GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 19, 2024

Cori Sharrard
Lourdes Alz Special Care Ctr Inc
2400 Watkins Lake Rd
Waterford, MI 48328

RE: License #: AL630007360
Investigation #: 2024A0605037
Clausen Manor

Dear Cori Sharrard:

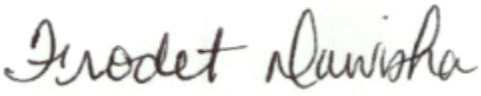
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd.
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Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007360
Investigation #:	2024A0605037
Complaint Receipt Date:	07/31/2024
Investigation Initiation Date:	08/01/2024
Report Due Date:	09/29/2024
Licensee Name:	Lourdes Alz Special Care Ctr Inc
Licensee Address:	2400 Watkins Lake Rd Waterford, MI 48328
Licensee Telephone #:	(248) 886-5830
Administrator/ Licensee Designee:	Cori Sharrard
Name of Facility:	Clausen Manor
Facility Address:	2400 Watkins Lake Road Waterford, MI 48328
Facility Telephone #:	(248) 886-5800
Original Issuance Date:	01/13/1995
License **Status:**	REGULAR
Effective Date:	02/01/2024
Expiration Date:	01/31/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A frequently attempts to escape the facility. Resident A was found by the lake five to six times.	No
Resident B has been neglected. He has a bottom issue that can be smelled from a long distance away.	No
Resident C and Resident D have had multiple falls, bruising on their faces and are not sent out to the hospital.	Yes
The facility smells and residents are having bowel movements everywhere.	No

III. METHODOLOGY

07/31/2024	Special Investigation Intake 2024A0605037
07/31/2024	APS Referral Adult Protective Services (APS) referral made
08/01/2024	Special Investigation Initiated - Telephone APS worker, Marcie Fincher called stating that the referral was assigned to APS worker John Cavanaugh
08/01/2024	Contact - Document Sent Email to APS worker John Cavanaugh
08/05/2024	Inspection Completed On-site Conducted unannounced on-site investigation
08/06/2024	Contact - Document Received Email from Cori Sharrard
08/22/2024	Contact - Telephone call made Interviewed direct care staff (DCS)
08/28/2024	Contact - Telephone call made Interviewed durable power of attorney (DPOA-C) of Resident C and left message for DPOA-D regarding Resident D
09/12/2024	Contact - Document Received Email from APS worker John Cavanaugh
09/18/2024	Contact - Telephone call made With Trinity Home Health Care (HHC)

09/18/2024	Contact - Telephone call made Discussed allegations with Resident D's DPOA-D
09/18/2024	Contact – Telephone call made With Resident B's DPOA-B
09/18/2024	Exit Conference Licensee designee Cori Sharrard with my findings

ALLEGATION:

- **Resident A frequently attempts to escape the facility. Resident A was found by the lake five to six times.**
- **Resident B has been neglected. He has a bottom issue that can be smelled from a long distance away.**
- **Resident C and Resident D have had multiple falls, bruising on their faces and are not sent out to the hospital.**

INVESTIGATION:

On 07/31/2024, intake #201873 was assigned for investigation. I initiated the special investigation by making a referral to Adult Protective Services (APS).

On 08/01/2024, I received an email from APS worker Marcie Fincher stating that John Cavanaugh was assigned this referral.

On 08/05/2021, I conducted an unannounced on-site investigation at Clausen Manor. Present were 19 residents, the licensee designee Cori Sharrard, direct care staff (DCS) Natalie Barkley, Erica Newbern, and Erica Crutcher. During this visit, Chief Executive Officer Richard Acho arrived at this facility.

I interviewed licensee designee Cori Sharrard regarding the allegations. Ms. Sharrard is a registered nurse (RN) and was appointed the licensee designee on 05/06/2024. Resident A was discharged from this facility on 07/31/2024 due to his multiple elopements from this facility. Prior to 05/06/2024, Ms. Sharrard was informed that Resident A went missing, police were contacted and found Resident A in the attic. There was a ladder in the storage room that Resident A climbed and got into the attic. Since that incident, a keypad lock was put on the storage door. The next incident occurred on 07/20/2024 when staff noticed Resident A was not inside the facility. Resident A left through bedroom #17 window. Around 5:30PM, dinner time Ms. Sharrard received a call from staff saying they cannot locate Resident A. Staff looked throughout the building and Resident A was not there. Police were immediately contacted, and Resident A was located lying down near the dumpster behind the building. Resident A was not injured. Resident A's bedroom was moved to an area where if Resident A got out, he would be in the courtyard that was fenced in. Ms.

