all required duties to assist her personal care needs. Janet White stated direct care staff members are not required to assist Resident A with replacing her catheter bag and Janet White stated she was aware that there have been issues with this in the past. Janet White stated Resident A has a home help agency that provides services for her catheter bag and when the home help agency is not available Resident A must be seen by her physician to get the care and services she needs as it pertains to

any complex care task Resident A requires such as replacing her catheter bag. Janet White stated direct care staff members are required to monitor the catheter bag and report any concerns to Resident A's home help provider. Janet White stated she has previously encouraged Resident A to seek medical attention when there was an issue with her catheter bag ripping and leaking. Janet White stated there is usually no issues with Resident A getting the home help agency to care for her catheter needs and the home help agency communicates with staff when there are matters that staff should know. Janet White stated Resident A has had to change home help agencies due to a change in her insurance on more than one occasion however Resident A is good about keeping a home help agency program in place to assist her with complex task that she needs.

I also conducted an interview with Residents A who stated that she has a nurse by the first name of Erica, last name not given, who is her home help worker that takes care of her catheter bag needs. Resident A stated her new agency is Bronson Home Help however she has worked with different agencies in the past due to insurance changes. Resident A stated she wants to keep direct care staff members "out of her business" as it pertains to her catheter bag and does not want them to know anything about her catheter bag care handled by the home help agency. Resident A stated she also does not want staff members talking to her nurse about anything related to her catheter care needs.

I reviewed Resident A's *Resident Evaluation* dated 7//26/2023. According to this evaluation Resident A has a catheter and staff are required to maintain cleanliness of the catheter and report changes in appearance of urine such as odor and color. Staff should encourage Resident A to perform as many task as possible related to her catheter care while assisting Resident A as needed such as gathering supplies to assist her.

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:	Based on my investigation which included interviews with direct care staff members Staff Member #1, Rebecca Mackinaw, Darnesha Singleton, Christine Brown, Aleah Shepherd, Lynette Gabbidon, administrator Janet White and review of Resident A's *Resident Evaluation* there was no evidence direct care staff members do not assist Resident A with her catheter bag as required. Staff Member #1 stated staff members allowed Resident A to have a ripped catheter bag and did not assist her with replacing her bag. Rebecca Mackinaw, Darnesha Singleton, Christine Brown, Aleah Shepherd, Lynette Gabbidon, and Janet White all stated direct care staff members are not required to replace Resident A's catheter bag but must provide routine care such as changing the bag when full and monitor the bag. These staff members also stated when Resident A had an issue with her catheter bag leaking, Resident A did not have a home help agency provider in place to assist her with her catheter complex needs therefore she was encouraged multiple times by direct care staff members to see a doctor which Resident A eventually agreed to do. Resident A stated she has a home help provider that handles issues with her catheter needs and does not prefer staff members to handle any of those matters. According to Resident A's *Resident Evaluation* staff members are not required to replace Resident A's catheter bag and should report any concerns. Staff members have assisted Resident A with her catheter needs as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff member Lynette Gabbidon mistreats Resident A and direct care staff member Michael Cuff has made Resident A feel uncomfortable.

INVESTIGATION:

This complaint also alleged direct care staff member Lynette Gabbidon mistreats Resident A and direct care staff member Michael Cuff has made Resident A feel uncomfortable.

On 4/10/2024, I conducted an interview with Staff Member #1 who stated that Resident A has reported to her that Lynette Gabbidon is rude to her and that she does not like working with both Lynette Gabbidon and Michael Cuff. Staff Member #1 stated Resident A stated she does not like working with Michael Cuff because he touched her while walking pass her and this made her feel uncomfortable. Staff Member #1 stated Resident A did not give details explaining why she felt uncomfortable however Staff Member #1 believes Resident A does not like to work with some male staff members

because of her own personal preference. Staff Member #1 stated she has never seen Lynette Gabbidon nor Michael Cuff mistreat Resident A.

