GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 17, 2024

Tonya Carter
c/o Matthew Sufnar
Encore McHenry
Suite 710
230 West Monroe
Chicago, IL 60606

RE: License #: AL630417058
Investigation #: 2025A0605001
The Courtyard at Auburn Hills 2

Dear Tonya Carter:

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.
Cadillac Place, Ste 9-100
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 #:	AL630417058
Investigation #:	2025A0605001
Complaint Receipt Date:	07/16/2024
Investigation Initiation Date:	10/01/2024
Report Due Date:	08/15/2024
Licensee Name:	Encore McHenry
Licensee Address:	Suite 710 230 West Monroe Chicago, IL 60606
Licensee Telephone #:	(248) 340-9296
Administrator/Licensee Designee:	Matthew Sufnar
Name of Facility:	The Courtyard at Auburn Hills 2
Facility Address:	3033 N. Squirrel Rd. Auburn Hills, MI 48326
Facility Telephone #:	(312) 623-0884
Original Issuance Date:	11/13/2023
License Status:	REGULAR
Effective Date:	05/13/2024
Expiration Date:	05/12/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was on the floor for three hours before staff found him and Resident B has a catheter and two different times it was full and leaked on the floor due to the facility being understaffed.	Yes
Resident A is being fed foods he cannot have.	No
The facility is dirty.	No

III. METHODOLOGY

07/16/2024	Special Investigation Intake 2025A0605001
07/16/2024	APS Referral Adult Protective Services (APS) made referral but will not investigate these allegations
10/01/2024	Special Investigation Initiated - Letter Email sent to licensee designee Tonya Carter
10/07/2024	Inspection Completed On-site Conducted announced visit
10/09/2024	Contact - Telephone call made Interviewed direct care staff (DCS) regarding allegations
10/10/2024	Contact - Telephone call made Interviewed DCS and home health care
10/16/2024	Contact – Telephone call made Attempted to contact licensee designee Mathew Sufnar, but the phone just rang to conduct exit conference.
10/16/2024	Exit Conference Conducted with licensee designee Tonya Carter

ALLEGATION:

Resident A was on the floor for three hours before staff found him and Resident B has a catheter and two different times it was full and leaked on the floor due to the facility being understaffed.

INVESTIGATION:

On 07/06/2024, intake 201694 was referred by Adult Protective Services (APS) regarding The Courtyard at Auburn Hills I. This investigation was initially assigned to licensing consultant Cindy Berry but then re-assigned to licensing consultant Frodet Dawisha on 09/30/2024.

On 10/01/2024, I emailed current licensee designee Tonya Carter advising her that I will be conducting an on-site investigation at the facility on 10/07/2024.

On 10/07/2024, I conducted an on-site investigation. I met with Tonya Carter who informed me that Resident A and Resident B reside at The Courtyard at Auburn Hills II, not at The Courtyard at Auburn Hills I. She refers to the buildings as “Cottages.” Resident A was discharged from Cottage II on 06/28/2024 and Resident B was discharged on 07/16/2024. I discussed the allegations with Ms. Carter. Ms. Carter took over as licensee designee on 08/01/2023. Resident A never had a virus during the time he resided at Cottage II. The only resident Ms. Carter is aware that had an illness that required quarantine was Resident C; however, Resident C was sent out to the hospital for diarrhea and at the hospital it was discovered he had C-DIF. This occurred this past 08/2024. Resident C remained in the hospital until his C-DIF cleared up and then was discharged back to Cottage II. There was a Covid outbreak beginning of 01/2024 in Cottage I only; however, all protocol was followed at Cottage I.

Ms. Carter stated that Resident A’s wife put a camera in Resident A’s bedroom when he lived at Cottage II. Resident A’s wife mentioned to Ms. Carter that the wife viewed the video and saw that Resident A had been sitting on the floor for three hours before staff arrived to help him off the floor. Ms. Carter requested to view the footage, but the wife never showed it to her. However, all staff were reeducated on conducting wellbeing checks of all residents every two hours. Ms. Carter does not believe that Resident A had fallen out of bed but stated that Resident A probably slid off the bed as he usually does when he sits in a chair. He had no injuries.