Sharrard also implemented close monitoring of Resident A by all staff; staff to ensure Resident A is in the facility at change of shifts and every hour after change of shift, and staff to ensure that they are checking on resident's location more often if he is in his room. (Note: This is documented in Resident A's assessment plan completed on 07/15/2024 and updated on 07/21/2024.) On 07/29/2024, the housekeeper noticed that bedroom #4 window was opened and the locks on the window were broken. Resident A jumped the eight-foot fence and eloped. Staff contacted Ms. Sharrard asking her if Resident A was with her and she said, "No." Police were contacted, and Resident A was found behind the building. Resident A was not injured. Due to these incidents and with the protective measures in place, Resident A was still eloping, so an emergency discharge was given to Resident A's family. Resident A was taken to a Geri psychiatric hospital on 07/31/2024 and did not return to this facility.

Ms. Sharrard stated that Resident B has a super pubic catheter that goes through his abdomen. He was at a nursing home, but then was discharged from the nursing home to this facility with Trinity Home Health Care (HCC). Resident B was in and out of the hospital because of blood in his urine. His scrotum is six-seven times bigger than the normal scrotum. Resident B's son who is also the DPOA-B is an anesthesiologist in Florida and clashed with Trinity HCC, so Trinity stopped servicing Resident B. However, the nurse practitioner (NP) began seeing Resident B weekly and providing the medical care. Resident B has difficulty sitting properly in his wheelchair due to the enlarged scrotum, which is extremely uncomfortable. Ms. Sharrard discussed this with the NP who stated that Resident B could not go through surgery and to continue applying ointment to the scrotum, which staff are doing. The staff have been following all recommendations by the NP and the DPOA-B reported to Ms. Sharrard that he followed up with Resident B's urologist who told the DPOA-B that there will always be blood in the urine and due to the yeast infection in the scrotum area, the smell is because of the bacteria.

Ms. Sharrard reported that she received a call from staff early morning on 07/24/2024 advising her that Resident C fell. Staff got her up and sat her in a chair. Ms. Sharrard arrived at the facility and assessed Resident C. Resident C had a bump on her head. She is non-verbal. Ms. Sharrard viewed the camera in the common area and saw that Resident C was sitting in the recliner with her feet up. Then Resident C tried getting up from the recliner by scooting down towards the end and then the recliner flipped up and hit Resident C's head. Resident C seemed ok; however, she fell again a couple hours later as she tripped over another residents' wheelchair. Ms. Sharrard assessed Resident C, called Resident C's daughter who came to the facility and determined not to send Resident C out to the hospital. The next day, Resident C's face was swollen and bruised. (Note: I reviewed both incident reports (IRs) written for Resident C on 07/24/2024, at 8AM, staff documented "balance been off.") Medical treatment was never sought for Resident C.

Ms. Sharrard stated that Resident D has spasms and is a two-person assist with all personal care and transfers. On 07/30/2024, DCS Jontae Subber was getting Resident D ready for the day by herself instead of waiting for another DCS to assist her. Resident

A was sitting up in bed, Ms. Subber turned to grab something, and Resident D had a spasm, fell off the bed and hit her head. Resident D was “bleeding pretty good,” had two black eyes and bruising on her face. Ms. Sharrard assessed her and contacted Resident D’s husband who is also the DPOA-D who advised not to take her to the hospital unless her condition changes. Resident D was monitored and seemed ok. Medical treatment was not sought for Resident D.

On 08/05/2024, I interviewed DCS Natalie Barkley regarding the allegations. Ms. Barkley is the medication technician at this facility. She has been employed with this corporation since 09/2015. She works first shift from 7AM-3PM and is a part-time employee. Resident A has eloped two-three times but never during her shift. She has always heard about what happened after he eloped. The first time she heard that Resident A climbed a ladder in the storage room and was found in the attic. After that incident, a keylock pad was added to the door. The second time was on 07/20/2024, she heard he eloped and was found near a dumpster behind the facility and the third time was on 07/29/2024, he got out of the window and found again behind the facility. After his second elopement, supervision was increased by Cori Sharrard; check on Resident A during shift changes and more often when Resident A is not in direct sight. During the day shift, Resident A is usually out of his room, so it is easier for staff to supervise him; however, Resident A likes to be in his room during the afternoon shift and that is when he eloped. Resident A was discharged from the facility on 07/31/2024 because he still eloped after protective measures were implemented.

