GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 3, 2025

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
PO Box 4338
East Lansing, MI 48823-9998

RE: License #: AL190383347
Investigation #: 2025A1033013
Vista Springs Grand Terrace at Timber Ridge

Dear Mr. Andriotti, Jr.:

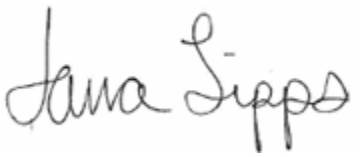
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,



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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383347
Investigation #:	2025A1033013
Complaint Receipt Date:	01/07/2025
Investigation Initiation Date:	01/09/2025
Report Due Date:	03/08/2025
Licensee Name:	IP Vista Springs Timber Ridge Opco, LLC
Licensee Address:	1140 Abbot Rd East Lansing, MI 48823-9998
Licensee Telephone #:	(303) 929-0896
Administrator:	Erin Witter, Administrator
Licensee Designee:	Louis Andriotti, Jr., Designee
Name of Facility:	Vista Springs Grand Terrace at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	20

Program Type:	ALZHEIMERS AGED

ALLEGATION(S)

	Violation Established?
The facility does not have adequate staffing to meet the needs of the current residents. There are combative residents the direct care staff cannot properly provide for their care.	No
Residents are not receiving adequate personal care. Resident A is being left in soiled incontinence briefs throughout the night.	No
Residents at the facility go weeks to months without a shower.	Yes
Resident medical needs are not being attended to by direct care staff. When direct care staff express to management that residents are ill, management does not respond in a timely manner.	No
There are female residents who refuse to have a male direct care staff provide their personal care, yet there are times the facility has been staffed with only male caregivers.	Yes

II. METHODOLOGY

01/07/2025	Special Investigation Intake 2025A1033013
01/07/2025	Contact - Document Sent- Email correspondence sent to Kimberly Horst, HFA.
01/09/2025	Special Investigation Initiated - On Site Interviews conducted with Administrator, Erin Witter, direct care staff, Lauryn Mackay, Joanna Woodruff, Jenna Lloyd, and Resident A. Review of resident records, direct care staff schedule, and additional documentation initiated.
01/10/2025	Contact - Telephone call made Attempt to interview Gina, RN case manager with The Care Team Hospice. Voicemail message left, awaiting returned call.
01/10/2025	Contact - Telephone call received Interview conducted with The Care Team Hospice RN case manager, Gina Gillis, via telephone.
02/03/2025	Exit Conference Conducted via telephone with licensee designee, Louis Andriotti, and Administrator, Erin Witter.

ALLEGATION:

- **The facility does not have adequate staffing to meet the needs of the current residents. There are combative residents and the direct care staff cannot properly provide for their care.**

- **Residents are not receiving adequate personal care. Resident A is being left in soiled incontinence briefs throughout the night.**

- **Residents at the facility go weeks to months without a shower.**

INVESTIGATION:

On 1/7/25 I received an online complaint regarding the Vista Springs Grand Terrace at Timber Ridge, adult foster care facility (the facility). The complaint alleged the following:

- Staffing at the facility is not adequate to meet resident needs, there are combative residents and the direct care staff cannot adequately provide for their care.
- Resident A is being left in soiled incontinence briefs throughout the night. Residents are not receiving adequate personal care.
- Residents at the facility go weeks or months without receiving a shower.

On 1/9/25 I conducted an unannounced, onsite investigation at the facility. I interviewed Administrator, Erin Witter. Ms. Witter had the following to report regarding the allegations:

- Ms. Witter reported that currently there are 16 residents residing at the facility. Ms. Witter reported that the facility is always staffed with at least two direct care staff members. She reported that there are shifts where three direct care staff are scheduled. Ms. Witter reported that Resident B is the only resident at the facility who requires a two-person assist with personal care, mobility, and transfers. Ms. Witter reported that she feels the facility is well staffed and that all resident care needs can be met with the current staffing levels. Ms. Witter reported that there are not any current residents at the facility who demonstrate combative behaviors. She further reported that Resident C has “exit seeking” behaviors, but the direct care staff can manage these behaviors with redirection. Ms. Witter reported that all direct care staff members are required to complete dementia/Alzheimer’s training upon hire to learn about how to approach residents with memory impairment and how to manage behaviors associated with these diseases.
- Ms. Witter reported that the direct care follow the *Task Administration Records* (TAR) which identify if a resident requires personal care or toileting checks. She

