GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 13, 2024

Hersel Fouladbash
Rose Gardan Inc.
176 N. Main St.
Elkton, MI 48731

RE: License #:	AL320385433
Investigation #:	2024A0123051
	Rose Gardan, Inc

Dear Hersel Fouladbash:

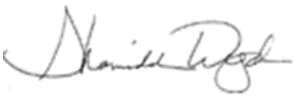
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL320385433
Investigation #:	2024A0123051
Complaint Receipt Date:	07/24/2024
Investigation Initiation Date:	07/26/2024
Report Due Date:	09/22/2024
Licensee Name:	Rose Gardan Inc.
Licensee Address:	176 N. Main St. Elkton, MI 48731
Licensee Telephone #:	(989) 553-2700
Administrator:	Chris Roth
Licensee Designee:	Hersel Fouladbash
Name of Facility:	Rose Gardan, Inc
Facility Address:	176 N. Main Elkton, MI 48731
Facility Telephone #:	(989) 553-2700
Original Issuance Date:	06/08/2022
License Status:	REGULAR
Effective Date:	12/08/2022
Expiration Date:	12/07/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
The staff ratio on third shift is 1 staff person to 21 residents.	No
One staff person is not able to provide all the necessary care for the residents at night.	Yes
Employees are using illegal drugs.	No
There are numerous medication errors every day.	No
The facility has one washing machine that's been sitting and leaking water for two months.	No

III. METHODOLOGY

07/24/2024	Special Investigation Intake 2024A0123051
07/26/2024	Special Investigation Initiated - Letter
07/26/2024	APS Referral APS referral completed.
07/31/2024	Inspection Completed On-site I conducted an unannounced on-site at the facility. Staff and residents were interviewed.
08/26/2024	Contact - Telephone call made I interviewed licensee designee Hersel Fouladbash.
08/26/2024	Contact- Document Sent I sent a follow-up email to LD Fouladbash requesting documentation.
09/09/2024	Contact- Document Received Requested documentation received via email.
09/09/2024	Contact- Telephone call made I interviewed staff Larisa Mauslof via phone.
09/09/2024	Contact- Telephone call made

	I made a follow-up call to staff Nancy Ligrow.
09/09/2024	Contact- Telephone call made I made a follow-up call to staff Alexandra Krull.
09/10/2024	Contact- Document Sent I sent an email requesting additional documentation.
09/12/2024	Contact- Document Received I received requested documentation.
09/12/2024	Contact- Telephone call made I interviewed manager Shelly Culp.
09/13/2024	Contact- Document Received I received requested documentation.
09/13/2024	Exit Conference I spoke with LD Hersel Fouladbash via phone.

ALLEGATION:

- **The staff ratio on third shift is 1 staff person to 21 residents.**

- **One staff person is not able to provide all the necessary care for the residents at night.**

INVESTIGATION: On 07/24/2024, the Bureau of Community and Health Systems received the above allegations. The written complaint also indicated that there are many residents who have sundowners that wonder at night. One staff is not able to provide all the necessary care for the residents when they are awake at night. There are residents that should be a two-person assist, but the facility refuses to make them a two-person assist. The facility is not documenting falls.

On 07/31/2024, I conducted an unannounced on-site at the facility. I interviewed staff Jessica Gibbard. Staff Gibbard stated she was hired to work third shift but has not worked third shift in about two weeks. Staff Gibbard stated that when the owner's other facility closed, the remaining residents moved into this facility. The facility used to have about 13 residents but is now at capacity with 20. Staff Gibbard stated that to her knowledge the facility has never been over capacity. Staff Gibbard stated that there are three to four staff working during the day and, and one staff on the night shift. Staff Gibbard stated that there is one full assist resident on hospice (Resident G), and Resident D may have dementia. Staff Gibbard stated that Resident G uses a wheelchair, Resident H uses a wheelchair, Resident B uses oxygen tank, and Resident A needs assistance pushing their wheelchair. Staff Gibbard stated that there may be residents who have sundowners but she is not sure. Staff Gibbard stated that Resident G and Resident H require brief checks every two hours, and