Ms. Barkley reported that Resident B has a catheter that is changed only by the urologist at the hospital. Staff are not required to change the catheter. Ms. Barkley denied there is a smell of urine from Resident B as she does not smell it nor has any other staff reported a smell of urine from Resident B. Other residents’ families are always visiting at this facility, and no one has complained. Resident B is obese and has skin folds, but staff always keep him clean.

Ms. Barkley stated that Resident C had fallen about two weeks ago when she was not present. She is unsure what happened but only knows that she fell and there was bruising observed on her face. She does not believe medical treatment was sought because the family did not want her to go to the hospital.

On 08/05/2024, I interviewed DCS Erica Newbern regarding the allegations. Ms. Newbern is full-time, works first shift from 7AM-3PM and has been here for six months. She was present on 07/20/2024 when Resident A eloped from this facility. On that day, she worked second shift from 3PM-11:30PM. During the shift change, DCS Jontae Subber told Ms. Newbern that Resident A had a behavior, was given his as needed medication, and was sleeping. Residents began eating dinner at 5PM. She thought Resident A was sleeping in his room when she did not see him at the dinner table around 5:20PM. Another staff member Jivanne Hillie went to check on Resident A, returned and said that Resident A was not in his bedroom. Staff searched the entire facility and could not locate Resident A. Ms. Newbern contacted Cori Sharrard who arrived at the facility with CEO Richard Acho. They viewed the cameras and called the

police. Officers arrived searched the facility and found Resident A behind the facility near the dumpster. He was not injured. Ms. Sharrard increased supervision after this incident. Staff must do checks during shift changes and increase checks when Resident A is not in direct sight. Ms. Newbern stated she would check on Resident A even if she was not responsible for him that day. On 07/29/2024, Resident A eloped again when she was not present. She heard he kicked the window out of someone else's bedroom and ended up in the courtyard. She does not know what happened afterwards. Resident A was discharged from this facility after that incident.

Ms. Newbern stated that Resident B has enlarged scrotum which is extremely uncomfortable for him to sit. His scrotum is being treated by the urologist and staff are told that nothing can be done for Resident B. Resident B has been having concerns with blood in his urine since before Cori Sharrard was licensee designee and since her arrival, Resident B has been receiving more care because Ms. Sharrard is a RN. There have not been any concerns about Resident B smelling or urine. No resident, no families and no other staff have complained about urine smelling from Resident B. Resident B is being cared for properly by all staff including Ms. Sharrard.

Ms. Newbern stated that she is aware of two residents' falling: Resident C and Resident D. She was not present when Resident C fell. She heard that Resident C was coming to breakfast, tripped over another residents' walker and hit her head. She is unsure if medical treatment was sought for Resident C. Ms. Newbern heard that Resident D fell out of bed when one of the staff was getting her ready for the day in the morning. Resident D is a two-person assist with all personal care, but DCS Jontae Subber was providing care by herself when Resident A had a spasm, fell out of bed and hit her head. Ms. Newbern stated that Resident A's husband who is the DPOA-D refused Resident A going to the hospital. She has no other information.

On 08/05/2024, I interviewed DCS Erica Crutcher regarding the allegations. Ms. Crutcher is part-time and works first shift from 7AM-3PM. She began employment with this corporation in 02/2024. She heard that Resident A eloped sometime in 03/2024 when she was not present. He found a ladder in the storage room, climbed it into the attic. She is unsure who found him. A keypad lock was added to the storage room door. On 07/20/2024, she was not working he eloped again. She does not know anything about that incident. Resident A's bedroom was moved to the courtyard so if he eloped, then he would not be able to leave the facility. However, on 07/29/2024, she heard he eloped again by "jumping the fence." Prior to this incident, supervision was increased for Resident A. Staff were to check on Resident A during shift changes, increase supervision when Resident A "appeared more active than usual," and redirection from him leaving the facility. Staff were following these protective measures, but he still eloped from the facility; therefore, he was discharged.