Ms. Carter stated that Resident B had a catheter since his admission into this facility on 03/14/2022. The only time the catheter was leaking was when staff were not closing it properly. As soon as Ms. Carter was aware of this issue, she reeducated staff on properly closing the catheter and ensuring the bag was emptied. However, staff have observed Resident B “fiddling,” with the catheter bag causing it to leak. Staff immediately close the back and call housekeeping to clean the fluid on the floor. An in-service was completed in 05/2024 to all staff. There were two instances close together

where the catheter leaked all down the hallway, but the carpet was cleaned by a professional company. The in-service was completed by the registered nurse at this facility and by Optimal Home Health Care (HHC). After the in-service, there were no issues with the catheter.

There are a total of 15 residents at Cottage II and Resident D who is bedbound is the only resident who is a two-person assist with a Hoyer lift for all his personal care needs and transfers. He is on hospice. Currently, there is only one direct care staff (DCS) per shift plus two floater staff which includes one medication technician staff between Cottages I and II. Ms. Carter stated she believed that having floater staff was sufficient to meet the requirements of Resident D being a two-person assist. The floater staff are readily available when the assigned staff at Cottage II contacts them for assistance with Resident D's care. Ms. Carter provided me with the last two months of the staff schedule. I reviewed August 2024 and September 2024 and both months only have one DCS assigned to Cottage 2 per shift and some days there is only one floating staff and other days there are two floating staff including a medication technician between Cottages I and II. Ms. Carter acknowledged there is insufficient staff at Cottage II per shift to provide for the needs of Resident D and all the other 14 residents with only one assigned DCS per shift. She stated she will reevaluate the staff to resident ratio and increase staff per shift.

Ms. Carter also observed the knot on Resident E's forehead and reviewed the communication book, but there were no notes by any staff member over the weekend regarding Resident E. Ms. Carter worked this past Friday and stated that the knot on Resident E's forehead was not present. The protocol is that if the incident is notable, such as the knot on the forehead, then it is documented on a skin assessment sheet, then the licensee designee must be contacted, complete an IR, and then notify hospice. Ms. Carter was never contacted by any staff member over the weekend. She could not locate the IR, but stated she was going to investigate and email me with the IR if found.

On 10/07/2024, I interviewed DCS LaDonna Whittaker regarding the allegations. Ms. Whittaker has worked for this corporation since 11/2023. She works first shift from 7AM-3PM. She is assigned as a DCS to Cottage II. There is only one DCS assigned per shift for Cottage II and one medication technician assigned for both Cottage I and II per shift. Sometimes there will be a floater staff also assigned for Cottage I and II. There are 15 residents at Cottage II. Resident A has never had a virus that she was aware of when he lived at Cottage II. She recalls residents getting the stomach flue as did Ms. Whittaker. There were signs put on the doors stating to wear masks, use gloves, and proper handwashing. This was sometime in either 06/2024 or 07/2024.

Ms. Whittaker was not on shift when Resident A was found on the floor in his bedroom. She heard about him on the floor but does not have any information regarding it. Whenever an incident occurs, it usually happens during the afternoon or midnight shifts. For example, she came in this morning and observed a "knot," on Resident E's forehead. The midnight shift staff never reported anything to her during the shift change. She did not see anything written in the staff communication log about the knot on his

head and it was not there after she completed her shift last week Thursday. Resident E cannot verbalize what happened due to his advanced dementia. The protocol is to write in the communication log, inform management, and then complete an incident report (IR). She is not sure if the IR was completed or if management was informed.

Ms. Whittaker reported that Resident B had a catheter that did leak but it was because the catheter would get wrapped in Resident B's wheelchair and get pulled out. She denied that staff were not properly closing the bag causing the urine to leak onto the floor. She stated that she always empties the bag and has never begun her shift and found the catheter bag full or found it leaking on the floor.