On 4/12/2024, I conducted an interview with direct care staff member Rebecca Mackinaw who stated that she has never seen Lynette Gabbidon be rude or mistreat Resident D. Rebecca Mackinaw also stated she has never seen Michael Cuff mistreat Resident D. Rebecca Mackinaw stated she once witnessed Michael Cuff walk passed residents including Resident A and Michael Cuff touched a male resident on the shoulder and said “hi”. Rebecca Mackinaw stated later that day Resident A then reported to Staff Member #1 that she didn’t like Michael Cuff and falsely reported that he tapped her on the shoulder making her feel uncomfortable. Rebecca Mackinaw stated she believes Staff Member #1 was trying to provoke Resident A to talk badly about Michael Cuff because Staff Member #1 was upset with Michael Cuff. Rebecca Mackinaw stated Resident A has not been mistreated by any staff member.

On 4/15/2024, I conducted an onsite investigation at the facility with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd. Lynette Gabbidon stated she has never been rude or mistreated Resident A. Lynette Gabbidon stated for some reason Resident A is very mean to her and constantly tells her that she doesn’t like her. Lynette Gabbidon stated she has worked at the facility for 11 years and understands that some residents will have their favorite staff members they prefer to work with therefore it does not bother Lynette Gabbidon that Resident A does not like her. Lynette Gabbidon stated her only concern is that Resident A has made false complaints against her such as telling other staff members that she is mean to her which is not true. Lynette Gabbidon states she tries to be nice to Resident A to form a relationship however Resident A will say things to her like "don’t talk to me”. Lynette Gabbidon stated she has never seen Michael Cuff mistreat any of the residents and has not seen him work directly with many of the residents in the facility as he transferred to another building shortly after working at the facility.

Darnesha Singleton stated she has not witnessed Lynette Gabbidon be rude or mistreat Resident A in any way however Resident A has reported that she does not like Lynette Gabbidon and complains about her when she works with her. Darnesha Singleton stated she has witnessed Resident A be very mean to Lynette Gabbidon for no reason at all and Darnesha Singleton stated she has reported this mistreatment by Resident A to management. Darnesha Singleton stated she has never seen Michael Cuff mistreat Resident A however believes Resident A has targeted Michael Cuff by making false allegations against him in the past. Darnesha Singleton stated she heard from another staff member that Michael Cuff touched a male resident’s shoulder and Resident A later made a false complaint against Michael Cuff and stated he touched her shoulder instead. Darnesha Singleton stated Resident A can be difficult to work with and often complains about things that are found to be untrue.

Aleah Shepherd stated she has not seen or heard Lynette Gabbidon or Michael Cuff mistreat any of the residents including Resident A. Aleah Shepherd stated Lunette Gabbidon has been working at the facility for many years and is a quality staff member.

Aleah Shepherd stated she has not seen Michael Cuff work directly with many of the female residents because they prefer to work with male staff members.

On 4/25/2024, I conducted an interview with direct care staff member Michael Cuff who stated he has never touched Resident A and did not directly work with Resident A when he worked at the facility. Michael Cuff further stated he has not seen Lynette Gabbidon mistreat Resident A or any other resident.

On 4/25/2024, I conducted an onsite investigation at the facility with direct care staff member Christine Brown who stated that she is also the life enrichment director therefore has a special relationship with many of the residents who often confides in her. Christine Brown stated she has observed Resident A to have personality differences with staff members therefore Resident A seems to like certain staff members better than others. Christine Brown stated she has not heard of any complaints or seen any staff member including Lynette Gabbidon and Michael Cuff mistreat Resident A. Christine Brown stated she has observed Lynette Gabbidon be a very good staff member who tries to encourage residents to come out of their rooms to engage in activities which is something she encourages staff members to do. Christine Brown stated Resident A complains about staff members trying to assist her because she prefers to be independent and has not disclosed any staff member behaviors that are inappropriate.

