GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 3, 2024

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL540398499
Investigation #: 2024A1033043
Evergreen Terrace Assisted Living

Dear Mrs. Clauson:

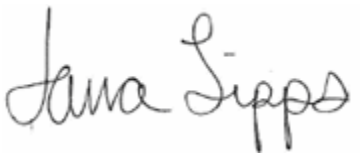
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9730.

Sincerely,



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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL540398499
Investigation #:	2024A1033043
Complaint Receipt Date:	05/23/2024
Investigation Initiation Date:	05/23/2024
Report Due Date:	07/22/2024
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Laura Whaley
Licensee Designee:	Connie Clauson
Name of Facility:	Evergreen Terrace Assisted Living
Facility Address:	801 Fuller Big Rapids, MI 49307
Facility Telephone #:	(231) 527-1050
Original Issuance Date:	04/28/2020
License **Status:**	REGULAR
Effective Date:	10/28/2022
Expiration Date:	10/27/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Tracy Snyder & Dawn Gould, do not treat residents with dignity and respect. They speak rudely to residents and in a derogatory manner.	Yes
Direct care staff, Tracy Snyder & Dawn Gould, have been physically abusive to residents at the facility.	No

III. METHODOLOGY

05/23/2024	Special Investigation Intake 2024A1033043
05/23/2024	APS Referral- APS already assigned to this intake.
05/23/2024	Special Investigation Initiated - Letter Email correspondence with Adult Protective Services, adult services worker, Samuel Talaske.
05/28/2024	Contact - Document Received Email correspondence received from Mr. Talaske, with APS.
05/31/2024	Inspection Completed On-site Interviews conducted with Administrator, Laura Whaley, direct care staff, Morgan Livermore, Dawn Gould, Hayley Johnson, Resident A, C, D, & E. Review of resident records initiated, review of employee files initiated.
06/03/2024	Contact - Telephone call made- Interview with direct care staff, Tracy Snyder, via telephone.
06/03/2024	Contact - Telephone call made- Interview with direct care staff, Alayna Heiler, via telephone.
06/05/2024	Contact - Telephone call made- Interview with direct care staff, Joanne Barnes, via telephone.
07/03/2024	Exit Conference Conducted via telephone with Administrator, Laura Whaley, at licensee designee, Connie Clauson’s request.

ALLEGATION: Direct care staff, Tracy Snyder & Dawn Gould, do not treat residents with dignity and respect. They speak rudely to residents and in a derogatory manner.

INVESTIGATION:

On 5/23/24 I received two, separate online complaints regarding the Evergreen Terrace Assisted Living, adult foster care facility (the facility). Complainants were two separate individuals who both alleged that direct care staff members Tracy Snyder & Dawn Gould, are not treating residents with dignity and respect alleging that they speak in a derogatory manner to the residents. On 5/23/24 I held email correspondence with Adult Protective Services, Adult Services Worker, Samuel Talaske, regarding the allegations. Mr. Talaske reported that he has been on-site to investigate the allegations and he received additional information regarding these allegations from interviews conducted while he was on-site visit at the facility on 5/23/24 with Law Enforcement Officer, Jason Kuiawa. Mr. Talaske provided his notes from the interviews conducted during the on-site investigation. Mr. Talaske reported that during this on-site investigation they received reports from direct care staff, Hayley Johnson & Alayna Heiler, who both stated Ms. Snyder is very loud with the residents and speaks to the residents in a rude manner. Ms. Johnson reported to Mr. Talaske and Officer Kuiawa that Ms. Gould had an incident with Resident A where she yelled at her in front of Administrator, Laura Whaley, and accused Resident A of being intentionally incontinent of stool while attending Bingo. Mr. Talaske's notes further reported that he interviewed Resident A during his on-site investigation on 5/23/24 and Resident A referred to Ms. Gould as "a bully." Resident A further reported that she has overheard Ms. Snyder make derogatory statements about other residents such as, "they're all losing their minds." Mr. Talaske also reported that he interviewed Ms. Gould during his on-site investigation and Ms. Gould reported that she did make a comment on how "[Resident A] poops and pees herself" while at Bingo but made a claim that she did not mean this statement in a disparaging way. Mr. Talaske reported that he asked for clarification from Ms. Gould regarding what she did mean by this comment and Ms. Gould reported that she was just trying to demonstrate to Resident A "that she's no better than anyone else."