Ms. Whittaker reported that there are several residents at Cottage II whom she believes are a two-person assist; Resident D, Resident E, and Resident F require two DCS for transfers. Resident D has a Hoyer lift that requires two-DCS to operate and Resident E has a Sit to Stand lift that she believes requires two-DCS to operate also and Resident F who had recently fallen, broke her hip and is now wheelchair bound. Ms. Whittaker stated these residents become "dead weight," when only one DCS is transferring them or trying to provide care such as rolling them over for brief changes. Ms. Whittaker calls the medication technician, or the floater staff assigned to Cottage I and II for assistance whenever possible, but stated that sometimes it can take up to 10 minutes to receive help because that staff member is helping a resident in Cottage I.

On 10/07/2024, I interviewed DCS Rashard Moore regarding the allegations. Mr. Moore has been working for this corporation since 05/2024. He is a floating staff between Cottage I and Cottage II. He works day shift from 7AM-3PM. Mr. Moore reported that before 09/2024, there was always two DCS per shift at Cottage II and one floater, but then that changed to one DCS per shift and two floating staff which includes one medication technician between Cottage I and Cottage II. Mr. Moore never met Resident A but spoke briefly with Resident A's wife who reported to Mr. Moore that she placed a camera in Resident A's bedroom and found him on the floor for three hours before staff arrived to pick him up off the floor. Resident A's wife never showed him the video and has no other information. He never worked with Resident B and does not know anything about Resident B's catheter leaking.

Mr. Moore begins working at Cottage II, prepares breakfast and then goes to Cottage I and does the same. He stated, "sometimes it can get overwhelming," when the assigned DCS at both Cottages I and II call. Mr. Moore stated he has been called by DCS from Cottage II requesting assistance with Residents D, E, and F because they are a two-person assist and it can take him between 15-20 minutes to get there because he is assisting a resident in Cottage I. He has heard that other DCS are frustrated with this process because they must wait for the floater to finish up before they can get assistance. Mr. Moore reported that Resident E falls a lot, and he had a bed alarm and a hospital bed that is lowered but has no bed rails. He is not sure what happed to his forehead because he did not work this past weekend. He had no other information to provide.

On 10/07/2024, I interviewed medication technician Tiffany Bottorff regarding the allegations. Ms. Bottorff has been working for this new corporation since it was licensed last year but has been a total of four years at these Cottages. She is a floating medication technician between Cottages I and II. She works day shift from 7AM-3PM. Two months ago, there were two DCS per shift at Cottage II, but then it changed to one DCS per shift and two floaters which includes a medication technician between Cottage I and Cottage II. When she begins her shift, she starts with passing medication to Cottage II and then goes to Cottage I; however, she tries to help more at Cottage II because this is the memory care unit that requires more help with the residents. Ms. Bottorff believes the only resident that is a two-person assist is Resident D. She stated that Resident E and Resident F are a one-person assist with all their care and transfers. Ms. Bottorff does not know anything about Resident A having a virus. She does recall a stomach virus going around that many residents got it including staff, but that those residents were quarantined. However, given their dementia diagnosis it was difficult keeping those residents in their bedrooms. Hands washing was discussed as was wearing masks and gloves which staff followed. Ms. Bottorff does not recall Resident A falling out of bed or that staff did not pick him up off the floor for three hours. All staff are required to conduct wellbeing checks of all residents every two hours. In the past, Resident A has slid down from his bed and chair, but never fallen during her shift. When he slides down, he is not injured. She stated that he may have slid off the bed in between the two-hour checks.

Ms. Bottorff stated that Resident B's catheter leaked because of the wheelchair, not because staff did not close the bag properly. In addition, Resident B would move around a lot causing the bag to leak. When this happened, staff would immediately empty the bag and clean up any fluid that had leaked. She has never arrived at her shift and found the bag full.

Ms. Bottorff was not working this past weekend, so she is unsure how Resident E sustained the knot on the left side of his forehead. The protocol of any injury is to write it in the staff communication log, complete an IR and report to management. She is unsure if any of the following was completed by staff.

On 10/07/2024, I attempted to interview Resident E, but he was unable to carry a conversation due to his advanced dementia. I observed the knot on the left side of his head. It was the size of a quarter and appeared bruised. He was sitting in his Brode chair and appeared to be clean and dressed appropriately for the day.