reported that the direct care staff typically assist residents with toileting needs when they wake up, before and after meals, before naps, after naps and before they go to bed for the night. Ms. Witter reported that residents are checked on throughout the night usually at 1am, 3am, and 5am for any care needs they may have. Ms. Witter reported that she has not received any complaints from residents or visitors to the facility that a resident has been found unclean and with poor hygiene. Ms. Witter reported that Resident A does receive care from the direct care staff during the overnight hours. She reported that Resident A has behaviors where he will remove his incontinence brief and urinate on the floor in his bedroom. She reported that direct care staff must check on him frequently to ensure he is dressed in clean clothing with a clean brief. Ms. Witter reported that Resident A showers himself with stand-by assistance from direct care staff. She reported that several months ago there was an issue with Resident A's mattress smelling of urine. She reported that his toileting schedule was increased to ensure he was clean and dry, and they replaced his mattress.

- Ms. Witter reported that all the residents are scheduled on a shower schedule weekly. She reported that the residents receiving hospice services receive their showers from hospice caregivers, but these are completed multiple times per week for these residents. Ms. Witter reported that residents who refuse their shower have this refusal documented on the TAR. Ms. Witter reported that she is not aware of any resident waiting a month for a shower. She reported that even if a resident refuses a shower, the direct care staff are usually still able to reschedule the shower for another day the same week of the refusal.

On 1/9/25 during the onsite investigation I interviewed direct care staff, Lauryn Mackay. Ms. Mackay had the following to report regarding the allegations:

- Ms. Mackay reported that she has worked at the facility for about four months. She reported that there are three adult foster care homes on the property and one home for the aged facility. She reported that she is cross trained and picks up shifts in all these locations. Ms. Mackay reported that she has worked on first (7am to 3pm) and third (11pm to 7am) shifts at the facility. She reported that she feels the facility has been adequately staffed when she has worked these shifts. Ms. Mackay reported that Resident B is the only resident at the facility who requires two-person assistance with mobility, transfers, and personal care. She reported that there are times when the facility is staffed with three direct care staff, but it is always staffed with at least two direct care staff members. Ms. Mackay reported that the staffing level at the facility has never dropped below two people. Ms. Mackay reported that she is not aware of any residents at the facility who demonstrate combative behaviors. She reported that the direct care staff can meet the needs of each resident at this facility with the current staffing.
- Ms. Mackay reported that residents who are incontinent are scheduled for regular toileting checks on the TAR. She reported that residents who are cognitively capable of using a call button will notify direct care staff when they need assistance using the restroom or changing their incontinence briefs. Ms. Mackay reported that Resident A is scheduled to be checked and have his incontinence brief changed every two hours through the overnight hours. She

reported having no knowledge of Resident A being left in a soiled incontinence brief for prolonged periods.

- Ms. Mackay reported that the residents are all placed on a shower schedule for weekly showers. She reported that there is a daily shower log posted in the medication room for direct care staff to reference. Ms. Mackay reported that she has observed the residents receiving showers and feels the direct care staff are meeting all resident needs in terms of showering. She further reported that each resident is provided personal care in the mornings when they wake for the day. Ms. Mackay reported that she has no knowledge of residents not receiving showers at the facility.

On 1/9/25 during the on-site investigation, I interviewed direct care staff, Joanna Woodruff. Ms. Woodruff had the following to report regarding the allegations:

- Ms. Woodruff reported that she has worked at the facility for about 1.5 years. She reported that she also works in each facility on the campus. Ms. Woodruff reported that she has worked on first and second (3pm to 11pm) shifts at the facility. Ms. Woodruff reported that the facility is usually staffed with two direct care staff members. She reported that there has never been less than two direct care staff scheduled while she has worked at the facility. She reported that there are times when she does not feel this is adequate staffing. She reported that Resident B is a two-person assist with mobility, transfers, and personal care. She further reported that Resident C & Resident D both demonstrate “exit seeking” behaviors and require regular supervision to ensure they do not elope from the facility. Ms. Woodruff reported that Resident B also has high levels of anxiety and screams and cries out during the day. She reported that Resident B takes a lot of time for direct care staff to redirect as she is not easily redirected. Ms. Woodruff reported that there are not any residents at the facility who are combative. She reported that there are just residents who are difficult to redirect due to their cognitive impairments.
- Ms. Woodruff reported that the protocol for incontinence care is for direct care staff to check and change incontinent residents every two hours, before and after meals, and shift change. Ms. Woodruff reported that there have been concerns from direct care staff members that the direct care staff working the overnight shift, are not providing adequate personal care to Resident A and Resident B. She reported that both residents have been found in saturated incontinence briefs after the overnight staff have worked. Ms. Woodruff reported that she is not aware of any residents having sores or wounds, but she reported that Resident B has experienced an on-and-off yeast infection in her groin. Ms. Woodruff attributes the yeast infection to poor incontinence care.
- Ms. Woodruff reported that the residents are scheduled on a regular shower schedule. She reported that this schedule is kept in the medication room at the facility and direct care staff can see which residents are scheduled to receive showers on which days of the week. Ms. Woodruff reported that when a resident refuses a shower it is documented on the TAR. Ms. Woodruff reported that she has concerns some of the residents are not receiving their scheduled showers. She reported that each shift has about four to five residents scheduled to receive

a shower as most residents are scheduled to receive two showers per week. Ms. Woodruff reported that she feels there is not adequate staffing per shift to be able to accommodate all the scheduled showers. She reported that she does believe there are times when a resident may go over a week without a shower.

During the on-site investigation on 1/9/25 I interviewed Resident E. Resident E reported that she likes the direct care staff who work at the facility. She reported that sometimes she must wait for a shower because the direct care staff members are very busy. She reported that she can go for multiple weeks waiting for a shower.

On 1/9/25 during the on-site investigation I interviewed direct care staff, Jenna Lloyd. Ms. Lloyd had the following to report regarding the allegations:

- Ms. Lloyd reported that she has worked at the facility for almost 1.5 years. She reported that she works at different facilities on the campus but has worked first shift at the facility. She reported that the staffing at the facility is "usually" adequate. She stated that due to the needs of the current residents, she feels the facility should be staffed with three direct care staff members on all shifts. She stated that the facility provides better care to the residents when they have three direct care staff scheduled per shift. She reported that most of the shifts are staffed with just two direct care staff members. Ms. Lloyd reported that Resident B is the only resident who requires two-person assistance with mobility, transfers, and personal care. She reported that Resident D and Resident F have high needs and require more attention from direct care staff than other residents. Ms. Lloyd reported that the facility is never staffed with less than two direct care staff members. Ms. Lloyd reported that there are not any combative residents at the facility.
- Ms. Lloyd reported that the direct care staff provide incontinence care to residents every two hours at a minimum. She reported that residents who require toileting checks are scheduled on the TAR. Ms. Lloyd reported there are some residents who use their call buttons to alert direct care staff when they require toileting or personal care assistance. She reported that Resident A can get himself up and go to the bathroom with direct care staff assistance. She reported that he likes to remove his incontinence brief and she has found soiled incontinence briefs laying on the floor of his bedroom. Ms. Lloyd reported that she has provided morning care for residents and noted that the overnight direct care staff did not provide incontinence care to Resident B. She reported that she has found Resident B in completely saturated incontinence briefs that appear to have not been changed for multiple hours.
- Ms. Lloyd reported that the direct care staff have a shower schedule that they follow for resident showers. She reported that this schedule is kept by the medication cart in the medication room. Ms. Lloyd reported that she does feel that there are times resident showers are "missed" or overlooked due to a lack of time. She reported that there are times when the direct care staff run out of time to shower everyone who was scheduled on the shower schedule for a specific day. Ms. Lloyd reported that these concerns have been addressed with Ms. Witter and the facility Wellness Director, Stacey Rowe. Ms. Lloyd reported that

Ms. Witter and Ms. Rowe developed the shower schedule to assist direct care staff in identifying who needs a shower on each day. She reported that prior to this the direct care staff did not have a shower schedule to utilize. Ms. Lloyd reported that the shower schedule has helped the direct care staff stay organized, but she still feels there are times that a resident has gone more than a week without a shower. Ms. Lloyd reported that Resident E has potentially gone several weeks in between her showers. She reported that Resident E only wants to shower on Thursdays at 7pm. She reported that Resident E will frequently refuse a shower if it is not offered at this time, if the room temperature is not to her liking, and/or if she has company at the time of her regularly scheduled shower. Ms. Lloyd reported that shower refusals are documented on the TAR.