On 5/31/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Whaley at this time. Ms. Whaley reported that Ms. Snyder has worked at the facility for the past twelve years. She reported that in November 2023 Ms. Snyder was promoted to the position of Resident Care Manager. She reported that Ms. Snyder still provides direct care to residents but also is responsible for ordering supplies, hiring, and training new direct care staff, reconciliation of medications in the medication carts and so forth. Ms. Whaley reported that over the years Ms. Snyder has worked in the facility there have been some complaints from family members or visitors of residents that Ms. Snyder can be "cold", "blunt," or "straight forward" in her communication style. Ms. Whaley reported that some family members and residents appreciate this about her personality. She reported that there has never been a complaint by a resident or family member that Ms. Snyder

has been verbally abusive to the residents. Ms. Whaley reported that she has directly observed Ms. Snyder using a harsh tone with Resident B while he was attempting to get extra coffee in the dining room. Ms. Whaley explained that Resident B's son does not want him to have too much coffee as it causes him to have loose stools which can become a problem for Resident B. Ms. Whaley reported that there was a day when Resident B was attempting to pour himself some extra coffee and she observed Ms. Snyder yell at Resident B in front of the other residents. Ms. Whaley reported that she is quite sure the tone of Ms. Snyder's voice embarrassed Resident B on this occasion. Ms. Whaley reported that Ms. Gould has worked at the facility for the past six years. She reported that previously Ms. Gould was a direct care staff member, but now works in the dietary department for the most part. Ms. Whaley reported that there was a recent incident with Ms. Gould and Resident A which involved the two yelling at one another in the dining room. Ms. Whaley reported that she did not observe the actual incident but reported that Ms. Gould came to her office after the incident to "self-report" what had happened. Ms. Whaley reported that Ms. Gould stated she and Resident A were involved in a disagreement because she asked Resident A to walk around Resident C's oxygen tubing and Resident A refused. Ms. Whaley reported that while Ms. Gould was reporting the incident to her, they were in Ms. Whaley's office and Resident A was also present at this time. Ms. Whaley reported that the conversation became heated between Ms. Gould and Resident A and Resident A stated to Ms. Gould, "You're a bully! You bully me about pooping my pants!" Ms. Whaley reported that Ms. Gould responded with, "You do poop your pants! You know you're not supposed to poop your pants!" Ms. Whaley reported that Ms. Gould was given a written disciplinary action on this date. Ms. Whaley also reported that Ms. Johnson came to her after the event in the dining room on this same date and reported that she observed Ms. Gould and Resident A during the altercation about the oxygen tubing and she noted to Ms. Whaley, "[Ms. Gould] should not have spoken to [Resident A] like that."

During the on-site investigation on 5/31/24 I interviewed direct care staff, Morgan Livermore. Ms. Livermore reported that she has worked at the facility for about two years. Ms. Livermore reported that Ms. Snyder speaks in a derogatory manner to residents and visitors of the facility. She reported that Ms. Snyder talks back to residents and speaks in a rude tone of voice. Ms. Livermore reported that Resident A and Resident D constantly complain about Ms. Snyder, stating "she's just mean." Ms. Livermore reported that Resident D will make a point to ask her if Ms. Snyder is working each day and seems relieved when the answer is "no". Ms. Livermore reported that Resident A has not given her any examples of how Ms. Snyder is "mean". Ms. Livermore reported that Ms. Gould is verbally direct with residents, but she has not seen her belittling residents or being disrespectful toward them. Ms. Livermore reported that she has not had any residents make complaints to her about Ms. Gould.

During the on-site investigation on 5/31/24 I interviewed Ms. Gould. Ms. Gould reported there was a recent incident between herself and Resident A regarding Ms. Gould requesting Resident A take an alternative route out of the dining room and

Resident A refusing to accommodate Ms. Gould's request. Ms. Gould reported that Resident A began to yell at Ms. Gould and the two did raise their voices during this incident. Ms. Gould reported that there was a statement made by herself about how Resident A chooses to be incontinent of stool while playing Bingo, instead of using the restroom. Ms. Gould reported that she feels Resident A can better control her bowels and was just pointing this out to Resident A. Ms. Gould reported that she has worked with Ms. Snyder for about five years. She reported that Ms. Snyder can be "loud" but she would not consider her behavior to be verbally abusive to the residents. Ms. Gould reported that she has never had a resident or visitor to the facility make a complaint to her regarding Ms. Snyder speaking in a derogatory manner to residents.

