GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 13, 2024

Sunil Bhattad
Drake Wood Manor Inc
1040 S. State Road
Davison, MI 48423

RE: License #: AL630280923
Investigation #: 2024A0991032
Caremore Assisted Living

Dear Sunil Bhattad:

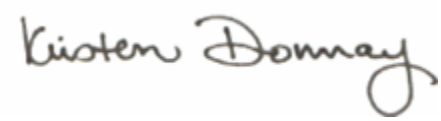
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630280923
Investigation #:	2024A0991032
Complaint Receipt Date:	09/10/2024
Investigation Initiation Date:	09/11/2024
Report Due Date:	11/09/2024
Licensee Name:	Drake Wood Manor Inc
Licensee Address:	1040 S. State Road Davison, MI 48423
Licensee Telephone #:	(248) 797-8519
Licensee Designee:	Sunil Bhattad
Name of Facility:	Caremore Assisted Living
Facility Address:	4353 W. Walton Blvd. Waterford, MI 48329
Facility Telephone #:	(248) 674-2658
Original Issuance Date:	08/21/2006
License Status:	REGULAR
Effective Date:	03/19/2024
Expiration Date:	03/18/2026
Capacity:	18
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
• Resident A fell and broke her hip because staff, Felicia Avis, reached for the bed remote and was not holding onto Resident A. • Staff yell and talk down to the residents. • Staff force the residents to go to bed so they can leave and go home early. Residents are left in bed. • Staff do not change the residents and ignore them when they need help. Resident D was left wet, and the staff did nothing despite being told about it. • One of the residents has wounds and is left in soiled blankets.	Yes Yes No No No
Staff, Angela Horton, hit Resident B in the face when putting her to bed. Angela will push Resident B in her wheelchair and let her hit the walls.	No
Staff, Amber Perkins, is smoking a weed pen and vaping in the house.	No
The facility is infested with cockroaches. They have been found in food, the refrigerator, and resident's briefs.	No
Additional Findings	Yes

III. METHODOLOGY

09/10/2024	Special Investigation Intake 2024A0991032
09/11/2024	Special Investigation Initiated - On Site Unannounced onsite inspection
09/11/2024	Inspection Completed On-site Interviewed home manager, staff, and residents
09/11/2024	APS Referral Sent complaint to Adult Protective Services (APS) Centralized Intake
09/11/2024	Contact - Document Received

	Assessment plan, hospital discharge
09/16/2024	Contact - Telephone call made To assigned APS worker, Jordan Walker
10/10/2024	Contact - Document Received Additional allegations received
10/11/2024	APS Referral Referred additional allegations to Adult Protective Services (APS) Centralized Intake
10/14/2024	Inspection Completed On-site Unannounced onsite inspection- interviewed home manager, staff, and residents
10/14/2024	Contact - Document Received Invoice from pest control company
10/14/2024	Contact - Document Sent Email to APS worker, Jordan Walker
10/29/2024	Contact - Document Received Additional allegations received
10/29/2024	Contact - Telephone call made To home manager, Amanda D'Amore
10/29/2024	Contact - Telephone call made To hospice nurse
10/29/2024	Contact - Telephone call made To Resident D's guardian
10/29/2024	Contact - Telephone call made To direct care worker, Felicia Avis
11/04/2024	Contact - Telephone call made To direct care worker, Amber Perkins
11/04/2024	Contact - Telephone call made Left message for direct care worker, Angela Horton
11/06/2024	Contact - Telephone call made To direct care worker, Angela Horton
11/07/2024	Exit Conference

	Via telephone with licensee designee, Sunil Bhattad

ALLEGATION:

- **Resident A fell and broke her hip because staff, Felicia Avis, reached for the bed remote and was not holding onto Resident A.**
- **Staff yell and talk down to the residents.**
- **Staff force the residents to go to bed so they can leave and go home early. Residents are left in bed.**
- **Staff do not change the residents and ignore them when they need help. Resident D was left wet, and the staff did nothing despite being told about it.**
- **One of the residents has wounds and is left in soiled blankets.**

INVESTIGATION:

On 09/11/24, I received a complaint alleging that a staff person at Caremore Assisted Living sat a resident on the edge of the bed with nothing to hold onto. The resident fell off the bed and broke their hip. I initiated my investigation by conducting an unannounced onsite inspection at Caremore Assisted Living on 09/11/24. I also made a referral to Adult Protective Services (APS) Centralized Intake on 09/11/24. The complaint was assigned to APS worker, Jordan Walker.