Ms. Crutcher stated that Resident B is wheelchair bound, has an enlarged scrotum that is infected. He has a catheter that is changed by his urologist at the hospital. Staff are required to clean him and apply an ointment prescribed by the NP and use yeast powder on him. Sometimes he does smell of urine, but he is being cleaned by staff. He

is large and has skin folds, so staff are always keeping his skin folds clean and dry. He is sent to the hospital whenever there is blood in his urine, but his son says, “it’s normal,” according to Resident B’s urologist. No one has complained about his odor nor his care.

Ms. Crutcher stated that Resident C fell during midnight shift. An IR was written regarding the fall that occurred around 6AM. Then Resident C fell again during first shift around 8AM when she tripped over a walker heading to breakfast. Cori Sharrard is a RN, so she assessed Resident C and took her vitals. Resident C had a “knot on her head,” from the previous fall but was not taken to the hospital. Resident C is ambulatory but her “balance is off.” There was bruising on her face. Management makes the determination if a resident is sent to the hospital or not. Ms. Crutcher was not present when Resident D fell out of bed. She came in the next day and was startled by the bruising on Resident D’s face. She had two black eyes. She heard that DCS Jontae Subber was getting Resident D ready for the day when Resident D fell out of bed. Resident D is a two-person assist, but Ms. Subber was providing care by herself. Ms. Crutcher does not know if Resident D was taken to the hospital or not.

On 08/05/2024, I interviewed the CEO Richard Acho regarding the allegations. The first elopement for Resident A was during the weekend. He climbed a ladder in the storage room. A keypad was put on the storage room door. After this incident, supervision was increased during shift change and every 30 minutes-one hours. On 07/20/2024, Resident A eloped again so an air tag was placed on Resident A’s hand that was agreed by his wife who is the DPOA-A. Additional cameras were added and window locks were also added since he had gotten out of the window. Resident A’s bedroom was moved to where the courtyard was so if he got out, he could not leave the facility. However, he eloped on 07/29/2024, by getting out of another resident’s window by breaking the window hinges and climbing out. Resident A somehow got over the fence and ended up next to the dumpster behind the facility. Mr. Acho stated there is a railroad and a lake nearby, so it was becoming a significant safety risk for Resident A to be at this facility; therefore, an emergency discharge was issued. Resident A was discharged on 07/31/2024.

Mr. Acho stated that Resident B has a catheter and a prostate issue. He has an enlarged scrotum. The son is aware of the condition and follows up with the urologist. Resident B is getting the care he needs at this facility and there has not been any complaints by Resident B, nor his son about his care.

Mr. Acho stated that it is the family’s decision for residents to be taken to the hospital after a fall or not. There are cameras in the residents’ bedrooms who have signed the consent and if there is a fall, then the desk phone rings, and management can view the camera to see how the resident fell and if the resident should seek medical treatment. Both Resident C and Resident D are older, and bruising is common after a fall, but Cori Sharrard who is a RN assesses them and speaks with the families who ultimately make the decision to have them sent out to the hospital or not.

On 08/05/2024, I attempted to interview Resident B, but was unable to due to his dementia. Resident B was in the sunroom area and appeared to have good hygiene. I did not smell urine coming from Resident B.

On 08/05/2024, I attempted to interview Resident C, but was unable to due to her advanced dementia. I observed yellowish bruising under her right eye, noise and left cheek.

On 08/05/2024, I attempted to interview Resident D, but was unable to due to her dementia. She was sitting in the sunroom. There was bruising under both eyes, forehead, and left cheek.

On 08/06/2024, I received an email from Cori Sharrard stating that after the incident on 07/20/2024 regarding Resident A, a 30-minute visual check was implemented but this was not something that was documented. In addition, Ms. Sharrard was working on some elopement management and prevention information to better educate the staff on resident elopement and to ensure that if a resident did elope that the staff had completed necessary training to know how to handle such an event. We also ensured we had a picture of the resident on hand, his name was in his clothing, the facility alarms are checked between each shift, and we were working with Geri Psych to change his medications as necessary. This was all in addition to what our Plant Operations Department had completed to secure the windows and move his room to be in the courtyard area. Ms. Sharrard also included Residents A, B, C, and D assessment plans and IRs. I reviewed the assessment plans and IRs.

On 08/22/2024, I interviewed DCS Tamika Cobb regarding the allegations. Ms. Cobb is the midnight supervisor that has been with this corporation since 05/2024. Resident A eloped three different times. He can read so the first time she was aware of him leaving the facility was on 07/20/2024 when he got out from the side door. He was found and brought back to the facility within minutes of him leaving. The second time he got out of the window. Ms. Cobb stated, “management did not do anything about it.” The last elopement he was found by the lake and then he was discharged. She had no other information to provide.