every hour staff are to do bed checks for everyone. Staff Gibbard stated that Resident F is full assist and needs assistance transferring to their wheelchair. Resident F cannot see well. Staff Gibbard stated that she does not think anyone requires a two person assist. Staff Gibbard stated that Resident A is not a two-person assist, but Resident A is over 300 lbs. Staff Gibbard stated that if Resident A were to have a fall, the facility would have to call EMT's for a lift assist. Staff Gibbard stated that Resident A has not had a fall at the facility, and Resident A can transfer on their own. Staff Gibbard stated that falls are documented on incident report forms.

On 07/31/2024, I interviewed staff Alexandra Krull at the facility. She stated that she works first and second shift, is a medication passer, and has worked in the facility for two weeks. She stated that there are about three to four staff that work on first and second shift. She stated that one or two staff work third shift. She denied having any knowledge of any residents with sundowners as she does not work third shift. She stated that she has not heard any resident complaints about personal care. She stated that incident reports are supposed to be filled out for falls. She denied any knowledge of incident reports not being completed. She denied that there are any residents who are currently a two-person assist. She stated there are only 20 residents in the home. She stated that if she worked third shift, she would not be able to evacuate all 20 residents timely if working alone. She stated that she would need assistance with Resident G (on hospice, wheelchair user) and Resident A (uses wheelchair, moves slowly). She stated that Resident F is blind.

On 07/31/2024, I interviewed staff Nancy Ligrow at the facility. Staff Ligrow stated that there are two staff on each shift, except third shift has one staff. Staff Ligrow stated that she has not heard anything about third shift not meeting resident care needs. Staff Ligrow denied having any knowledge of any resident having sundowners. Staff Ligrow denied that anyone is currently a two-person assist. When asked if anyone is a fall risk, she stated that Resident J does not pick up their feet. Resident J had a fall, was sent out to the hospital, and an incident report was completed a couple weeks ago.

On 07/31/2024, I interviewed staff Samantha Warchuck at the facility. Staff Warchuck stated that she works first shift and works only a couple days a week. Staff Warchuck stated that she never works third shift. She stated that there are 20 residents in the facility. Staff Warchuck stated that there are two care aides, a med passer, and nurse that work first and second shift, and there's one or two staff on third shift. Staff Warchuck denied having any knowledge of a lack of personal care being provided on third shift. When asked if anyone has sundowner's she stated that she believes Resident D and Resident G have dementia/Alzheimer's. Staff Warchuck denied any knowledge of any residents having any complaints of resident(s) wandering the facility. Staff Warchuck stated that if a resident requires a two-person assist, they cannot live here unless they decline to the point of hospice and are actively passing. Staff Warchuck denied having any knowledge of residents having falls recently. Staff Warchuck stated that incident reports are completed for falls, whether witnessed or unwitnessed.

On 07/31/2024, I interviewed Resident A at the facility. Resident A stated that everyone is willing to accommodate Resident A. Resident A stated that their personal care needs are being met. Resident A denied knowing how many staff work per shift, then stated that there is three to four staff during the day, and one or two at night.

On 07/31/2024, I interviewed Resident B and Resident C in their shared room. Resident B and Resident C stated that the facility meets their needs and are really helpful. They denied knowing how many staff work per shift. Resident C stated that staff are good with doing bed checks. Resident C stated that they had a fall and staff handled it well. They both denied having any issues with inadequate staffing.

On 07/31/2024, I interviewed Resident D at the facility. Resident D stated that their personal care needs are being met by staff. Resident D stated that they are mobile, and does not use a walker, and has no issues with falls. Resident D denied knowing how many staff work on third shift and denied needing personal care assistance on third shift.

On 07/31/2024, I attempted to interview Resident F. Resident F did not appear to be very cooperative with answering questions, but very bluntly stated that things are good, they like it in the facility, they have not complaints, and staff are meeting their needs. Resident F is legally blind.