On 09/11/24, I interviewed the home manager, Amanda D'Amore. Ms. D'Amore stated that Resident A broke her hip on 08/11/24. She stated that she was not working at the time, but it was reported to her that staff, Felicia Avis, was transferring Resident A from her bed. Ms. Avis had Resident A sitting up on the edge of the bed. The bed remote got stuck in the bed, and Ms. Avis was trying to fix it. While Ms. Avis was fixing the bed remote, Resident A fell forward to the floor. Resident A is her own guardian and refused to be sent out to the hospital immediately following the fall. Her hip was hurting later that day, so she was sent to the hospital. It was found that she had fractured her left hip. Resident A had surgery and returned to the home on 08/14/24. Ms. D'Amore stated that staff are now required to use a Hoyer lift every time they transfer Resident A. Resident A is fully wheelchair bound and requires assistance with transfers. The Hoyer lift was previously ordered as a PRN on an as needed basis, but Resident A could also be transferred with a one person assist. Ms. D'Amore stated that for safety reasons, they are only using the Hoyer lift now.

On 09/11/24, I interviewed Resident A. Resident A stated that a few weeks ago, she fell off her bed and broke her hip. Staff, Felicia, was helping her transfer out of bed. She swung her feet over the side of the bed, but then she got dizzy and fell over because she didn't have anything to hold onto. She stated that it was an accident, because Felicia turned around to look at the remote for the hospital bed. While Felicia was reaching for the remote, she let go of Resident A. The bed rail was down, so Resident A could not hold onto anything. She fell over and hit the side of her mouth and her hip.

Resident A stated that she was “mad as hell” when it happened. She stated that it was like a “drunk driving accident. It was an accident, but it could have been prevented.” Resident A stated that this happened around 11:00am. She did not want to go to the hospital at first, but she went around 6:00pm. Resident A stated that she needed surgery and had two screws put into her hip because it was broken. She is receiving physical therapy now. She stated that the home manager, Amanda, made it a rule for staff to use the Hoyer lift when they transfer her now. She feels safer being transferred with the Hoyer lift.

On 09/11/24, I interviewed direct care worker, Angela Horton. Ms. Horton stated that she has worked at Caremore Assisted Living for three years. She stated that she was working the afternoon shift on the day that Resident A fell out of bed. She stated that Resident A fell during the morning shift when Felicia was working, but she refused to be sent to the hospital. Ms. Horton could not recall the details of how Resident A fell. She stated that Resident A got up for dinner around 5:00pm, but then went back to bed. Ms. Horton was changing Resident A in her bed and asked Resident A to roll over. Resident A started complaining that she felt weird. Ms. Horton asked her if she felt pain in her hip. She pressed on Resident A and touched her lower backside lightly. Resident A told her that it really hurt. Resident A told her that she does not like hospitals and did not want to be sent out. Ms. Horton stated that she contacted the home manager, and they called Resident A’s son who told Resident A that she should have gone to the hospital earlier. They called an ambulance, and Resident A was sent to the hospital around 6:00pm.

On 10/29/24, I interviewed direct care worker, Felicia Avis. Ms. Avis stated that she has worked in the home for three years. She stated that she was on shift by herself when Resident A fell. Ms. Avis stated that she was getting the residents ready for lunch around 11:15am. She went into Resident A’s room to get her up for lunch. Another worker likes to wrap the remote control for Resident A’s hospital bed around the bed rail. She was having trouble pushing the bed rails down, so she was trying to undo the remote control. Resident A was sitting on the edge of the bed, holding onto the sides of the bed. While Ms. Avis was untangling the remote, Resident A slid off the bed and onto the ground. Ms. Avis stated that Resident A did not really fall, as she just slid off the side of the bed. Ms. Avis had her had in front of Resident A, but she was not holding onto her. Ms. Avis picked up Resident A from the floor and put her in her wheelchair. She took her vitals and wrote an incident report. Resident A is her own guardian and did not want to be sent out to the hospital. Later that day, Resident A was complaining about pain. Staff called the home manager, and they convinced Resident A to go to the hospital. Ms. Avis stated that staff are now required to use a Hoyer lift every time they transfer Resident A. Prior to the fall, staff could transfer Resident A as a one person assist. Ms. Avis stated that Resident A is dead weight, so it is difficult to transfer her.