During the on-site investigation on 5/31/24, I interviewed Ms. Johnson. Ms. Johnson reported that she has worked at the facility for about nine months. She reported that Ms. Snyder is "aggressive and mean" to the residents. She did not have any specific examples of verbal abuse that Ms. Snyder has committed toward any of the current residents. Ms. Johnson reported that she was a witness to the recent altercation between Ms. Gould and Resident A. She reported that the incident occurred in the dining room. Ms. Johnson reported that Ms. Gould wanted Resident A to walk around Resident C's oxygen tubing and a verbal altercation between Ms. Gould and Resident A ensued. Ms. Johnson reported she observed Ms. Gould state to Resident A, "I'm gonna win this, you're not!". Ms. Johnson reported that after the incident she observed Resident A and Ms. Gould in Ms. Whaley's office and Ms. Gould was yelling at Resident A. Ms. Johnson reported that she heard Ms. Gould state to Resident A, "No one feels sorry for you! Don't sit there and act like you don't poop your pants and make a mess and make people clean it up for you!"

During the on-site investigation on 5/31/24 I interviewed Resident A. Resident A reported that she has been a resident at the facility for the past 12 years. She made the following statements when asked about the direct care staff; "I don't like the way they treat me sometimes." "I don't like people getting upset with me, if I don't do things just their way." Resident A reported that Ms. Snyder is known as "Sarge" to some of the residents of the facility. She reported that she received this nickname because, "she's bossy." Resident A was not able to provide any specific examples for how Ms. Snyder is "bossy". Resident A reported that she recalled the incident in the dining room with Ms. Gould. She reported that Ms. Gould was yelling at her in front of everyone in the dining room as it was mealtime. She reported that this occurred because Ms. Gould did not want Resident A to walk through the area where Resident C's oxygen tubing was. Resident A did not have a recollection of Ms. Gould yelling at her about her bowel incontinence on this date. Resident A reported that Ms. Snyder has previously commented to her about her bowel incontinence and noted to Resident A, "you should control it better", referring to her incontinence issues. When asked if Resident A felt safe in the facility she responded, "oh yes".

During the on-site investigation on 5/31/24 I interviewed Resident D. Resident D reported that she has lived at the facility for three to four years. She reported that she feels safe at the facility and feels like she is treated with dignity and respect. Resident D reported that there was a former direct care staff member who did not treat the residents well but noted that this person recently stopped working at the facility. She could not recall this person's name and reported, "we all breathed a sigh of relief" when this caregiver stopped working here. Resident D was not capable of providing any specific examples of statements made by this direct care staff which made her feel uncomfortable.

During the on-site investigation I interviewed Resident C and Resident E, together, as they are husband and wife. Both, Resident C and Resident E, stated that they feel safe at the facility. Both acknowledged that they are treated very well by direct care staff members. Resident C stated, "[Ms. Snyder] is a wonderful person". Resident E reported that the direct care staff treat the residents, "firm but gentle" and followed up this statement with, "we are treated like royalty". Resident C reported that he did observe the altercation in the dining room between Ms. Gould and Resident A. He reported that Resident A was not listening to Ms. Gould which led to the disagreement that ensued. Resident C reported that he did not feel Ms. Gould's tone of voice with Resident A during that incident, was disrespectful. Resident C stated that there have been times when the direct care staff will yell at Resident B about getting extra coffee, but he attributed this yelling being related to Resident B being hard of hearing. He reported that he has overheard direct care staff state to Resident B, "[Resident B] take your seat".

On 6/3/24 I interviewed Ms. Snyder, via telephone. Ms. Snyder reported that she has worked at the facility for the past 12 years. She reported that she has never had another complaint alleging that she has been verbally abusive to residents at the facility. Ms. Snyder reported that she has never made statements that the residents are "all losing their minds". She reported that she has never sworn at a resident and never spoken with residents in a derogatory or intimidating manner. Ms. Snyder reported that she has never witnessed Ms. Gould using derogatory language or being verbally abusive toward the residents.

On 6/3/24 I interviewed Ms. Heiler, via telephone. Ms. Heiler reported that she has no direct knowledge of Ms. Gould being verbally abusive toward Resident A. Ms. Heiler reported that she had received secondhand information from Ms. Johnson regarding the incident that occurred between Resident A and Ms. Gould. She reported that she was not present to observe this incident. Ms. Heiler reported that she does not often work with Ms. Snyder. Ms. Heiler did not have any reported information regarding Ms. Snyder being verbally abusive toward the residents.

On 6/5/24 I interviewed direct care staff, Joanne Barnes, via telephone. Ms. Barnes reported that she has worked at the facility for about 18 years. She reported that sometimes the direct care staff can be rude with how they verbally interact with residents. She reported that she would consider this behavior as the direct care staff

are not treating residents with dignity and respect. Ms. Barnes reported that Ms. Snyder can be “rude and loud” with residents. She reported that she has never observed Ms. Snyder cussing at the residents, but she has observed her interact with the residents in an abrupt manner. Ms. Barnes reported that she has also observed Ms. Gould speaking to residents with a disrespectful tone of voice. She reported that she has not observed Ms. Gould using profanity toward the residents but she does speak with them in a manner that is not compassionate.