On 1/9/25 I interviewed The Care Team Hospice, RN case manager, Gina Gillis, via telephone. Ms. Gillis had the following to report regarding the allegations:

- Ms. Gillis reported that she makes weekly visits to the facility as she has patients who are residents at the facility. Ms. Gillis reported that she has no concerns about the current staffing levels at the facility. She reported that the direct care staff appear to be providing adequate care and appear skilled in managing residents with behaviors related to dementia/Alzheimer's disease.
- Ms. Gillis reported that she makes unannounced visits to the facility. She reported that she has never entered the facility and found a resident to be unkempt or in need of personal care. She reported that the residents she provides services to all appear to be well kempt and as though they are receiving adequate personal care.
- Ms. Gillis reported that she has no concerns about residents going weeks to months without receiving a shower. She reported that she would find it hard to believe the residents go weeks to months without a shower.

During the on-site investigation on 1/9/25 I reviewed the following documents:

- *Vista Springs Timber Ridge Village, Weekly Schedule*, for the dates 12/1/24 through 1/4/25. These direct care staff schedules identified that on every shift there were at least two direct care staff members scheduled to provide for resident protection, supervision, and personal care needs.
- I reviewed the resident care plans for all 16 residents. I made the following observations:
    - Seven of the 16 residents have an assistive device listed on their care plan. The other 9 care plans indicate that these residents do not use an assistive device to assist with mobility or ambulation.
    - None of the 16 care plans reviewed indicated that a resident was combative or physically aggressive in any capacity.
    - Four of the 16 care plans indicated a resident who had behaviors of wandering, exit seeking, or elopement.
    - All residents had at least weekly showering and every two hour “purposeful rounding” identified on their care plan.
    - None of the 16 care plans indicated that a resident would require a two person assist with mobility, transfers, or personal care.

- *Assessment Plan for AFC Residents* documents were reviewed for Resident A, B, C, E, F, G, H, I, & J. None of the assessment plans reviewed identified a resident who exhibited aggressive or self-injurious behaviors. None of the assessment plans identified a resident who required a two-person assist with mobility, transfers, or personal care needs.
- *Task Administration Record (TAR).* Ms. Witter reported that this document is accessed in the electronic medical record for each resident at the facility. She reported that this document is where daily tasks, such as showering, toileting, and so forth are documented as completed by direct care staff members. I reviewed the TARs for the month of December 2024 for Resident A, B, C, D, E, F, G, H, I, & J. The following observations were made during this review:
    - Resident A: The TAR lists, "Bathing – Assist and Cue (Tues/Saturday) Please assist [Resident A] to take shower on assigned days." I observed that there was a period of 9 consecutive days where it was not documented that Resident A had a shower. 12/15-12/23. There were not any notations to indicate why the shower did not occur on any of these dates.
    - Resident B: The TAR lists Resident B scheduled for "Incontinent Care. Check Community Member brief and change if wet or soiled" every two hours from 10pm through 8am. The TAR documents this care being provided consistently except for the dates 12/25/24 and 12/28/24. Ms. Witter reported that Resident B receives her showers from Heart-to-Heart Hospice and the caregivers through this program provide for her showers two times per week.
    - Resident C: The TAR lists, "Bathing – Assistance." The TAR records no more than three days between showers provided/offered to Resident C.
    - Resident D: The TAR lists, "Bathing – Assistance No Males." There was no more than two days in between Resident D being provided or offered a shower. Also listed, "Incontinence Care. Check community member brief and change is wet or soiled". This care is listed to be performed daily at 2am and 6am. It was observed that these daily checks were not accounted for on the dates, 12/25/24 and 12/28/24.
    - Resident E: The TAR lists, "Bathing – 1X Assist. Sunday and Wednesday between 6:30pm and 7:30pm." It was observed that there was a ten-day period in which a shower was not documented as being offered/provided to Resident E. 12/12/24 – 12/21/24.
    - Resident F: Ms. Witter reported that hospice services provide the shower for Resident F at least two times per week.
    - Resident G: The TAR lists, "Bathing Assist". It was observed that not more than two days elapsed between Resident G being provided/offered a shower.
    - Resident H: Ms. Witter reported that Resident H showers independently and does not require direct care staff assistance.
    - Resident I: The TAR lists, "Bathing Assist". It was observed that there was an eleven-day period, 12/18/24-12/28/24, in which Resident I did not have

a shower. However, there were multiple documentations from direct care staff that Resident I was refusing showers being offered during this period.