On 07/31/2024, during my unannounced on-site visit, I observed multiple residents throughout the facility, and in the dining area of the home. Resident G was observed asleep on a recliner chair. Resident H was observed in their wheelchair in the hallway. Resident E was observed asleep as well. They appeared clean and appropriately dressed. No issues were noted.

During this on-site, I obtained a copy of the facility's staff schedule for 07/22/2024 thru 08/04/2024. There is one third shift staff person noted from 11:00 pm to 7:00 am each day.

On 08/26/2024, I interviewed Licensee Designee (LD) Hersel Fouladbash via phone. LD Fouladbash denied the allegations. LD Fouladbash stated that there are no residents in the home that require a two-person assist. Resident A is overweight, but there are three staff working during the day. Resident A is not a fall risk. LD Fouladbash stated that the residents are mostly independent. LD Fouladbash stated that from 11:00 pm to 6:00 am there is one staff on shift, and there are about three staff on during the day. LD Fouladbash denied ever having 21 residents. He stated that when residents "fall" it is usually more so them sliding out of their wheelchairs. LD Fouladbash stated that he writes each incident report and signs them.

On 09/092024, I interviewed staff Larisa Mauslof via phone. Staff Mauslof stated that there are currently 20 residents in the facility. Staff Mauslof denied that anyone

currently requires a two-person assist. Staff Mauslof stated that when there are falls, incident reports are completed, and phone calls are made.

On 09/09/2024 and 09/12/2024, I obtained requested documentation. A copy of the facility's *Resident Register* was reviewed. The *Resident Register* reflects that there are currently 20 residents residing in the facility.

A copy of the facility's staff schedule for 07/29/2024 through 09/01/2024 was reviewed. It shows that all but two shifts for the time period, had only one staff on shift between 11:00 pm and 7:00 am or 11:00 pm to 6:00 am.

Assessment Plans for AFC Residents and *Health Care Appraisals* were received and reviewed for Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, Resident H, Resident I, and Resident J.

Resident A's assessment plan, dated 08/30/2024, notes that Resident A uses a wheelchair and is unable to independently propel themselves long distance. Resident A requires stand by assistance when using their walker. Resident A cannot stand for long periods of time. Resident A needs assistance with most care needs except eating/feeding and grooming. Toileting assistance is on an as needed basis.

Resident A's *Health Care Appraisal* dated 09/12/2024, notes that Resident A is diagnosed with type II diabetes, schizophrenia, etc. Resident A's weight is approximately 300 lbs. Resident A uses a wheelchair and walker. The health care appraisal also notes that Resident A "*needs to increase ambulation. [Resident A] falls often & this could be improved with strengthening & weight loss.*"

Resident B's assessment plan, dated 08/28/2024, states Resident B cannot *Move Independently in Community*. Resident B needs assistance with their oxygen tank, has a slow gait, and is unsteady at times. For *Walking/Mobility* it notes that Resident B uses a rollator (i.e. rolling walker), uses oxygen 24/7, and needs assistance with standing when not in lift chair. Resident B needs some assistance with bathing, dressing as well.

Resident C's assessment plan, dated 08/17/2024, notes that for walking/mobility Resident C uses a rollator, refuses stand by assistance, and does not need assistance with walking/mobility. Resident C needs assistance with most care needs, but not with eating/feeding, personal hygiene (cueing only), and walking/mobility.

Resident D's assessment plan, dated 08/29/2024, notes that Resident D does not require assistance with walking. For toileting, Resident D needs assistance when they allow staff to assist. Resident D will hide soiled briefs. Resident D needs some assistance with personal care needs except eating/feeding, dressing, and walking/mobility.

Resident D's *Health Care Appraisal* dated 09/12/2024 states that Resident D is diagnosed with HTN, migraine, anxiety, and Alzheimer's. Resident D is fully ambulatory.