During the on-site investigation on 5/31/24 I reviewed the following document:

- *Resident Negotiated Service Plan Without Schedule*, dated 8/9/23, for Resident A. On page 2, under section, *Bathroom Assistance*, it reads, “Has intermittent episodes of incontinence with employees assistance required. Inform resident discreetly and privately of need to change incontinence products or clothing. Assist to remove soiled clothing and/or incontinence products. Assist onto toilet as needed and assist resident with personal cleaning tasks. Report increasing frequency of incontinence episodes.”

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based upon interviews conducted with Ms. Whaley, Ms. Johnson, Mr. Talaske, Ms. Heiler, Ms. Snyder, Ms. Barnes, Ms. Gould, Ms. Livermore, Resident A, Resident C, Resident D, & Resident E, it can be determined that there is factual evidence to support the allegation that Ms. Gould is not treating the residents with dignity and respect. This evidence came from interviews with Ms. Whaley, Ms. Johnson, & Ms. Gould, who all confirmed that Ms. Gould was observed yelling at Resident A and making derogatory remarks about Resident A's bowel incontinence during this argument in a humiliating manner for Resident A. There is also a preponderance of evidence to suggest that Ms. Snyder has been speaking with residents in a rude manner, causing residents to feel uneasy and to feel as though they are not being treated with dignity and respect. There were multiple reports made during this investigation that Ms. Snyder speaks in a rude manner that is not consistent with providing these residents with personal dignity and respect. Due to these findings a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff, Tracy Snyder & Dawn Gould, have been physically abusive to residents at the facility.

INVESTIGATION:

On 5/23/24 I received two, separate online complaints regarding the facility. The complainants were two separate individuals who both alleged that direct care staff, Tracy Snyder & Dawn Gould, have been physically abusive toward residents at the facility. These allegations reported that Ms. Snyder has caused a skin tear on Resident F's hand, put soap in the mouth of Resident G, carelessly ran Resident H's wheelchair into the doorframe causing her to hit her head on the doorframe, and that Ms. Gould has forcefully shoved Resident A during an altercation in the dining room of the facility.

On 5/28/24 Mr. Talaske shared notes from his recent on-site investigation at the facility, via email. These notes detailed the following information:

- Mr. Talaske and Officer Kuiawa interviewed Ms. Whaley on 5/23/24, who reported that Resident F did make an accusation that Ms. Snyder caused his skin tear, but Ms. Snyder has denied this allegation and there were no eyewitnesses to this incident. Ms. Whaley reported that skin tears are very common for elderly residents and could be caused by a multitude of factors. Ms. Whaley reported being aware of Resident H hitting her head on the doorframe and stated she was made aware of this incident by Ms. Johnson.

- Mr. Talaske and Officer Kuiawa interviewed Ms. Johnson on 5/23/24. Ms. Johnson reported that Ms. Snyder has aggressive behaviors with residents such as “pushing, shoving, and yelling” (no specific examples were stated in these notes). Ms. Johnson reported that there was an issue during lunch where Ms. Gould pushed Resident A. Ms. Johnson reported that she bandaged Resident F’s skin tear on his hand but did not observe how he received the skin tear. Ms. Johnson reported that Ms. Snyder transported Resident H backwards in her wheelchair and her head hit the doorframe. Ms. Johnson reported that she did not observe this incident.
- Mr. Talaske and Officer Kuiawa interviewed Ms. Heiler on 5/23/24. She stated that Resident I reported that Ms. Snyder hit her in the shower a few weeks ago and now Resident I is afraid of Ms. Snyder. Ms. Heiler reported that Resident F had made a complaint about Ms. Snyder being rough with him getting him into bed and the next day Resident F had a wound on his hand. She reported that Resident F accused Ms. Snyder of causing the wound and Ms. Snyder denied these allegations. Ms. Heiler reported that she has heard that Ms. Snyder put soap in the mouth of Resident G, but she did not witness this. Ms. Heiler reported that she observed Ms. Snyder transporting Resident H in her wheelchair, by pulling her backwards in the chair. Ms. Heiler reported that when Ms. Snyder turned to enter Resident H’s bedroom the resident’s head hit the doorframe and the resident stated, “owe!” and then Ms. Heiler reported Ms. Snyder stated, “Sit up then!”.
- Mr. Talaske and Officer Kuiawa interviewed Resident F. Resident F reported that two days ago Ms. Snyder left him in the bathroom for 45 minutes. Mr. Talaske and Officer Kuiawa questioned Resident F about his hand and he denied the allegations. They asked him how he felt about Ms. Snyder and he reported with a hand gesture that she was “so-so”, and he denied being fearful of her.
- Mr. Talaske and Officer Kuiawa interviewed Resident I regarding the allegations. Resident I denied being hit by Ms. Snyder in the shower. She also denied being fearful of Ms. Snyder.
- Mr. Talaske and Officer Kuiawa interviewed Resident G regarding the allegations. Resident G denied being physically abused during her showers by having soap put in her mouth.
- Mr. Talaske and Officer Kuiawa interviewed Resident A regarding the allegations. Resident A reported that Ms. Gould pushed her in the dining room near Resident C’s oxygen tubing. She stated she had a bruise on her right shoulder from the incident. Mr. Talaske and Officer Kuiawa did not visualize the bruise on this date.
- Mr. Talaske and Officer Kuiawa interviewed Ms. Gould regarding the allegations. Ms. Gould reported that during the incident in the dining room with Resident A, the resident shoved at Ms. Gould with her walker. Ms. Gould reported that she grabbed Resident A’s walker and pushed it backwards. She reported she was trying to keep the flow of traffic from walking over Resident C’s oxygen tubing. Ms. Gould reported she does not recall if Resident A stumbled or fell backwards during the incident.