I reviewed the hospital after visit summary from Trinity Health Oakland Hospital. It notes that Resident A was hospitalized from 08/12/24-08/14/24 and had surgery for a hip fracture (left, closed). I reviewed a copy of Resident A’s assessment plan dated

07/06/24. It notes that Resident A has physical limitations and requires “max assistance” with toileting, bathing, dressing, and personal hygiene. The assessment plan notes that Resident A is unable to walk and uses a wheelchair and Hoyer lift. Resident A’s assistive devices include a hospital bed, bed rails, wheelchair, Hoyer lift, and transfer board. Resident A’s health care appraisal dated 09/06/24 notes that Resident A is non-mobile and requires max assistance. It states that she is a high risk for falls. Resident A had an assistive device authorization on file signed by a nurse practitioner, which notes she utilizes a manual wheelchair, hospital bed with rails, and a Hoyer lift (PRN).

The complaint also alleged that staff yell and talk down to the residents. Staff force the residents to go to bed so they can leave and go home early. They leave residents in bed. Staff do not change the residents and ignore them when they need help. On 10/25/24, I received additional allegations that Resident D was left wet on 10/16/24, and the staff did nothing despite being told about it. The complaint also stated that another resident has wounds and is left is soiled blankets.

On 09/11/24, I interviewed the home manager, Amanda D’Amore. Ms. D’Amore had no knowledge of staff yelling or talking down to the residents. She stated that they currently have eight residents in the home, and they typically have two staff per shift. There are times when there is only one staff person on shift. She stated that the staff do not yell or talk down to the residents when she is in the home. She stated that all of the staff have been working at the home for a while, and she trusts them. Ms. D’Amore stated that Resident A sometimes complains about the staff if she does not get something fast enough, but usually Resident A is the one yelling at staff. None of the other residents have complained about staff to her.

Ms. D’Amore stated that the residents typically stay up until 8:00 or 9:00pm. Resident E is on hospice, so he goes to bed earlier. She was not aware of any residents being forced to go to bed early so that staff could leave. Ms. D’Amore stated that the residents are typically up during the day, and they are not left in bed. Resident A and Resident C prefer to be in bed, so they will ask to go back to bed after breakfast and lunch. This is their choice, and the staff would get them out of bed if they asked. Ms. D’Amore stated that she gets Resident A out of bed for all of her meals. She was aware of one time that staff informed her Resident A stayed in bed for a meal. Ms. D’Amore instructed staff that they are to get Resident A out of bed for all meals unless Resident A refuses. Ms. D’Amore stated that Resident C prefers to stay in bed and gets her meals in bed. She has a skin condition, so it is more comfortable for her to be in bed. If she wants to get up, staff will get her out of bed.

Ms. D’Amore stated that staff change the residents every two hours or more often if needed. She was not aware of anyone being ignored or being left wet.

On 09/11/24, I interviewed direct care worker, Angela Horton. Ms. Horton stated that the residents are not forced to go to bed. They typically get up early, so they are usually

ready for bed between 8:30pm-9:15pm. If any of the residents wanted to stay up later, they could. She was not aware of any staff forcing residents to go to bed so they could leave early. Ms. Horton was not aware of any residents being forced to stay in bed all day. She stated that Resident C likes to stay in bed and is the only resident who gets her meals in bed. Resident A refuses to get up sometimes, but she typically gets out of bed for her meals. Ms. Horton stated that she has never yelled or talked down to any of the residents. She was not aware of any other staff doing so either. She stated that some of the residents are hard of hearing, so you must speak loudly. Ms. Horton stated that she changes the residents every one to two hours or more often if needed. She stated that she usually knows when they are wet or if they had a bowel movement. She felt all staff followed this protocol and was not aware of any time when a resident was not changed. Ms. Horton stated that the residents are well taken care of, and she did not have any concerns about any of the staff in the home.

On 09/11/24, I interviewed Resident A. Resident A was in her bedroom lying in bed. Resident A stated that if she wants to get up, staff will get her out of bed. She stated that the home manager, Amanda, makes staff get her out of bed. Resident A stated that staff sometimes talk down to her, but she could not give any examples or additional information. Resident A stated that she cannot stand to be wet, so staff change her often.

On 09/11/24, I interviewed Resident B. Resident B stated that staff sometimes pick on her. They do not yell, but they talk down to her. She could not provide any additional information about which staff do this or what they say. Resident B stated that staff change her often and do not leave her sitting in a wet or soiled brief. She stated that staff do not leave the residents in bed or force them to go to bed. She typically goes to bed at 9:00pm. She never asked to stay up later.