Resident E's assessment plan, dated 08/22/2024, notes that Resident E needs some personal care assistance with bathing, personal hygiene, walking (uses rollator, and cane). Resident E cannot move independently in the community.

Resident F's assessment plan, dated 08/19/2024, notes that Resident F requires assistance with all personal care needs, including toileting, and walking/mobility. Staff have to be a standby assist for guidance. Resident F uses a rollator. Resident F is legally blind per the assessment plan.

Resident G's assessment plan, dated 08/30/2024, notes that Resident G requires assistance with all personal care needs. Resident G is incontinent and is on hospice. For walking/mobility, it notes that Resident G uses a rollator with stand by staff assist for hands on guidance. Resident G uses a wheelchair and is unable to propel themselves. The assessment plan also notes that Resident G cannot move independently in the community and needs to use their rollator, with stand by staff assist for very short distance.

Resident G's *Health Care Appraisal* dated 09/11/2024, notes that Resident G is diagnosed with essential HTN, UTI, HLD, major depressive disorder, and arthritis. It notes that Resident G requires extensive assist w/ transfers and ambulation. Resident G uses a walker and wheelchair, and requires close monitoring to prevent choking, and frequent prompts.

Resident H's assessment plan, dated 08/26/2024, notes that Resident H cannot move independently in the community and uses a special wheelchair with back breaks. Resident H is dependent on staff for all personal care needs. The assessment plan notes that Resident H does not ambulate and uses the wheelchair for mobility. Resident H has a history of anoxic brain injury.

Resident I's assessment plan, dated 08/20/2024, states that Resident I cannot move independently in the community, needs guidance, a rollator at times, and needs supervision otherwise. Resident I requires assistance with all personal care needs except dressing. Resident I sporadically needs assistance transferring from sitting to standing. For toileting, Resident I needs peri care assistance.

Resident J's assessment plan, dated 08/17/2024, notes that Resident J requires some personal care assistance with 1:1 supervision for eating, bathing (stand by assistance), personal hygiene (cueing). Resident J can walk independently but the assessment plan states Resident J has "*slow shuffle gait, occ* (occasionally) *trips over feet. Dr* (doctor) *aware- P.T*. (physical therapy) *ordered- does not help*."

On 09/09/2024, I received copies of four *AFC Licensing Division- Incident/Accident Reports* that document falls that took place in the facility since March 2024 for Resident E, Resident F, Resident J, and Resident C. The incident report for Resident C dated 07/28/2024, notes Resident C tripped over Resident B's oxygen cord. No injuries were reported. Resident B was educated by staff on proper storage of their oxygen tubing. On 04/2/2024, Resident J had a fall. Ther were no injuries, but it is documented that three staff assisted Resident J to help Resident J get up. Resident J tripped over their shoes. Staff spoke with Resident J about keeping their shoes on the side of the couch, and not in front of them. The incident report for Resident F, dated 06/19/2024 notes that Resident F was found bleeding from the head. Blook was on the corner of the TV stand. Resident F reported tripping over their own feet. Staff called other staff for assistance. Pressure was applied to the injury, and an ambulance was called. Staff informed Resident F to ring the call button when assistance is needed, and to use their walker. Resident E's fall occurred on 03/23/2024. No injuries were reported. Resident E was found by staff after slipping out of bed and landing on their butt. Resident E slid to the hallway to get help. The corrective measures noted were staff speaking with Resident E about getting a rug, staff checking on Resident E more often, and helping Resident E to and from their room.

On 09/09/2024, I received copies of the facility's fire drills since January 2024. A fire drill done on 02/15/2024 at 6:18 am was completed by two staff and 13 residents, with an evacuation time of 3 minutes and 46 seconds. But it notes that they did not evacuate the building due to cold weather. A fire drill conducted on 04/23/2024 at 11:04 pm by two staff persons and 14 residents, had an evacuation time of 3 minutes and 38 seconds. Another third shift fire drill conducted on 08/28/2024, by two staff, with 17 residents participating, had an evacuation time of 4 minutes and 13 seconds. First and second shift fire drills conducted during this time frame had evacuations times of 4 minutes and 3 seconds or less, with three to five staff participating.