I also conducted an interview with Resident A who stated that she does not have a problem with staff however she believes there are some male staff that are “homosexual” and she does not want to be around “homosexual” staff members. Resident A stated there are some staff members she likes and there are some staff members she just does not care for. Resident A stated her biggest issue now is with staff members that she works with outside the facility through her home help program.

APPLICABLE RULE	
R 400.15308	**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:	Based on my investigation which included interviews with direct care staff members Staff Member #1, Rebecca Mackinaw, Darnesha Singleton, Michael Cuff, Christine Brown, Aleah Shepherd, Lynette Gabbidon and Resident A there is no evidence direct care staff member Lynette Gabbidon mistreated Resident A or that direct care staff member Michael Cuff made Resident A feel uncomfortable. All the staff members interviewed stated that they have not seen Lynette Gabbidon or Michael Cuff mistreat Resident a in any way. Resident A also stated she does not have a problem with any staff member.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff members accepts money from Resident D.

INVESTIGATION:

This complaint also alleged direct care staff members accepts money from Resident D.

On 4/10/2024, I conducted an interview with Staff Member #1 who stated she heard a rumor that Resident D gives direct care staff members money “as a tip” when direct care staff members braid her hair. Staff Member #1 stated she has no direct knowledge of this however it was also reported to her by Resident D. Staff Member #1 further stated personal funds are not managed by staff members and believes Resident D has a relative who will give her money for her own personal spending when he visits with her.

On 4/12/2024, I conducted an interview with direct care staff member Rebecca Mackinaw who stated that she has no knowledge of any direct care staff members receiving tip money from Resident D. Rebecca Mackinaw stated Staff Member #1 is the only staff member that braids Resident D’s hair to her knowledge. Rebecca Mackinaw further stated during Christmas time in 2023, Resident D gave staff members a Christmas card with $20 inside. Rebecca Mackinaw stated to her knowledge some people returned the money back to Resident D however she also believes some staff members accepted the money. Rebecca Mackinaw stated she knows that money is not supposed to be accepted from residents therefore she returned the $20 back to Resident D.

On 4/15/2024, I conducted an onsite investigation at the facility with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd who all stated they have never heard of Resident D giving tip money to any staff members. Lynette Gabbidon stated for the past two years, Resident D has given Christmas cards to staff members with $20 inside the card. Lynette Gabbidon stated since this was a Christmas gift she has accepted the $20 from Resident D. Darnesha Singleton also stated Resident D gave out Christmas cards in December 2023 to staff members with $20 inside however Danesha Singleton did not accept the $20 from Resident D. Aleah

Shepherd also stated she received a Christmas card from Resident D in December 2023 with $20 inside the card and accepted the $20 as a Christmas gift from Resident D.

On 4/25/2024, I conducted an onsite investigation at the facility with direct care staff member Christine Brown who stated that she is has no knowledge of any resident including Resident D giving money to any staff member and has no knowledge of Christmas cards being given to staff members with money inside from residents.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Staff Member #1, Rebecca Mackinaw, Darnesha Singleton, Christine Brown, Aleah Shepherd, and Lynette Gabbidon there is evidence to support the allegation that some direct care staff members accepted money from Resident D. According to Rebecca Mackinaw, Darnesha Singleton, Lynette Gabbidon and Aleah Shepherd Resident D has given Christmas cards to staff members with $20 inside the card. Both Lynette Gabbidon and Aleah Shepherd confirmed accepting and keeping the $20 from Resident D. Other direct care staff interviewed reported returning the $20 to Resident D. There was no evidence any direct care staff member received a tip for performing any personal care task for Resident D. However, some direct care staff members have accepted money from Resident D even with the consent of the resident which is not allowed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The maintenance on the property is not well maintained. The kitchen pipes and toilets have been broken and not addressed.

INVESTIGATION:

This complaint also alleged the maintenance on the property is not well maintained. The kitchen pipes and toilets have been broken and not addressed.