- Mr. Talaske and Officer Kuiawa interviewed Resident C regarding the allegations. Resident C reported that he observed the incident in the dining room between Resident A and Ms. Gould. He reported that he did not observe either party touch the other party during the altercation. He reported that no one was “hit” and stated, “there might have been some belly pushing” but no one was hit.

On 5/31/24, during on-site investigation, I interviewed Ms. Whaley regarding the allegations. Ms. Whaley reported that she has never had any previous complaints about Ms. Snyder or Ms. Gould being physically abusive toward a resident. Ms. Whaley reported that she was just recently made aware, by Ms. Johnson, that Resident H was being transported in her wheelchair by Ms. Snyder and her head hit the doorframe of her bedroom. Ms. Whaley reported that Ms. Johnson did not directly observe this incident and stated she was informed of the incident by Ms. Heiler. Ms. Whaley reported that she interviewed Ms. Heiler about the incident and Ms. Heiler admitted that she did not directly witness the incident but was present on the hallway and heard the resident say, “ouch!”. Ms. Whaley reported that Ms. Heiler indicated that she looked up from her task at that time, but she had no further report regarding the alleged incident. Ms. Whaley reported that she spoke with Ms. Snyder about the incident who confirmed that Resident H’s head did hit the doorframe of the bedroom when she turned her wheelchair into the bedroom but stated that it was not carelessness or malicious it was just an accident. Ms. Whaley reported that she had Ms. Snyder complete an incident report for this incident and this was filed in Resident H’s resident record. Ms. Whaley reported that Ms. Johnson also stated to her that Resident F had a skin tear on his hand and she “knew [Ms. Snyder] did it.” Ms. Whaley reported that Ms. Johnson did not directly observe any incident to indicate that she had proof this was maliciously caused by Ms. Snyder. Ms. Whaley reported that Ms. Johnson stated that she observed Resident F with a skin tear on his hand, asked him how he got it, and Resident F stated that Ms. Snyder caused it. Ms. Whaley reported that she then went to interview Resident F, who denied having any concerns about the direct care staff and did not indicate that Ms. Snyder caused a skin tear on his hand. Ms. Whaley reported that after the altercation with Resident A and Ms. Gould she did speak with them both in her office. She reported that it was stated that Ms. Gould was attempting to redirect Resident A in the dining room so that she would not walk on Resident C’s oxygen tubing as she did not want the resident to trip and fall. It was stated that Resident A pushed forward and tried to walk over the tubing and then Ms. Gould put her hands on Resident A's walker and pushed back against her force. Ms. Whaley reported that it was reported to her that this turned into a yelling match between Resident A and Ms. Gould in which Resident A referred to Ms. Gould as “a bully!”. Ms. Whaley reported that she interviewed Resident C regarding the altercation and Resident C reported that he observed Ms. Gould put her hands on Resident A’s walker, but she did not put hands on Resident A. Ms. Whaley also reported that she has no knowledge of Ms. Snyder being physically abusive to Resident G in the shower. She reported that has not been any reports of Ms. Snyder putting soap in Resident G’s mouth. Ms. Whaley reported that her meeting with Mr. Talaske was the first time she had heard of this

allegation. She reported that there have not been any direct care staff complaints that Ms. Snyder has been physically abusive to Resident G in the shower. Ms. Whaley reported that two people need to work together to shower Resident G as she can become quite combative and will hit, kick, and pull hair when being showered. Ms. Whaley reported that she has interviewed Ms. Snyder regarding these allegations of physical abuse, and she denies all accounts. She reported that Ms. Snyder agreed Resident H's head did hit the doorframe but reported this to be an accident.