On 09/12/2024, I interviewed manager Shelly Culp. Staff Culp stated that she does not work as a direct care worker. Staff Culp stated that Resident D is the only resident with dementia. Staff Culp stated that Resident A would require a two-person assist if Resident A were to fall, or the facility would have to call an EMT for a lift assist. Staff Culp stated that Resident A has had one fall. Staff Culp stated that some staff are not physically strong enough to lift Resident A, as Resident A is over 300 lbs. Resident A can transfer to their wheelchair independently. Staff Culp stated that Resident G is on hospice. There are two residents who use amigos. Resident F is blind but uses a walker. Resident F tries to do things independently but cannot see well. Staff Culp stated that there are 20 residents in the home, and the facility has never been over capacity.

On 09/13/2024, I conducted an exit conference with LD Hersel Fouladbash via phone. I informed LD Fouladbash of the findings and conclusions. LD Fouladbash

stated that he will figure out a plan to address staffing on third shift. LD Fouladbush stated that they are ordering lift equipment for Resident A.

APPLICABLE RULE	
R 400.15105	**Licensed capacity.**
	(1) The number of residents cared for in the home and the number of resident beds shall not be more than the capacity that is authorized by the license.
ANALYSIS:	On 07/31/2024, I conducted an unannounced on-site at the facility. Staff Jessica Gibbard, staff Alexandra Krull, staff Samantha Warchuck were interviewed and denied the allegations. During the course of the investigation, I also interviewed LD Fouladbash, staff Larisa Mauslof, and staff Shelly Culp who all denied the allegations. On 09/09/2024, I obtained requested documentation. A copy of the facility's *Resident Register* was reviewed. The *Resident Register* reflects that there are currently 20 residents residing in the facility. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 07/31/2024, I conducted an unannounced on-site at the facility. I interviewed staff and residents. Staff Jessica Gibbard and staff Nancy Ligrow were interviewed. They reported that there is one staff person on third shift. Staff Alexandra Krull and Staff Samantha Warchuck stated that there is one to two staff on third shift. Staff Krull stated that she would be unable to evacuate all 20 residents if working alone on third shift.

	Resident A, Resident B, Resident C, Resident D, and Resident F were interviewed on 07/31/2024, and did not express any personal care concerns. During this on-site, I obtained a copy of the facility's staff schedule for 07/22/2024 thru 08/04/2024. There is one third shift staff person noted from 11:00 pm to 7:00 am each day. A copy of the facility's staff schedule for 07/29/2024 through 09/01/2024 was reviewed. It shows that all but two shifts for the time period, had only one staff on shift between 11:00 pm and 7:00 am or 11:00 pm to 6:00 am. On 09/09/2024, I received copies of the facility's fire drills since January 2024. Each fire drill conducted on third shift, was conducted by two staff persons, which is not reflective of the current staffing pattern for third shift, which is mostly staffed with one person. During the course of the investigation, I reviewed *Assessment Plans for AFC Residents* 10 residents. Multiple residents require a higher level of assistance with personal care needs including walking/mobility assistance, toileting, and transferring. Resident F is blind and requires full assistance with personal care needs. Resident G is on hospice and requires full assistance with personal care needs. Resident H and Resident I are dependent on staff for most or all personal care needs. It is documented that Resident B and Resident J have slow gaits. Resident D is diagnosed with Alzheimer's. Based on the interviews with staff, as well as review of documentation throughout the course of this investigation, including *Assessment Plans for AFC Residents*, *Health Care Appraisals*, *fire drills*, *Resident Register,* and *AFC Licensing Division- Incident/Accident Reports*, there is a preponderance of evidence to substantiate a rule violation for insufficient staffing on third shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Employees are using illegal drugs.