On 4/10/2024, I conducted an interview with Staff Member #1 who stated that in the past the pipes in the kitchen have busted which left water on the floor that was not addressed until days later. Staff Member #1 also stated she remembers when one of

the bathrooms used by staff members was not able to flush properly with the handle and this issue was not addressed for over a week. Staff Member #1 stated she just believes the facility should be better maintained.

On 4/12/2024, I conducted an interview with direct care staff member Rebecca Mackinaw who stated that the residents have their own private bathroom, and she has no knowledge of any resident or staff toilets not working. Rebecca Mackinaw stated a few months ago the kitchen pipe busted and was fixed within 24 hours by maintenance. Rebecca Mackinaw stated if any repairs are needed, she has observed matters taken care of right away by maintenance and has never seen any issues with their work. Rebecca Mackinaw further stated they have housekeepers that clean the facility throughout the week and staff members also clean the facility when needed. Rebecca Mackinaw believes the facility is well maintained and has not seen any issues.

On 4/15/2024, I conducted an onsite investigation at the facility with direct care staff members Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd who all stated that when repairs are needed around the facility maintenance is notified right away, and they have not seen any issues with repairs not being addressed in a timely manner. Lynette Gabbidon, Darnesha Singleton, and Aleah Shepherd also all stated they have no knowledge of issues with the pipes in the kitchen or toilets in the facility not working properly and have not heard any complaints from residents regarding their toilets or any maintenance issues. These staff members also all stated part-time housekeepers are available that clean the facility throughout the week and staff members also clean when needed.

While at the facility, I inspected the property including resident bathrooms, common areas and kitchen areas and found no concerns.

On 4/25/2024, I conducted an onsite investigation at the facility with direct care staff member Christine Brown who stated that the facility is well maintained, and maintenance does a good job addressing any issues when they are notified. Christine Brown further stated she believes staff does a good job notifying maintenance when repairs are needed, and she has no knowledge of any toilets or kitchen pipes having issues.

I also conducted an interview with administrator Janet White who stated that she has no knowledge of any repairs needed that were not addressed in a timely manner. Janet White stated staff members notify maintenance when there are maintenance issues observed and they also have housekeepers who cleans throughout the week that will also bring any concerns with premises to her for maintenance to address. Janet White stated all toilets have been working properly to her knowledge and kitchen pipes are in good condition.

I conducted interviews with Residents A, B, and C who all stated that they have not had any issues with their toilet and have no concerns with the maintenance of the premises.

While at the facility again on 04/25/2024, I inspected the property including resident bathrooms, common areas and kitchen area and found no concerns.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Staff Member #1, Rebecca Mackinaw, Darnesha Singleton, Christine Brown, Aleah Shepherd, Lynette Gabbidon, Residents A, B, and C, administrator Janet White and inspection of the facility there is no evidence to support the allegation the maintenance on the property is not well maintained or that kitchen pipes and toilets have been broken and not addressed. Rebecca Mackinaw, Darnesha Singleton, Lynette Gabbidon, Christine Brown, Janet White and Aleah Shepherd all stated when repairs are needed around the facility maintenance is notified right away, and they have not seen any issues with repairs not being addressed in a timely manner nor have they seen issues with the facility toilets and kitchen pipes. Rebecca Mackinaw stated a few months ago a kitchen pipe busted and was repaired within 24 hours. In addition to direct care staff members, there are housekeepers that clean the facility throughout the week to maintain the premises of the facility. While at the facility I found no concerns with the conditions of the facility therefore the premises are well maintained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 5/27/2024, I conducted an exit conference with licensee designee Connie Clauson. I informed Connie Clauson of my findings and allowed her an opportunity to ask questions and make comments.

IV. RECOMMENDATION

Upon an acceptable corrective action plan, I recommend the current license status remain unchanged.

Ondrea Johnson
Licensing Consultant

5/27/2024
Date

Approved By:

05/29/2024

_____

Dawn N. Timm
Area Manager

Date