On 09/11/24, I interviewed Resident C. Resident C was in her bedroom lying in bed. Resident C stated that she did not have any concerns about the home, and she was receiving good care. She stated that sometimes staff get her out of bed, but usually she prefers to stay in bed. She stated that if she wants to get out of bed, staff will get her up. Resident C stated that she has a wound, so it feels better to lie down. Resident C stated that staff change her every two or three hours, or more often if she asks for help. Resident C stated that staff do not yell or talk down to her. Staff usually treat her well.

During the onsite inspection, I observed Resident D, Resident E, Resident F, and Resident G sitting in the living room area of the home. The residents have dementia and were unable to participate in an interview due to limited cognitive and verbal abilities. They appeared to be well-groomed and had good hygiene. I did not observe any odors in the home.

On 10/10/24, I received additional allegations alleging that staff, Angela Horton, is always screaming at Resident B. On 10/14/24, I conducted an unannounced onsite inspection. I interviewed Resident B. When asked if staff yell at her, Resident B said, “I

can’t say no to that.” She stated that she did not wish to elaborate and would like to keep her complaints to herself. She would not say who yells or what they say. She stated that she feels safe in the home.

On 10/14/24, I interviewed Resident A. Resident A stated that staff yell always at her and Resident B. She did not want to provide additional information.

On 10/14/24, I interviewed Resident C. Resident C stated that staff yell at Resident B a lot. She stated that Resident B can be uncooperative and staff yell at her tell her that she will have to go to her room if she keeps acting like that. Resident C stated that she did not wish to go on record about which staff yell.

On 10/29/24, I interviewed Ms. D’Amore regarding the new allegations that Resident D was left wet, and another resident has wounds and is left in soiled blankets. Ms. D’Amore stated that she had not heard any complaints about Resident D being left in a wet brief. She stated that Resident D is diabetic, so she urinates frequently. She is changed at least every two hours or more often if needed. She stated that staff could change Resident D, and she would be soaked a half an hour later. Ms. D’Amore stated that Amber Perkins and Angela Horton were on shift on 10/16/24 when it was alleged that Resident D was wet. She stated that Resident D has a lot of visitors who come to the home. Staff, Felicia Avis, told Ms. D’Amore that Resident D had a friend who was visiting, and she stated that the friend was acting different towards staff and was complaining about Resident D’s hair looking dirty. Ms. D’Amore stated that Resident D’s son-in-law is coming to the home tomorrow to do her hair, as it is difficult for staff to do because of her hair type. She stated that Resident D is showered twice a week and is never dirty. None of Resident D’s family or friends have voiced any complaints to her, and she is in regular contact with Resident D’s family members.

Ms. D’Amore stated that Resident C does not have wounds, but she has a skin condition which sometimes leaks and soaks her sheets. She stated that staff change her sheets regularly and she was not aware of Resident C or any other resident being left in soiled sheets.

On 10/29/24, I interviewed Resident C’s hospice nurse from Harmony Cares. The nurse stated that Resident C has a skin condition called bullous impetigo, which causes large fluid filled blisters to form on her hips and private areas. She stated that Resident C is receiving continuous antibiotics to treat this, and the doctor thinks it may be an autoimmune condition. The nurse stated that staff change Resident C’s bandages on a daily basis, except for on the days when hospice staff comes out twice a week. The hospice aides also bathe Resident C twice a week. The hospice nurse stated that staff at Caremore Assisted Living are following Resident C’s care plan. She did not have any concerns about Resident C not being changed or being left in soiled blankets. The hospice nurse stated that Resident C typically stays in bed, because she wants to stay in bed. It is more comfortable for her due to her skin condition, as it can be painful for her to sit in a chair. The hospice nurse stated that there are no concerns that staying in

bed is causing any wounds, as Resident C can move around in bed. Staff would get her up if she wanted to be out of bed. The hospice nurse stated that she visits many facilities, and Caremore is one of the better facilities as far as patients getting the care they need. She stated that she also sees Resident E and Resident F, who are receiving hospice services as well. She did not have any concerns regarding their care. She stated that the residents are being changed regularly. The home manager contacts hospice immediately if there are any concerns about UTIs or other issues. She stated that the residents appear to be well cared for. She never observed staff yelling or talking down to the residents while she was visiting the home.

On 10/29/24, I interviewed Resident D's guardian. Resident D's guardian stated that he felt staff at Caremore Assisted Living are doing a pretty good job in caring for Resident D. He stated that he goes to the facility quite often and does not have any concerns. The home manager oversees everything and contacts him if there are any issues. He stated that staff change Resident D frequently, and he did not have any concerns about her sitting in a wet brief. He stated that he provides briefs for Resident D, and he felt staff were probably changing her too much rather than not enough, at the rate they are going through briefs. He stated that Resident D is showered regularly and always appears clean. There are never any odors at the facility. He stated that the other residents in the home are typically up and sitting in chairs when he visits the home. He never observed any staff yelling or talking down to the residents. He stated that on one occasion, staff were arguing and yelling between each other, but it was not directed at the residents. He stated that he did not believe that staff worked in the home anymore.