During the on-site investigation I interviewed Ms. Livermore regarding the allegation. Ms. Livermore reported that she has no knowledge of Ms. Gould or Ms. Snyder being physically abusive to any of the residents. She reported she has not received any reports that either Ms. Gould or Ms. Snyder may have been physically abusive to any of the residents.

During the on-site investigation I interviewed Ms. Gould regarding the allegation. Ms. Gould reported that the altercation between she and Resident A occurred because she had tried to redirect Resident A to a different walking path through the dining room for her own safety as she was trying to walk over Resident C's oxygen tubing. She reported that Resident A was not listening to her and charged forward. Ms. Gould reported that she grabbed Resident A's walker and pushed it back. She reported that the resident may have "slightly lost balance" but she did not fall. Ms. Gould reported that she then took ahold of Resident A's arm and escorted her the correct direction. Ms. Gould reported that she has no knowledge of any incident in which Ms. Snyder was physically abusive with a resident.

During the on-site investigation on 5/31/24 I interviewed Ms. Johnson, regarding the allegation. Ms. Johnson reported that Ms. Snyder has injured a resident by "head butting", hitting, kicking, slapping, and putting soap in the mouth of Resident G. I asked Ms. Johnson if she has ever directly witnessed these events and she reported, "no". She reported that her girlfriend, Citizen 1, is a former employee of the facility and reported the events to her. I requested a telephone number for Citizen 1 and was told that Ms. Johnson does not know the telephone number. I gave Ms. Johnson my business card and requested that she had Citizen 1 contact me with a statement. This communication was never received.

During my interview with Ms. Johnson, she reported that Resident F had a skin tear on his hand. She reported that she did not observe this incident occur, but overheard Resident F stated to Ms. Snyder, "you did it" when Ms. Snyder asked him how he hurt his hand. Ms. Johnson reported that she also did not witness Resident H's incident where she hit her head on the doorframe of her bedroom. Ms. Johnson reported that this information was shared with her by Ms. Heiler. Ms. Johnson reported that Citizen 1 also made statements that Ms. Gould duct taped Resident H's mouth on another occasion. Again, she did not provide a contact number for Citizen 1 and I did not receive any telephone contacts from Citizen 1 to confirm this allegation from Ms. Johnson. Ms. Johnson further reported that she did witness the

incident with Resident A and Ms. Gould. She reported that Ms. Gould did put her hands on Resident A's walker and forcefully made her walk around in the direction Ms. Gould wanted Resident A to move towards.

During the on-site investigation I interviewed Resident A regarding the allegations. Resident A reported that during the incident with Ms. Gould in the dining room she reported that Ms. Gould pushed her against the wall and that she had a bruise on her shoulder. She stated that Ms. Gould, "bullied me and held me between the table and the wall". Resident A reported that Ms. Gould had her hands on Resident A and not on the walker. When asked if Resident A feels safe at the facility she responded, "oh yes".

During the on-site investigation I interviewed Resident D. Resident D reported that she feels safe at the facility. She reported no knowledge of any physical abuse from direct care staff to residents.

During the on-site investigation I interviewed Resident C and Resident E together as they are husband and wife. They both reported feeling safe at the facility. They both reported having no knowledge of any physical abuse from direct care staff toward residents. Resident C reported that he was a witness to the incident between Resident A and Ms. Gould in the dining room concerning his oxygen tubing. Resident C reported that he has macular degeneration, and he cannot be certain if Ms. Gould used her hands and touched or shoved Resident A in any manner.

On 6/3/24 I interviewed Ms. Snyder regarding the allegations. Ms. Snyder reported that she had completed an incident report for Resident H regarding her head hitting the doorframe of her bedroom. Ms. Snyder reported that Resident H tends to fall asleep and become very limp in her wheelchair. She reported that this was the situation the date of the incident and she had been wheeling Resident H backwards so that she would not be pushed forward out of her chair in the sleeping position she was in at the time. She reported that when she turned the corner to take Resident H into her bedroom, her limp body shifted in the chair and her head hit the doorframe. She reported that she had been holding Resident H up in the chair by having one hand on the wheelchair handle and one hand on Resident H's shoulder. She reported that she did not realize her head was going to shift in the manner that it did and reported that this was merely an accident, not a malicious event. Ms. Snyder further reported that she has never physically abused Resident G. She reported she has never head butt, kicked, slapped, hit, or put soap in the mouth of Resident G. Ms. Snyder reported that she showers Resident G with an assistant due to Resident G's aggressive behaviors and usually it is Ms. Barnes who assists with the showers. Ms. Snyder reported that she has no knowledge how Resident F's hand received a skin tear. She reported that Resident F did attempt to accuse her of this incident, but she reported no knowledge of this event. She reported that the day prior to her noticing the skin tear she had provided care to Resident F, and he did not have any skin tears. She reported she arrived for work the following date and Resident F was in the office with Ms. Johnson. She reported that she noticed the skin tear and asked