- Resident J: The TAR lists, “Bathing – Stand by/Independent (Mondays and/or Fridays)”. There is No documentation of a completed shower between the dates 12/21/24 - 12/31/24. On 12/25/24 There is documentation which reads, “OTH”. Ms. Witter reported that “OTH” stands for “Other”. The TAR also identifies the task, “Showering”. There is a ten-day period from 12/7/24 – 12/16/24 where there is not documentation of a completed shower, but there are notes reading, “OTH” on dates 12/10/24 and 12/13/24. There is also an 11-day period where there is not documentation of a completed shower for Resident J, from 12/21/24 – 12/31/24, but there are notes reading “OTH” on 12/24/24, “FAM” on 12/27/24, and “REF” on 12/31/24. Ms. Witter reported that “FAM” means “With family”, and “REF” means “Refused”.

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 upon interviews conducted and documentation reviewed it can be determined that there is not adequate evidence to suggest that the facility is not adequately staffed to provide for the personal care, supervision, and protection of the current residents. I reviewed resident assessment plans and individual care plans for 8 of the 16 residents. I did not find any of these residents to be listed as two-person assist with mobility, transfers, or personal care. In reviewing these documents, I did not find any notations of residents with aggressive or combative behaviors. The individuals interviewed all agreed that Resident B is the only resident who requires a two-person assist with mobility, transfers, or personal care and they all identified that the facility has consistently been staffed with at least two direct care staff members, and sometimes three. The direct care staff appear to be following the schedules outlined on the resident TAR forms regarding toileting and hygiene, however there were some residents lacking documentation regarding showering. I did not observe any residents who appeared to be unkempt or lacking in personal hygiene during my on-site investigation. Although Ms. Lloyd and Ms. Woodruff both reported having found some residents in saturated incontinence briefs when they arrived for a morning shift, it cannot be determined whether these residents were left unattended for multiple hours by other direct care staff members, or whether they experienced excessive urination on these instances. Ms. Gillis, who makes unannounced visits to the facility, reported no concerns about resident hygiene or direct care staffing levels at the facility. Based upon a lack of available evidence a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Based upon interviews conducted and documentation reviewed during the investigation it can be determined that there is adequate evidence to support the direct care staff are providing/offering resident showers at least weekly. The resident showers appear to be scheduled at least twice per week but the TARs for Resident A and Resident E indicated that there were 9-to-10-day periods where there was not documentation of a shower offered or received for these residents. Furthermore, Ms. Lloyd & Ms. Woodruff reported that they have concerns that residents are not being showered weekly and that some of the resident showers have been missed or pushed back due to lack of time during their shifts. Finally, Resident E was interviewed and expressed concern to this consultant that she was not being offered a shower weekly, as she would prefer. She reported that there are times she is made to wait multiple weeks for a shower. Based on this information a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident medical needs are not being attended to by direct care staff. When direct care staff express to management that residents are ill, management does not respond in a timely manner.

INVESTIGATION:

On 1/7/25 I received an online complaint regarding the facility. The complaint alleged that the direct care staff have concerns that resident medical needs are not being responded to in a timely manner by the Administrator. The allegation did not have a specific resident or incident noted. On 1/9/25 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Witter on this date. Ms. Witter reported that she is unaware of any resident medical needs that have not been handled immediately by direct care staff or herself. Ms. Witter reported that many of the residents have a visiting medical provider who comes to the facility to provide for their care needs. Ms. Witter reported that these providers are frequently on-site and provide resident care. Ms. Witter reported that if any resident had a medical emergency, they would be sent to the emergency department for evaluation.

On 1/9/25, during the on-site investigation, I interviewed Ms. Mackay regarding the allegation. Ms. Mackay reported that she has no knowledge of a resident who required medical treatment and was not attended to immediately. Ms. Mackay reported that there are multiple medical providers who visit the facility on a weekly basis to check on different residents. Ms. Mackay had no knowledge of any instance when a resident did not have received needed medical care.

On 1/9/25, during the on-site investigation, I interviewed Ms. Woodruff, regarding the allegations. Ms. Woodruff reported that she has no knowledge of residents who required medical treatment and were not treated immediately. Ms. Woodruff reported that medical providers are frequently visiting residents at the facility and providing care.