On 10/29/24, I interviewed direct care worker, Felicia Avis. Ms. Avis stated that she has never heard of any staff yelling or talking down to the residents, and she has never yelled or talked down to them. The residents have never complained about this to her. Ms. Avis stated that the residents typically get out of bed every day, with the exception of Resident C, who does not like to get out of bed. She stated that Resident A also likes to stay in bed, but they get her up for meals. She was not aware of anyone being forced to go to bed so staff could leave. She stated that the residents typically go to bed around 8:30-9:00pm, but they could stay up later if they wanted to, as nobody forces them to go to bed. Ms. Avis stated that one of Resident D's friends complained to her last week that when they visited the home on the previous Wednesday, Resident D was soaking wet and looked dirty. The friend stated that she asked staff to help her, but they ignored her. Ms. Avis stated that she never observed any of the residents being left in wet briefs on her shift. She stated that the midnight staff typically has all of the residents up and changed before she comes in for her shift. She changes the residents every two hours or more often if needed.

On 11/04/24, I interviewed direct care worker, Amber Perkins. Ms. Perkins stated that she has never observed staff yelling or talking down to the residents. She stated that on one occasion, Resident B was yelling and screaming at staff, Veila. She was in the other room and did not know why Resident B was yelling. When she asked her later,

Resident B could not tell her why she was yelling. Ms. Perkins stated that the home manager told her that Resident B sometimes screams and has outbursts, but she had never observed this before. She did not observe Veila being verbally or physically aggressive towards Resident B. Ms. Perkins stated that she has worked shifts with Angela Horton. She never observed Angela Horton screaming or yelling at Resident B or any other resident. Ms. Perkins stated that she was not aware of any residents being forced to go to bed so staff could leave early. She stated that Resident E goes to bed early, because he wakes up early. He typically falls asleep in his chair, so staff will put him to bed. The other residents usually go to bed on their own around 8:00-9:30pm. If they wanted to stay up later, they could. Ms. Perkins stated that she was not aware of any residents being neglected or left to sit in wet briefs. She stated that they change the residents every two hours or more often if necessary. Ms. Perkins stated that Resident D did have friends visit a couple of weeks ago. The visitors were really nice while they were at the home. They hugged and prayed over the staff. She stated that Resident D was not wet when they were visiting the home, but Resident D could be changed and then be wet within the next thirty minutes or hour. She stated that the visitors did not raise any concerns. Ms. Perkins stated that Resident D had another visitor who said she was dirty because her hair was not done. Ms. Perkins stated that they shower Resident D regularly and she is always clean, but her family comes in to braid her hair. Ms. Perkins stated that she was not aware of anyone with wounds being left in soiled sheets. Resident C has a skin condition, but her pads and sheets are changed daily. She stated that some of the sheets are permanently stained, but they are clean. She stated that Resident C is never left wet, and she is well taken care of. Ms. Perkins did not have any concerns about any of the staff in the home mistreating or neglecting the residents.

On 11/06/24, I interviewed direct care worker, Angela Horton. Ms. Horton stated that she does not yell or scream at Resident B. She stated that Resident B is hard of hearing, so you have to talk loud for her to hear, but she does not yell or scream. Ms. Horton stated that she was working with Amber Perkins on 10/16/24. Resident D had visitors who came to the home after dinner to see her. Ms. Horton stated that they always change the residents and put them in their pajamas after dinner. Amber Perkins had just changed Resident D when the visitors arrived. One of the visitors told Ms. Perkins that Resident D was soaking wet and smelled horrible. Ms. Perkins told the visitor that she had just changed her a few minutes ago. The visitor did not like that response and turned around and yelled that Resident D was soaking wet. Ms. Horton stated that she also told them Resident D had just been changed. She stated that she did not smell any odor on Resident D. Resident D has health issues and urinates frequently, so staff can change her, and she will be wet again a few minutes later. She stated that the visitors were not at the home for more than 30 minutes. All of the residents are changed every two hours or more often if they are wet. Ms. Horton stated that Resident D was changed and clean during the visit. Ms. Horton stated that Resident C sometimes refuses to be changed, but she can usually redirect her. She stated that Resident C’s blisters do leak onto her sheets, but staff change them as

needed, which is usually every day. She stated that Resident C is not left in soiled sheets. She did not have any concerns about the care of the residents in the home.