Resident F what happened, and he stated, “yeah, and you did it!” She denies these allegations and reports that she then reported this incident and accusation to Ms. Whaley.

On 6/3/24 I interviewed Ms. Heiler regarding the allegations. Ms. Heiler reported that she did not have direct knowledge of the altercation that occurred between Ms. Gould and Resident A in the dining room. She reported that Ms. Johnson reported this incident to her and stated that Ms. Gould had shoved Resident A backwards. Ms. Heiler reported that the day Resident H hit her head on the doorframe of her bedroom, Ms. Heiler had been in the office at the time of the incident. She reported that the office is close to Resident H’s bedroom, and she observed Ms. Snyder transporting Resident H in her wheelchair at the time of the incident. She reported that she observed Resident H to be sleeping in her chair and hunched over. She reported that she observed Resident H’s head hit the doorframe and heard the resident say, “owe”. Ms. Heiler reported that Ms. Snyder’s response at the time was, “Well you need to sit up,” referring to Resident H and insinuating that if she had been sitting up straight her head would not have hit the doorframe. Ms. Heiler reported that she went and checked on Resident H after the incident and she appeared to be uninjured and doing well. Ms. Heiler reported that she felt the incident was most likely accidental, but she felt it could have been avoided if Ms. Snyder had been more careful during the transport. Ms. Heiler reported that she had been working the day prior to Resident F’s skin tear being observed on his hand. She reported that the day prior she did hear Resident F say “owe” while he was in his room, but she did not have eyes on him when this happened or know why he said “owe”. Ms. Heiler reported that later this same day Resident F stated to her that Ms. Snyder was rough on him. She did not ask clarifying questions to determine what he meant by this. Ms. Heiler reported that on this date she did not observe any skin tears on Resident F’s hand and he did not report being injured on this date. She reported that it was the following day when the skin tear was observed and she was present in the office when Resident F stated to Ms. Snyder, “it was you”, referring to who caused his skin tear on his hand. Ms. Heiler further reported that she has never observed Ms. Snyder provide a shower for Resident G. She reported that primarily Ms. Barnes is the one who assists with Resident G’s showers.

On 6/5/24 I interviewed Ms. Barnes via telephone regarding the allegation. Ms. Barnes reported that she does assist with Resident G’s showers and has assisted Ms. Snyder on numerous occasions with Resident G’s showers. Ms. Barnes reported that she was asked to assist Ms. Snyder with Resident G’s showers due to Resident G’s behaviors. Ms. Barnes reported that Resident G will hit, punch, and kick at the direct care staff when they attempt to shower her. Ms. Barnes reported that Ms. Snyder has been very patient with Resident G in the shower and maintains a professional atmosphere. Ms. Barnes reported she has never observed Ms. Snyder to head butt, kick, slap, or put soap in the mouth of Resident G. Ms. Barnes reported that she does not believe Ms. Snyder would ever physically harm a resident.

During the on-site investigation on 5/31/24, I reviewed the following documents:

- *Health Care Appraisal*, dated 5/3/24, for Resident G. Under section *7. Diagnoses*, it reads, “HTN, Recurrent UTI, Dementia with behaviors”.
- *Resident Negotiated Service Plan Without Schedule*, dated 8/9/23, for Resident A. On page 2, under section, *Life Enrichment Activities/Socialization*, it reads, “Gets along well with others”. On page 3, under section, *Incidents*, it reads, “Resident has had 1 fall within last 3 months. Ensure call light is in reach. Use personal tab alarm. Report increasing evidence of unsteadiness or other safety concerns. Place resident in common area during appropriate times.”
- *Resident Negotiated Service Plan Without Schedule*, dated 1/17/24, for Resident G. On page one under section, *Orientation*, it reads, “Severe orientation deficits with past history of poor judgement creating potential unsafe behaviors to self or others.” Under section, *Behaviors*, it reads, “Wanders with no regard of personal items and space of others. Possible exit seeking behaviors.” “Aggression-anxious; uses foul language, belligerent; destructive; or exhibits self-injurious behavior.”
- *Resident Negotiated Service Plan Without Schedule,* dated 3/14/24, for Resident F. On page one, under section, Orientation, it reads, “Has occasional confusion and some difficulty recalling details. Needs occasional prompting or orientation.”
- *Resident Negotiated Service Plan Without Schedule,* dated 2/1/24, for Resident H. On page 3, under section, Category/Resident Needs, it reads, “Resident requires assist of 1 person transferring. Remind resident to wait for staff assistance to transfer. Provide transfer assistance with good technique to protect resident and care staff. Report increasing difficulty with transfers or other safety concerns.”
- *Leisure Living Management Incident Investigation Report,* dated 5/8/24, for Resident H. This report noted the date of the incident to be 5/7/24 and was completed by Ms. Snyder. The report noted, “Resident was in one of her sleeping spells. I was bringing her back to her room and she bumped the left side of her head on the door jam.” One page 2, under the section, *Section V – Corrective Measures*, is the narrative, “Be more alert to doorway. Hospice notified.”
- *Quiz: Resident Abuse And Neglect*, dated 5/29/24. Ms. Whaley provided copies of this quiz for each direct care staff member and reported that this training was provided as a result of the current investigation with LARA, APS, and Law Enforcement.
- *Disciplinary Record,* dated 5/23/24, for Ms. Gould. This document noted that Ms. Gould was being reprimanded for a resident rights violation related to not treating residents with consideration and respect. It noted that the corrective action plan would be completion of an in-service training on the abuse policy and resident rights.
- *Baruch Senior Ministries Employee Peer Review,* dated 1/26/21 and 1/28/21 for Ms. Gould. Under the section, Weaknesses, the document dated 1/28/21, noted, “Needs to walk away from resident that upset her. Don’t argue with

them." On the document dated 1/26/21 in the same section, it reads, "Sometimes I feel she needs to walk away from [Resident J]. [Resident J] gets her very upset."

- *Disciplinary Record,* dated 5/23/24 for Ms. Snyder. This document indicated that Ms. Snyder was placed on a suspension pending the current APS investigation. It further noted that Ms. Snyder was interviewed on 5/23/24 and denied all allegations.

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 upon interviews conducted with Ms. Whaley, Ms. Johnson, Mr. Talaske, Ms. Heiler, Ms. Snyder, Ms. Barnes, Ms. Gould, Ms. Livermore, Resident A, Resident C, Resident D, & Resident E, as well as review of resident records and employee files for Ms. Snyder and Ms. Gould, there is sufficient evidence to indicate that Ms. Gould has not been treating residents with dignity and respect and ensuring their protection and safety in accordance with the provisions of the act. Ms. Gould admitted that she became involved in a disagreement with Resident A, in the dining room of the facility, which was observed by Ms. Johnson, confirmed by Resident A, and Resident C as another bystander to the event. It is noted that Ms. Gould placed hands on Resident A's walker and forcibly pushed backwards on Resident A's walker when Resident A was not complying with Ms. Gould's verbal request. Ms. Gould was provided a written disciplinary citation in her employee file for this incident and a violation of resident rights was cited above so no additional violation will be cited. Regarding the allegations surrounding Ms. Snyder physically abusing the residents, there is not substantial evidence to prove that these allegations are accurate. Ms. Barnes, who showers Resident G, with Ms. Snyder reported that she has never observed Ms. Snyder physically abusive toward any of the residents, including Resident G. The skin tear on Resident F's hand was not witnessed by any direct care staff members. Each direct care staff who reported about this skin tear was viewing this injury, after it occurred and had no clear idea of how this injury happened. Ms. Snyder denied causing this injury or having any knowledge of the injury. Even though there were witnesses who heard Resident F state, "It was you" to Ms. Snyder, the resident denied this incident when interviewed by Mr. Talaske and Officer Kuiawa. In terms of the incident in which Resident H hit her head on the doorframe of her bedroom while being transported by Ms. Snyder, it cannot be determined that Ms. Snyder intentionally or recklessly caused this incident to occur. When interviewed, Ms. Heiler reported that this was most likely an accident, and she felt it could have been avoided, but she did not think it was done maliciously by Ms. Snyder. After reviewing the evidence gathered during this investigation a violation has not been established regarding resident protection and safety as Ms. Gould was provided a written disciplinary action prior to this investigation and was previously cited in this report for a resident rights violation of resident dignity and respect, furthermore there was not a preponderance of evidence

	gathered to indicate that Ms. Snyder has been physically abusive to the residents at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

7/3/24

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Jana Lipps Date
Licensing Consultant

Approved By:

07/03/2024

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Dawn N. Timm Date
Area Manager