On 10/07/2024, I attempted to interview Resident F, but she too was unable to carry a conversation due to her advanced dementia. She was sitting in her Geri chair and appeared to be clean and dressed appropriately for the day.

On 10/07/2024, I observed Residents G, H, and I sitting in the dining room ready to have lunch. They were clean and dressed appropriately for the day. Resident G did not

respond to any questions but Residents H and I both stated they are ok and that they liked living here.

Note: I reviewed Resident D's assessment plan completed on 03/12/2024 and it stated that Resident D is a two-person assist with toileting, dressing, personal hygiene, and is a one-to-one for feeding.

On 10/09/2024, I interviewed DCS Tierra Davis via telephone regarding the allegations. Ms. Davis has been working for this corporation since 08/2024. She works afternoon shifts from 3PM-11PM. She is an assigned staff and there is a floater staff that works during that shift too, but that floater works at both Cottages I and II. Ms. Davis started after Residents A and B were discharged so she has no information regarding them. She stated that Resident D and Resident F are two-person assists. Resident D requires two DCS to roll him over to change his briefs and for all transfers. About three-four weeks ago, Resident F had three falls and is now also a two-person assist with all personal care and transfers. Ms. Davis stated when she needs the floater to assist, she calls them, but if they are unavailable then she stated, "I make it happen because they have to be changed and we're short staffed."

On 10/09/2024, I interviewed medication technician Vanessa Hamilton via telephone regarding the allegations. Ms. Hamilton has only worked for this corporation for one-month. She works third shift from 10PM-7AM. Residents D and F are two-person assists so whenever they need to be changed the floater staff assists her. Since she has been at Cottage II, she never has had to call the floater because they were always present when she needed assistance.

On 10/09/2024, I interviewed via telephone Jantise Norris regarding the allegations. Ms. Norris has been working for this corporation since 01/2024. She works third shift from 10PM-7AM. She is assigned at Cottage II and there is a floater staff that works between Cottages I and II. When she began working for this corporation, there were two assigned staff members per shift plus a floater staff, but about a couple of months ago, it changed to one assigned staff per cottage plus two floater staffs between Cottages I and II. Resident A never had a virus, but there was a stomach virus that went around months ago. She cannot recall who was sick but stated that several residents and staff got it. Precautions were taken by wearing masks, gloves, and handwashing. Ms. Norris has never found Resident A or any other resident on the floor. Staff conduct wellbeing checks every two hours. Ms. Norris has never provided care for Resident B and does not know anything about the catheter bag leaking.

On 10/09/2024, I interviewed DCS Israel Williams via telephone regarding the allegations. Mr. Williams has been with this corporation for seven-months. He works day shift from 7AM-3PM. He works alone with one floater staff that goes between Cottages I and II. Residents D and F are a two-person assist at Cottage II with their personal care needs and transfers. When Mr. Williams needs help providing care for Residents D and F, he calls the floating staff for assistance. There are times when it can take up to 10

minutes before he receives help. Mr. Williams stated that Resident E has never fallen on his shift.

Mr. Williams does not recall Resident A having a virus but stated there was a stomach virus that went around months ago. Staff and residents caught the virus, but he is not sure who had it first. The residents were quarantined, and staff had to wear masks, gloves and frequent handwashing. Mr. Williams heard that Resident A fell but he never heard that Resident A was on the floor for three hours before staff helped him up. Mr. Williams stated that Resident B had a catheter bag that sometimes it was full but never leaked out. He would always empty the bag and close it properly.

On 10/09/2024, I interviewed DCS Shanice Watkins via telephone regarding the allegations. Ms. Watkins has been with this corporation for two years. She works second shift and there is only one DCS assigned to Cottage II plus a floating medication technician that goes between Cottages I and II. There are three residents who she feels are a two-person assist with their personal care needs and transfers: Resident D, Resident E, and Resident F. When she began working for this corporation there were two DCS per shift plus a floating staff, but then a couple of months ago, it changed to one DCS plus a floating staff between Cottages I and II.