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 the information gathered through my investigation, there is sufficient information to conclude that Resident A's safety and protection was not attended to at all times. Resident A requires full assistance while transferring from bed. On 08/11/24, direct care worker, Felicia Avis, got distracted and let go of Resident A while she was transferring her out of bed in order to untangle the cord of the bed remote. While Ms. Avis was untangling the remote cord, Resident A did not have anyone to hold onto and she slid from the bed onto the floor, causing her to break her hip. Staff did not follow the proper procedure to safely transfer Resident A from bed when they let go of Resident A to fix the remote. There is insufficient information to conclude that staff force the residents to go to bed so they can leave early. All of the staff stated that the residents typically go to bed between 8:00pm-9:30pm, but they could stay up later if they wished. None of the residents stated that staff force them to go to bed or stay in bed. Resident A and Resident C like to stay in bed, but they stated that staff get them up if they want to get out of bed. There is insufficient information to conclude that staff do not change the residents and ignore them when they need help, or that Resident D was left wet, and the staff did nothing despite being told about it. All of the staff stated that they change the residents every two hours or more often if needed. They were not aware of any residents, including Resident D, being left wet. Resident D is diabetic and urinates frequently. Her guardian did not have any concerns about the care she is receiving in the home. There is insufficient information to conclude that one of the residents has wounds and is left in soiled blankets. Resident C has a skin condition, which can seep through her bandages and onto her blankets. Staff all stated that they change Resident C's

	sheets regularly. Resident C is never left wet or soiled. Resident C's hospice nurse did not have any concerns about the care staff are providing at the home to Resident C or the other residents in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse.
ANALYSIS:	There is sufficient information to conclude that staff did not treat the residents with dignity when they yelled and talked down to them. While staff denied yelling or talking down to the residents, Resident A, Resident B, and Resident C all stated that staff have yelled or talked down to them. They were hesitant to share additional information regarding the details of who yelled at them, but they stated that it does happen. Resident A and Resident C stated that staff frequently yell at Resident B. Resident C stated that staff threaten to send Resident B to her room if she does not act right.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff, Angela Horton, hit Resident B in the face when putting her to bed. Angela will push Resident B in her wheelchair and let her hit the walls.

INVESTIGATION:

On 10/10/24, I received additional allegations that staff, Angela Horton, hit Resident B in the face when putting her to bed. The complaint also alleged that Ms. Horton pushes Resident B's wheelchair and lets her hit the walls. I conducted an unannounced onsite inspection on 10/14/24. I interviewed the home manager, Amanda D'Amore. Ms. D'Amore stated that she was not aware of Angela Horton hitting Resident B in the face or pushing her wheelchair into the walls. Ms. D'Amore stated that Resident B does not have any marks or bruises on her face. Ms. D'Amore stated that Ms. Horton worked the

midnight shift the night before and when she arrived to work today, she saw Ms. Horton talking to Resident B. Everything seemed fine and Resident B did not appear to be scared of Ms. Horton. Ms. D'Amore stated that Resident B never told her that Ms. Horton was physically aggressive towards her. She has not received complaints from any of the residents about Ms. Horton.

On 10/14/24, I interviewed direct care worker, Velia McCallister. Ms. McCallister stated that was not aware of anyone being physically aggressive towards Resident B. She stated that she never saw or heard of anyone mistreating Resident B. She would report it if she did. Resident B never told her that any staff person was physically aggressive towards her.

On 10/14/24, I interviewed Resident B. Resident B stated that none of the staff in the home ever hurt her. She stated that staff never hit her in the face or pushed her wheelchair into the walls. I did not observe any marks or bruises on Resident B.

On 10/29/24, I interviewed direct care worker, Felcia Avis. Ms. Avis was not aware of any staff being physically aggressive towards Resident B. She never saw anyone hit Resident B or push her wheelchair into the walls. Resident B never reported any concerns to her.

On 11/04/24, I interviewed direct care worker, Amber Perkins. Ms. Perkins stated that she sometimes works on shift with Angela Horton. She stated that she never saw Ms. Horton or any other staff being physically aggressive towards Resident B. She never saw anyone hit Resident B or push her wheelchair into the walls. She stated that this does not go on at all in the home.