On 1/9/25, during the on-site investigation, I interviewed Ms. Lloyd, regarding the allegation. Ms. Lloyd reported that she has no knowledge of an instance where a resident required medical treatment and was not offered services.

On 1/10/25 I interviewed Ms. Gillis, via telephone, regarding the allegations. Ms. Gillis reported that she has no concerns about resident medical care needs not being attended to by direct care staff members or the Administrator. Ms. Gillis reported that medical providers are frequently in and out of the building providing services to multiple residents.

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 upon the interviews conducted during this investigation it can be determined that there is no evidence to suggest that any of the current residents have experienced a medical issue that has been ignored or not treated in a timely manner by the current direct care staff and/or Administrator. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are female residents who refuse to have a male direct care staff provide their personal care, yet there are times the facility has been staffed with only male caregivers.

INVESTIGATION:

On 1/7/25 I received an online complaint regarding the facility. The complaint alleged that there are residents who reside at the facility who have requested not to be bathed by a male caregiver and the facility has staffed shifts with only male caregivers present. On 1/9/25 I conducted an unannounced on-site investigation at the facility. I interviewed Ms. Witter on this date. Ms. Witter reported that Resident E, Resident G, and Resident H have requested not to be showered by a male direct care staff member. She reported

direct care staff are aware of this request because in the electronic resident record an “M” appears next to the resident’s profile picture. Ms. Witter reported that the “M" stands for “no males”. Ms. Witter reported that the facility does employ male direct care staff members, and these men only work on third shift (11pm to 7am). She reported that there have been shifts when the direct care staff scheduled to work were just males. Ms. Witter reported that Resident E, Resident G, and Resident H are not scheduled for their showers on third shift. I inquired of Ms. Witter what these residents would do if they were to have an episode of incontinence and require a shower on third shift when only a male direct care staff member was scheduled. Ms. Witter reported that she would have to switch direct care staff members with another adult foster care facility, located on the same property. Ms. Witter reported that the direct care staff members are all trained to each building and would be able to switch with another on-campus facility to have a female direct care staff member come and assist in this situation.

On 1/9/25, during the on-site investigation, I interviewed Ms. Mackay regarding the allegation. Ms. Mackay reported that Resident B and Resident F have requested to only receive personal care, including showers, from female direct care staff members. Ms. Mackay reported that she is not aware of any shifts where only male direct care staff members were scheduled.

On 1/9/25, during the on-site investigation, I interviewed Ms. Woodruff, regarding the allegations. Ms. Woodruff reported that Resident B, Resident E, Resident H, and Resident J, all refuse personal care and showers from male direct care staff members. Ms. Woodruff reported that she is aware of shifts where only male direct care staff members were scheduled to work at the facility. She reported that she is not sure how personal care and showering is handled for these residents when only male direct care staff are scheduled at the facility.

On 1/9/25, during the on-site investigation, I interviewed Resident E regarding the allegation. Resident E reported that she does not allow male direct care staff members to provide for any of her personal care, showering, dressing or undressing activities. Resident E reported that there have been times when only male direct care staff members have been available at the facility. She reported that she just refused care on these occasions.

On 1/9/25, during the on-site investigation, I interviewed Ms. Lloyd regarding the allegation. Ms. Lloyd reported that Resident D and Resident E both refuse personal care and showering from male direct care staff members. Ms. Lloyd reported that there have been times on third shift when only male direct care staff members were scheduled to work, but this has recently changed. She reported that now there is usually at least one female direct care staff member on each shift.

During the on-site investigation on 1/9/25, I reviewed the following documents:

- I reviewed the resident care plans for all 16 residents at the facility. The care plans for Resident E, Resident G, and Resident H all had the “M” notation by

their profile picture. As Ms. Witter indicated the “M” stands for “no males” to provide for personal care or hygiene tasks.