Ms. Cobb stated that Resident B “should have been in a skilled nursing because we’re not nurses.” His bottom and scrotum are “horrible.” She brought to Cori Sharrard’s attention there is blood in the urine, but Ms. Sharrard says, “the son does not want him out.” He smells horrible and needs more care than what staff can provide.

Ms. Cobb heard that Resident C fell in the open area off the recliner and hit her head. She was not taken to the hospital. Hours later she was walking to the breakfast area, her balance is off, so she tripped over another resident’s walker and fell again. Again, she was not taken to the hospital. She heard that Resident D fell but has no information about that fall.

On 08/22/2024, I interviewed DCS Arina Borja regarding the allegations. She works second shift from 3PM-11PM. She began employment with this corporation 06/2024 but had to quit after two weeks due to her grandmother being ill. Ms. Borja does not know who Resident A is as she was not there long enough to work with him.

Ms. Borja is familiar with Resident B and stated that she was trained on how to provide care to his bottom. She was advised to apply ointment which she did, and she and staff always made sure he was clean. He was being cared for properly and she did not receive any complaints from anyone regarding poor hygiene.

Ms. Borja stated no one has fallen during her shift; therefore, she has no information on Resident C nor Resident D.

On 08/22/2024, I interviewed DCS April Dunbar regarding the allegations. Ms. Dunbar is part-time workers day shift from 7AM-3PM and has been here for two-and-a-half years. Resident A has eloped about four times. The first time he was found in the attic, the second time she was sitting in her car, saw Resident A outside and immediately called staff who brought him back into the facility. The third time it was in the afternoon, she saw him at 3:30PM, but then around dinner time she could not locate him. He was outside near the railroad tracts. He was found and brought back to the facility. The last time he kicked out the window and was found behind the facility near the dumpster. Resident A was issued an emergency discharge and moved out on 07/31/2024. Some of the safety measures in place were keypad door locks on the storage rooms, locks on the windows, keep all bedroom doors closed, and extra supervision on Resident A. Even with these safety measures, he was eloping; therefore, the reason for the discharge.

Ms. Dunbar stated that she believes Resident B requires 24 hours of skilled nursing because of his catheter. He is a “heavy man,” and has skin folds so Ms. Dunbar does not think staff are qualified enough to provide care because “staff here are not nurses.” Ms. Dunbar reported that the catheter sometimes leaks so the nurse comes to the facility and fixes it. He gets changed and cared for by staff, but Ms. Dunbar again believes he needs skilled nursing.

Ms. Dunbar stated that Resident C fell “back-to-back.” DCS Tamika Cobb told Cori Sharrard that Resident C “needs to go to the hospital,” but Ms. Sharrard declined. Resident C’s face was bruised, and her balance was off, but no medical treatment was sought. Resident D fell face first and did not go to the hospital. Ms. Sharrard called Resident D’s husband who said, “do not send her out.” Ms. Dunbar was not present; she does not know how Resident D fell.

On 08/22/2024, I interviewed DCS Jontae Subber regarding the allegations. She works first shift from 7AM-3PM and has been with this corporation since 12/2023. She heard that Resident A eloped the first time when he got out of the window and then the second time was when he got out from another resident’s bedroom window. After he left the first time, supervision was increased to check on him during shift change and then more

often when Resident A was not in the common area. She stated after Resident A got out the last time, he was discharged from this facility.

Ms. Subber stated that Resident B should be in a skilled nursing facility because “we think he needs more care than what we can give him.” Ms. Subber stated that she and other staff (did not provide names) believe that Resident B needs a nurse to care for him. There was blood in his urine bag and his son told them that the urologist said, “it was ok.” She had no other information to provide.

Ms. Subber heard that Resident C fell but she was not present and does not know anything about it. She was providing care to Resident D the morning of 07/30/2024. She stated, “Resident D jerks sometimes in the morning,” so when I went to change her, I reached back to get a glove and she was sitting on the bed, then when I turned around, she jerked and fell out of bed and hit her head on the floor.” Cori Sharrard was called and came to check her. Blood was coming from the top of her forehead near the hairline. Gauze was put on her head, but management decided not to take her to the hospital. Ms. Subber stated that Resident D is a two-person assist but she thought she could provide care to Resident D by herself.