On 11/06/24, I interviewed direct care worker, Angela Horton. Ms. Horton stated that she never hit Resident B and that the allegation was totally false. She denied ever being aggressive towards Resident B and stated that she never pushed her wheelchair into the walls. She stated that she has worked in this field for over twenty years and would never mistreat a resident.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff, Angela

	Horton, mistreated Resident B by hitting her in the face or pushing her wheelchair into the walls. Resident B stated that staff never hit her or pushed her wheelchair into the walls. Ms. Horton stated that the allegations were false. None of the other staff had any knowledge of Ms. Horton being physically aggressive towards Resident B. I did not observe any marks or bruises on Resident B during my onsite visit.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff, Amber Perkins, is smoking a weed pen and vaping in the house.

INVESTIGATION:

On 10/10/24, I received additional allegations that staff, Amber Perkins, is smoking a weed pen and vaping in the house. I conducted an unannounced onsite inspection on 10/14/24. I interviewed the home manager, Amanda D'Amore. Ms. D'Amore did not have any knowledge of Ms. Perkins ever smoking or vaping in the home. She stated that she has never observed Ms. Perkins smoking or vaping, even outside. Ms. D'Amore stated that she was not aware of any staff smoking or vaping in the home. This was never brought to her attention by any staff or residents.

On 10/14/24, I interviewed direct care worker, Velia McCallister. Ms. McCallister stated that she was not aware of anyone smoking or vaping in the home. She stated that she was not even aware of any staff smoking. None of the residents ever reported anything to her about staff smoking or vaping in the home.

On 10/14/24, I interviewed Resident A, Resident C, and Resident B. None of the residents ever saw anyone smoking or vaping in the home.

On 10/29/24, I interviewed direct care worker, Felicia Avis. Ms. Avis was not aware of any staff smoking, vaping, or using a weed pen in the home. She never saw Amber Perkins smoking anything while on shift.

On 11/04/24, I interviewed direct care worker, Amber Perkins. Ms. Perkins stated that she does not vape and she barely smokes weed. She stated that she has never smoked anything while on shift and never brought any marijuana into the home. She stated that she never observed any other staff smoking, vaping, or using marijuana in the home or while on shift.

On 11/06/24, I interviewed direct care worker, Angela Horton. Ms. Horton stated that she never observed any staff smoking, vaping, or using a weed pen in the home. She never observed any staff who appeared to be under the influence of marijuana while on shift.

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:	There is insufficient information to conclude that staff, Amber Perkins, is not suitable to meet the needs of the residents due to smoking a weed pen and vaping in the home. Ms. Perkins stated that she has never smoked weed or vaped in the home. None of the other staff or residents had any knowledge of Ms. Perkins or any other staff person smoking weed or vaping in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility is infested with cockroaches. They have been found in food, the refrigerator, and resident's briefs.

INVESTIGATION:

On 10/10/24, I received additional allegations alleging that the home is infested with cockroaches, which have been found in food, the refrigerator, and residents' briefs. I conducted an unannounced onsite inspection on 10/14/24. I interviewed the home manager, Amanda D'Amore. Ms. D'Amore stated that they have had an issue with cockroaches at the facility. A staff person, Velia McCallister, has an issue with cockroaches at home and it is believed that she brought some to the facility. The cockroaches have been found in the kitchen at the facility, near the dishwasher and in two bottom drawers. These drawers have been cleaned out and are no longer being used. Ms. D'Amore stated that staff, Felicia Avis, reported that she saw a cockroach in the refrigerator about a week ago. Staff cleaned out the refrigerator and they disposed of all of the food. They had a pest control company come out to the home a few times to treat the home for cockroaches. Ms. D'Amore stated that she has also been using boric acid to try to get rid of the cockroaches. She stated that she has not observed any cockroaches in the residents' food or briefs. None of the staff or residents have reported seeing cockroaches in their food or briefs. Ms. D'Amore stated that she has instructed Velia McCallister not to bring in a purse and to shake off before she enters the home.

On 10/14/24, I interviewed direct care worker, Velia McCallister. Ms. McCallister stated that she has worked in the home for one year. Ms. McCallister stated that she has seen

cockroaches in the home once in a while. She saw one on the floor in the kitchen. She never saw any cockroaches in food, resident bedrooms, or briefs. She stated that it is not that bad, just an occasional sighting. She stated that she did have an issue with cockroaches at home, but she is no longer bringing any bags into the home, and she always checks her clothing. She stated that the facility had a pest control company come out a few weeks ago to address the issue.

On 10/14/24, I interviewed Resident B. Resident B stated that she never saw any cockroaches in the home. She saw some flies in the home, but that is normal. She never observed any cockroaches in her food, bedroom, or briefs.