Ms. Watkins never found Resident A on the floor, nor has she heard that he had fallen, and that staff did not find him on the floor until three hours later. She stated that staff are good with conducting wellbeing checks every two hours and more frequently for residents who are fall risks such as Resident A. Resident B had a catheter bag that never leaked during her shift but there were times when she arrived at her shift and found the bag full. She would empty the bag and always closed it properly. She never heard about the bag leaking on the floor.

On 10/09/2024, I received the IR from Tonya Carter regarding Resident E. The IR was dated 10/06/2024 by staff member Krista Smith. The IR stated, “I was doing rounds and noticed the nodule on Resident E’s head was more prominent than usual. Notified hospice. Hospice will follow-up.”

On 10/10/2024, I interviewed Resident E’s hospice registered nurse (RN) Derrick with All American Hospice. Resident E began hospice services about five weeks ago. He is a one person assist with the Sit to Stand Lift. Resident E has a history of falls. On 10/07/2024, Derrick visited with Resident E and discovered that Resident E had a knot, bruise on the left side of his forehead. The protocol was that staff must contact the hospice line whenever there is an injury. Derrick was the on-call hospice RN on 10/06/2024 when this incident allegedly occurred and stated that no one from Cottage II contacted him regarding Resident E. He saw Resident E on 10/07/2024 because that was the scheduled appointment. Derrick stated he recommended bed alarm for Resident E and a fall mat. He believes the fall mat has been placed near the bed and the staff requested a Brode chair because it reclines more and helps with fall prevention. Derrick suggested to call King Communications to find out if Cottage II called hospice on 10/06/2024.

On 10/10/2024, I contacted King Communications and spoke with Emily who stated she does not see any calls/messages on 10/06/2024 from any staff member at The Courtyard at Auburn Hills.

On 10/10/2024, I interviewed DCS Krista Smith via telephone regarding the allegations. She has been with this corporation for two years. Ms. Smith works the morning shift from 7AM-3PM on the weekends. She is a floating staff member between Cottages I and II. On 10/06/2024, around the end of her shift she was making her rounds she saw Resident E in his chair and noticed a nodule on the left side of his forehead. She stated, “I assumed it was a lump because he gets cream to put on there. He did not have any other injuries or bruising to indicate he had fallen.” Ms. Smith documented the IR and stated she Googled “All American Hospice,” and believed she called the right number but is now not sure since she is told that they never received a call. When she began working there were always two DCS per shift plus a floating staff between Cottages I and II. She stated after the change in staff per shift, it has been “more challenging,” because Resident D is a two-person assist. Ms. Smith must call the floating staff for assistance and sometimes when that staff is at Cottage I, helping another resident, there is a wait.

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:	Based on my investigation and information gathered, there is insufficient staff on duty at all times for the supervision, personal care, and protection of Resident D. According to Resident D’s assessment plan completed on 03/12/2024, Resident D requires two-person with his toileting, personal care and transfers but there is only one DCS working per shift with two floating staff between Cottages I and II. There are times when the floating staff are not at Cottage II because they are assisting residents or administering medications in Cottage I. I reviewed the staffing schedule for 08/2024-09/2024 and there are days when there is one DCS assigned for Cottage II with only one floating staff between Cottages I and II. Staff reported sometimes they must wait up to 20 minutes for assistance.
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 personal needs, including protection and safety are not attended to at all times because there is insufficient staff per shift. Resident D is a two-person assist with all his personal care, but there is only one DCS assigned at Cottage II to provide care to Resident D plus 14 other residents. Staff reported that sometimes it can take up to 20 minutes for the floating staff to assist them with Resident D.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is being fed foods he cannot have.

INVESTIGATION:

On 10/07/2024, I discussed the allegations with Tonya Carter. Resident A was never prescribed a special diet by his physician. I reviewed Resident A's health care appraisal dated 02/15/2024 completed by a physician who wrote, "none," under special dietary instructions and recommended caloric intake. However, Resident A's wife told Ms. Carter that Resident A cannot have beef and pork which was written in Resident A's assessment plan dated 03/25/2024. One time, the staff (unknown which staff) without realizing it gave Resident A hotdog. Resident A's wife reported diarrhea due to the hotdog. Since that incident, the cook always prepares chicken or some other protein when beef or pork are on the menu. There are times when Resident A will grab food off the cart, such as chocolate ice cream and eat it, but then the wife is upset and tells the staff that Resident A cannot have that even though Resident A has no dietary restrictions from his physician.