- *AFC-Resident Care Agreement* document for Resident B, dated 2/1/24, noted on page one, “I agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.”
- *AFC-Resident Care Agreement* document for Resident E, dated 2/15/24, noted on page one, “I agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.”
- *AFC-Resident Care Agreement* document for Resident H, dated 4/10/24, noted on page one, “I do not agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.”
- *AFC-Resident Care Agreement* document for Resident G, dated 2/22/24, had both “I agree” and “I do not agree” marked under the section, “to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.”
- *AFC-Resident Care Agreement* document for Resident D, dated 2/7/24, noted on page one, “I agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.”
- *AFC-Resident Care Agreement* document for Resident F, dated 7/2/24, noted on page one, “I agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.”
- *AFC-Resident Care Agreement* document for Resident J, dated 4/5/24, noted on page one, “I do not agree” marked under the section, “to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.”
- I reviewed the *TARs* for December 2024 for Resident B, D, E, F, G, H, & J. The TAR for Resident D reads, “Bathing – Assistance No Males.” There was not any notation on the other TARs reviewed regarding a preference in male or female direct care staff performing personal care, hygiene, or dressing tasks.
- I reviewed the Assessment Plan for AFC Residents documents for Residents B, D, E, F, G, H, & J. None of these documents had any notations about a preference in male or female direct care staff providing personal care, hygiene, or dressing tasks.
- *Vista Springs Timber Ridge Village Weekly Schedules* for the dates 12/1/24 through 1/4/25. On the following dates and times, I observed that only male direct care staff were assigned as direct care staff at the facility:
    - 12/1/24: 11pm to 7am. Direct care staff, Joseph Goedert & Anthony Allen Jr.
    - 12/4/24: 11pm to 7am. Direct care staff, Eric Lewke & Anthony Allen Jr.
    - 12/5/24: 11pm to 7am. Mr. Goedert & Mr. Allen.
    - 12/6/24: 11pm to 7am. Mr. Lewke & Mr. Allen.

- 12/13/24: 11pm to 7am. Mr. Lewke & Mr. Allen.
- 12/17/24: 11pm to 7am. Mr. Lewke & Mr. Allen.
- 12/18/24: 11pm to 7am. Mr. Lewke & Mr. Allen.
- 12/22/24: 11pm to 7am. Mr. Lewke & Mr. Allen.
- 12/29/24: 11pm to 7am. Mr. Goedert & Mr. Allen.

On 1/28/25 Ms. Witter sent an email correspondence and included the facility Admission Policy and Program Statement for my review. I reviewed these documents and there was not a notation in either document referencing same sex direct care staff for resident personal hygiene, bathing, or dressing services.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(6) A licensee shall afford a resident the opportunity to receive assistance in bathing, dressing, or personal hygiene from a member of the same sex, unless otherwise stated in the home's admission policy or written resident care agreement.

ANALYSIS:	Based upon interviews conducted and documentation reviewed it can be determined that there are at least two residents, Resident H & Resident J, who identified on their *Resident Care Agreement* documents that they did not agree to receive assistance in bathing dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available. In the interviews conducted there were verbal statements from direct care staff members indicating that there were as many as seven residents who do not wish to receive bathing, dressing, or personal hygiene assistance from a male direct care staff member. These residents were identified as Resident B, D, E, F, G, H, & J. In reviewing the *TAR* documents for these seven residents for the month of December 2024, it was noted on Resident D's *TAR*, "Bathing Assistance No Males". The other six *TAR* documents did not make a notation about preference of direct care staff for personal hygiene, bathing, or dressing. I also reviewed the Care Plans for each of these seven residents. Ms. Witter noted if a resident did not agree to receive personal hygiene, dressing, or bathing assistance from a male direct care staff member that an "M" would appear next to their profile picture on their resident care plan. I noted an "M" on the care plans for Resident E, G, & H. Resident J, whose *Resident Care Agreement* document specified she did not wish to receive personal hygiene, bathing, or dressing services from a male direct care staff member, did not have an "M" on her resident care plan to identify this request. Additionally, I reviewed the direct care staff schedule for the period 12/1/24 through 1/4/25. There were 9, 8-hour shifts, recorded where two male direct care staff members were scheduled to provide care for the residents of the facility, without a female direct care staff member also being scheduled. Ms. Witter reported that in the event one of the female residents, who had not agreed to receive personal hygiene, bathing, or dressing services from a male direct care staff member, required assistance in these areas that they would need to trade direct care staff members with another facility on the same campus to accommodate this need. This investigation has found that the process by which residents are identified to direct care staff regarding whether they are willing to receive care from a direct care staff member of the opposite sex is cumbersome, inconsistent and inaccurate at times. There were multiple dates when only male direct care staff were assigned to provide personal hygiene, bathing, and dressing support to residents who had requested not to receive care from a male, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

1/30/25

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Jana Lipps Date
Licensing Consultant

Approved By:

01/31/2025

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Dawn N. Timm Date
Area Manager