INVESTIGATION: On 07/31/2024, I conducted an unannounced on-site at the facility. I interviewed staff Jessica Gibbard. Staff Gibbard denied ever seeing anyone at work under the influence.

On 08/26/2024, I interviewed licensee designee Hersel Fouladbash via phone. LD Fouladbash denied the allegations. LD Fouladbash stated that he has not been informed of any staff doing drugs, and that he drug tests employees at hire.

On 09/09/2024, I interviewed staff Larisa Mauslof via phone. Staff Mauslof denied the allegations. Staff Mauslof stated that she has no concerns about any co-workers working under the influence of drugs.

On 09/09/2024, I conducted a follow-up call with staff Nancy Ligrow. Staff Ligrow denied the allegations. Staff Ligrow stated that she has no knowledge of any staff using drugs.

On 09/09/2024, I conducted a follow-up call with staff Alexandra Krull. Staff Krull denied the allegations. Staff Krull stated that a concern regarding staff using drugs has never been brought to her attention.

On 09/12/2024, I interviewed manager Shelly Culp. Staff Culp denied having any knowledge of any staff using drugs. Staff Culp stated that she is present in the facility five days per week.

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:	On 07/31/2024, I conducted an unannounced on-site at the facility. I interviewed staff Jessica Gibbard. She denied ever seeing anyone at working under the influence of drugs. During the course of the investigation, I also interviewed licensee designee Hersel Fouladbash, staff Larisa Mauslof, staff Nancy Ligrow, staff Alexandra Krull, and staff Shelly Culp who all denied having knowledge of the allegations. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There are numerous medication errors every day.

INVESTIGATION: On 07/31/2024, I conducted an unannounced on-site at the facility. I conducted the following interviews with staff and residents:

I interviewed staff Jessica Gibbard. Staff Gibbard denied having any knowledge of any medication errors.

I interviewed staff Alexandra Krull at the facility. Staff Krull stated that she works first and second shift, is a medication passer, and has worked in the facility for two weeks. Staff Krull denied any knowledge of any medication errors.

I interviewed staff Nancy Ligrow at the facility. Staff Ligrow denied having any knowledge of any medication errors.

I interviewed staff Samantha Warchuck at the facility. Staff Warchuck denied having any knowledge of medication errors.

I interviewed Resident A in their bedroom. Resident A stated that they received their medications daily, on time, and denied having any concerns.

I interviewed Resident B and Resident C in their shared room. They both denied having any concerns regarding their medications.

I interviewed Resident D at the facility. Resident D stated that they receive their medications daily, on time, and denied having any issues with medications.

I attempted to interview Resident F. Resident F did not appear to be very cooperative with answering questions, but very bluntly stated that things are good, they like it in the facility, they have not complaints, and staff are meeting their needs. Resident F is blind.

On 07/31/2024, during my unannounced on-site, I observed the medication stored in the medication carts, two medication administration books with all resident medication administration records for the month of July (each resident's record was reviewed), and a box full of new monthly medications. I was told since it was the last day of the month, the medication in the box were the changeover medications for the month of August. No issues were noted.

On 08/26/2024, I interviewed licensee designee Hersel Fouladbash via phone. LD Fouladbash denied the allegations.

On 09/09/2024, I interviewed staff Lisa Mauslof via phone. Staff Mauslof denied the allegations. Staff Mauslof stated that she is a medication passer and had no knowledge of any medication errors.

On 09/12/2024, I interviewed manager Shelly Culp. Staff Culp denied having any knowledge of medication errors.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 07/31/2024, I conducted an unannounced on-site. I interviewed staff Jessica Gibbard, staff Alexandra Krull, staff Nancy Ligrow, and staff Samantha Warchuck. During the course of the investigation, I also interviewed licensee designee Hersel Fouladbash, staff Lisa Mauslof, and staff Shelly Culp. They all denied the allegations. On 07/31/2024, I interviewed Resident A, Resident B, Resident C, Resident D, and Resident F. They denied having any issues with medications. During the unannounced on-site, I observed the locked medication carts, medications, and medication administration records. No issues were noted. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility has one washing machine that's been sitting and leaking water for two months.