On 10/14/24, I interviewed Resident C. Resident C stated that she never saw any cockroaches in the home. She stated that she eats most of her meals in her bedroom. She never saw any cockroaches in her food or in her briefs. She stated that staff are constantly cleaning around the home.

On 10/14/24, I interviewed Resident A. Resident A stated that she heard there were cockroaches in the home, but she never saw them. She stated that she believes they are mostly in the kitchen area of the home. She heard staff yelling about the bugs and staff said they were in the kitchen. She stated that she never saw any cockroaches in her food, in her bedroom, or in her briefs. She stated that there are not even flies in the home. She stated that she only knew about the cockroaches because she heard staff “freaking out” about it.

During the unannounced onsite inspection on 10/14/24, a walkthrough of the facility was completed, including all areas of the kitchen. No cockroaches or evidence of cockroach activity was observed.

On 10/29/24, I interviewed direct care worker, Felicia Avis. Ms. Avis stated that they had cockroaches in the home, but she has not seen any in the past few weeks. They had a pest control company coming out to the home regularly to treat the issue. She stated that she saw one cockroach dead in the refrigerator. She called the home manager to tell her about it and then cleaned out the refrigerator. She threw away all of the food and cleaned it with bleach. She stated that she saw a few cockroaches running in the kitchen. She never saw any in the residents’ food or briefs. She stated that the home manager is on top of it and is addressing the issue.

On 10/29/24, I interviewed the hospice nurse for Resident D, Resident F, and Resident E. She stated that she regularly visits the home. She never observed any cockroaches in the residents’ bedrooms or in the home.

On 10/29/24, I interviewed Resident D’s guardian. He stated that he regularly visits the home. He stated that he never observed any cockroaches in the home.

On 11/04/24, I interviewed direct care worker, Amber Perkins. Ms. Perkins stated that she saw one cockroach in the kitchen area of the home. It was by the stove on the counter. She stated that she reported this to the home manager. She was not sure if a

pest control company had been to the home. She stated that she never saw any other cockroaches in the home, in resident bedrooms, briefs, or in their food.

On 11/06/24, I interviewed direct care worker, Angela Horton. Ms. Horton stated that the home did have an issue with cockroaches, but she has not seen any lately. They had an exterminator come out to treat the home. The home manager was also using boric acid to address the issue and put out traps. She stated she saw the cockroaches in the kitchen by the sink. She thought they were coming in by the drain to the dishwasher. She never saw cockroaches in any other area of the home, in resident briefs, or in their food.

I reviewed an invoice from Presidio Pest Management dated 08/16/24, it notes that they applied treatment to the kitchens, bathrooms, and dining areas for German roaches. No live activity was found. A few dead roaches were discovered on the glue board under the kitchen sink. All glue boards were replaced, and cracks, crevices, and plumbing voids were treated. A follow-up is scheduled for two weeks from today.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the home did not maintain a pest control program and that cockroaches were found in resident briefs and food. The home did have an issue with cockroaches, but they were contained to the kitchen area of the home and were never observed by staff or residents to be in the resident's food or briefs. The facility utilized Presidio Pest Management to treat the cockroach issue. No live activity was detected during their visit to the home on 08/16/24. I did not observe any cockroaches in the home during my onsite inspections.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 10/14/24, a walk-through of the home was conducted. The kitchen cupboards were dirty and had crumbs on the shelves. The kitchen floor was

sticky. There was a buildup of ice and crumbs in the freezer and refrigerator. The fan and smoke detector in the living room area were covered in dust.

On 11/07/24, I conducted an exit conference via telephone with the licensee designee, Sunil Bhattad, to review the findings. Mr. Bhattad stated that he would submit a corrective action plan to address the violations. He stated that the home has been cleaned and that they will continue to maintain a pest control program to address the cockroach issue. The pest control company came to the home yesterday and did not find any evidence of cockroaches. He stated that staff must talk loudly to some of the residents, as they are hard of hearing and some residents interpret that as yelling.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	During the onsite inspection on 10/14/24, the housekeeping standards did not present a clean appearance. The kitchen cupboards were dirty and had crumbs on the shelves. The kitchen floor was sticky. There was a buildup of ice and crumbs in the freezer and refrigerator. The fan and smoke detector in the living room area were covered in dust.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kristen Donnay 11/07/2024

Kristen Donnay Date
Licensing Consultant

Approved By:

Denise Y. Nunn 11/13/2024

Denise Y. Nunn Date
Area Manager