On 08/28/2024, I interviewed Resident C’s son who is DPOA-C regarding the allegations. DPOA-C was made aware of Resident C falling twice. Resident C is unstable and has fallen multiple times and during those times, she did not need to go to the hospital. On 07/24/2024, DPOA-C sister was contacted and went to the facility to see Resident C. Sister felt that Resident C did not meet the guidelines of being hospitalized. She did not have dilated pupils and although her face looked “bad,” DPOA-C did not feel seeking medical treatment was necessary; therefore, she refused the facility to have her taken to the hospital. DPOA-C stated she understood that staff wanted Resident C to go to the hospital, but DPOA-C questions if Resident A needs to go to the hospital every time she falls. DPOA-C does not have any concerns about the care Resident C receives at this facility.

On 09/12/2024, I received an email from APS worker John Cavanaugh. He will not be substantiating his case.

On 09/18/2024, I contacted Beth with Trinity HHC who stated that they have not provided services to Resident B for over a year.

On 09/18/2024, I contacted Resident B’s son who is the DPOA-B. He reported no concerns regarding his father residing at this facility. He is happy with the care Cori Sharrard is providing.

On 09/18/2024, I called Resident D’s husband who is also DPOA-D regarding the allegations. DPOA-D stated he was aware of the fall Resident D had on 07/30/2024 after he received a telephone call from Cori Sharrard. Ms. Sharrard assessed Resident D and advised DPOA-D her assessment and DPOA-D did not feel Resident D needed to go seek medical treatment based on Ms. Sharrard’s assessment. He did inform Ms.

Sharrard if there was any change in Resident D's behavior and/or condition then she can be taken to the hospital. He has no concerns with the care that is provided to Resident D at this facility.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and information gathered, Resident D's supervision and protection were not provided as defined in Resident D's assessment plan completed on 07/15/2024. According to the assessment plan, Resident D is a two-person assist with all care due to her spasms. On 07/30/2024, DCS Jontae Subber sat Resident D on the bed, turned around to grab a glove and Resident D had a spasm, fell off the bed and hit her head. Ms. Subber acknowledged that Resident D was a two-person assist, but stated she thought she could provide care by herself.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 and information gathered, Resident D's protection and safety were not attended to at all times by DCS Jontae Subber. Resident D had a spasm on 07/30/2024, fell and hit her head on the floor because Ms. Subber did not follow Resident D's assessment plan of a two-person assist with all care.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my investigation and review of IRs regarding Resident C, medical care should have been sought. Resident C's gait is unsteady. On 07/24/2024, Resident C fell around 6AM when the recliner she was sitting on flipped over her when she tried getting up. She was picked up off the floor and assessed with a" knot on her head," but no medical treatment was sought. Again, same day around 8AM, as Resident C was walking to breakfast, she tripped over another resident's walker, falling and injuring herself. Resident C was assessed by licensee designee Cori Sharrard who is also a RN. Ms. Sharrard contacted Resident C's daughter who arrived at the facility and declined to have Resident C go to the hospital even though this was the second time Resident C fell within a couple of hours of each other. According to the IR written at 8AM, it was noted that "Resident C's balance was off." Based on the balance being off and a knot on Resident C's head, there was an adverse change in her physical condition; therefore, medical care should have been sought.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility smells and residents are having bowel movements everywhere.

INVESTIGATION:

During the on-site investigation on 08/05/2024, I observed the facility to be clean. I also observed residents to have good hygiene. There was no smell or urine or feces in the facility. The facility's floors were clean, there were no stains on the floors nor the carpets. This facility has housekeeping that provides at least 35 hours per week of maintenance.

On 09/18/2024, I conducted the exit conference with licensee designee Cori Sharrard with my findings. Ms. Sharrard acknowledged the findings and stated that she has made changes to staffing; DCS Jontae Subber's employment was terminated, and she will be providing staff with additional training on assessment plans. She will be submitting a corrective action plan regarding these violations.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on my observations of this facility on 08/05/2024, this facility's housekeeping standards presented a comfortable, clean and orderly appearance. I did not smell urine or feces at this facility during my unannounced visit.
CONCLUSION:	VIOLATION NOT ESTABLISHED

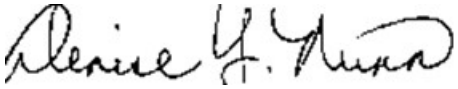
IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.

09/19/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



09/19/2024

Denise Y. Nunn Date
Area Manager