INVESTIGATION: On 07/31/2024, I conducted an unannounced on-site at the facility. I interviewed staff Jessica Gibbard. She stated that there are three washing machines but one is down currently. She stated that the one was leaking, and staff are not using it.

On 07/31/2024, during my unannounced on-site, I observed the laundry room. The laundry room appeared clean. No visible leaking was found on the floor. Three washing machines were observed. One of the three had a sign that said do not use. There were two dryers. One washer and one dryer were actively in use.

On 07/31/2024, I interviewed staff Alexandra Krull at the facility. Staff Krull stated that she works first and second shift and has worked in the facility for two weeks. Staff Krull stated that there are no issues with the laundry room. Staff Krull denied seeing any leaks.

On 07/31/2024, I interviewed staff Nancy Ligrow at the facility. Staff Ligrow stated that she assists with laundry. Staff Ligrow stated that one washer machine is not working, but there has been no disruption with being able to do laundry. Staff Ligrow denied seeing any water on the laundry room floor.

On 07/31/2024, I interviewed staff Samantha Warchuck at the facility. Staff Warchuck stated that she has never seen any standing water in the laundry room, and that the facility has always had multiple washers and dryers.

On 07/31/2024, I interviewed A in their bedroom. Resident A stated that staff does their laundry and did not express any concerns about the laundry.

On 07/31/2024, I interviewed Resident B and Resident C in their shared room. They stated that staff does laundry about two times per week and there are no issues with the laundry.

On 07/31/2024, I interviewed Resident D at the facility. Resident D stated that the staff does their laundry.

On 07/31/2024, I attempted to interview Resident F. Resident F did not appear to be very cooperative with answering questions, but very bluntly stated that things are good, they like it in the facility, they have not complaints, and staff are meeting their needs. Resident F is blind.

On 08/26/2024, I interviewed licensee designee Hersel Fouladbash via phone. LD Fouladbash denied the allegations. LD Fouladbash stated that there are three washing machines in the facility. A new washer was purchased three weeks ago to replace the one with issues.

On 09/09/2024, I made a follow-up call to the facility. I interviewed staff Larisa Mauslof. Staff Mauslof denied the allegations. Staff Mauslof stated that she has not observed any water on the floor during her shifts since working at the facility.

On 09/12/2024, I interviewed manager Shelly Culp. Staff Culp denied the allegations. Staff Culp stated that a new washer was ordered.

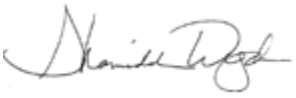
APPLICABLE RULE	
R 400.15404	**Laundry.**
	A home shall make adequate provision for the laundering of a resident's personal laundry.

ANALYSIS:	On 07/31/2024, I conducted an unannounced on-site at the facility. During this on-site, I interviewed staff Jessica Gibbard, staff Alexandra Krull, staff Nancy Ligrow, and staff Samantha Warchuck. They all denied the allegations. I interviewed staff Larisa Mauslof and staff Shelly Culp who denied the allegations as well. Resident A, Resident B, Resident C, and Resident D, and Resident F were interviewed and did not express any concerns regarding laundry. On 07/31/2024, during my unannounced on-site, I observed the laundry room. The laundry room appeared clean. No visible leaking was found on the floor. Three washing machines were observed. One of the three had a sign that said do not use. There were two dryers. One washer and one dryer were actively in use. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 09/13/2024, I conducted an exit conference with LD Hersel Fouladbash via phone. I informed LD Fouladbash of the findings and conclusions.

IV. RECOMMENDATION

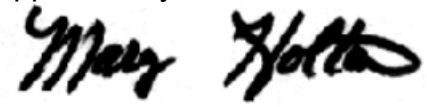
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home (capacity 1-20).



09/13/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



09/13/2024

Mary E. Holton Date

Area Manager