On 10/07/2024, I interviewed DCS LaDonna Whittaker regarding these allegations. Resident A does not have any special diet orders prescribed by his physician. However, Resident A's wife said, "no beef or pork," because it was causing "diarrhea." The cook always makes substitutions for Resident A, and she has never given Resident A beef or pork to eat and has never observed Resident A eat beef or pork.

On 10/07/2024, I interviewed Tiffany Bottorff regarding the allegations. Ms. Bottorff stated that Resident A did not have any special dietary requirements, but that his wife did not want him to have beef and pork. Ms. Bottorff does not recall any staff giving Resident A beef and pork and stated that the cook would make substitutions for Resident A if beef or pork was being served.

On 10/09/2024, I interviewed Jantise Norris regarding these allegations. Ms. Norris stated that Resident A was not prescribed with a special diet, but that his wife said not to feed him beef or pork. She stated sometimes she has caught Resident A in the kitchen taking food out of the fridge and has redirected him but that she nor any other staff have given him beef or pork.

On 10/09/2024, I interviewed Israel Williams regarding these allegations. Mr. Williams stated that Resident A never had a prescribed special diet; however, there was a log kept for the residents as to what they liked to eat or what they did not like. Resident A did not eat beef and pork, so he always received substitutions.

On 10/09/2024, I interviewed Shanice Watkins regarding these allegations. Ms. Watkins stated that Resident A was never fed any food that he was not supposed to have even though he was never prescribed with a special diet.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Based on my investigation and review of Resident A's health care appraisal dated 02/15/2024, Resident A was not prescribed with a special diet. However, Resident A's wife informed staff that Resident A cannot have beef or pork. All the staff denied that they have fed or served Resident A beef or pork and stated that Resident A gets substitutions when beef or pork are served.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility is dirty.

INVESTIGATION:

On 10/07/2024, I interviewed Tonya Carter regarding the allegations. Ms. Carter denied that the facility is dirty. She stated that housekeeping is always cleaning Cottage II. I

observed Cottage II to be clean. The carpet and flooring were clean. I did not smell an odor and all the residents I observed appeared to have good hygiene. There have not been any family members that have complained about Cottage II being dirty.

On 10/07/2024, I interviewed LaDonna Whittaker regarding these allegations. Cottage II gets cleaned and there have not been issues reported by anyone that Cottage II was dirty.

On 10/07/2024, I interviewed Tiffany Bottorff regarding these allegations. Cottage II gets cleaned daily and there have not been any concerns or complaints about Cottage II being dirty from anyone.

On 10/09/2024, I interviewed Vanessa Hamilton regarding these allegations. She too has never observed Cottage II dirty nor has anyone complained about it being dirty.

On 10/09/2024, I interviewed Jantise Norris regarding these allegations. Ms. Norris stated that Cottage II gets cleaned regularly and there have not been any concerns or complaints about it being dirty.

On 10/09/2024, I interviewed Israel Williams regarding these allegations. He too reported that there were no concerns with Cottage II being dirty and no one has complained to him.

On 10/09/2024, I interviewed Shanice Watkins regarding these allegations. Ms. Watkins reported no concerns, and no complaints received regarding Cottage II being dirty because it is always clean.

On 10/16/2024, left message conducting exit conference with Tonya Carter with my findings.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	During my on-site investigation on 10/07/2024, the facility was clean and in an orderly appearance. I did not smell urine, and the carpet and floors were clean.
CONCLUSION:	VIOLATION NOT ESTABLISHED

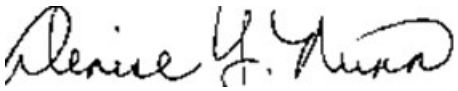
IV. RECOMMENDATION

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

10/17/2024

Frodet Dawisha — Date
Licensing Consultant

Approved By:



10/17/2024

Denise Y. Nunn — Date
Area Manager