David R. Devereaux and Patrice K. Acosta
323 East Wisconsin Avenue
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**DELIVERED VIA E-MAIL**

August 2, 2011

Rex W. Chronister, Attorney at Law
Chronister Fields & Flake, PLLC
309 N. 7th Street
P.O. Box 66
Ft. Smith, AR 72902

Dear Rex,

Attached please find a an update to our previously submitted management report reflecting our review of information related to Maurice J. Brigance and Dorothy Brigance, as previously requested.

Based on the information available in the personnel file for Mitzi Bailey, while employed at The Brookfield at Fianna Oaks, and a review of Ms. Bailey's video deposition recently completed in Fort Smith, AR, our earlier conclusions remain unchanged.

Specifically, our findings continue to indicate the following:

- Brookfield at Fianna Oaks, through the actions of its facility leadership, staff and operating/ownership group, created an environment that placed resident needs at risk, and neglected to operate its facility in a manner consistent with generally accepted operating principles. This conclusion is derived through records review and several years of long-term care operating experience, across many states, including Arkansas. Additionally, there is a very strong belief that a small group of individuals behaved with protection of Brookfield as a primary purpose, with personal integrity as a secondary consideration. This determination is based on the record review of documentation related to the care and services provided to both Mr. and Mrs. Brigance, and expanded views are provided in the body of the management report
.
- The Office of Long Term Care, through the actions of it surveyors and supervisors, failed to investigate the matters as requested in a comprehensive fashion, and examined family feedback and complaint information in an incomplete manner. This conclusion is based on review of the Statements of Deficiencies and Plans of Correction, surveyor notes and supporting materials and e-mail correspondence between numerous parties over parts of the 2008-2009 calendar years. As former health care executives with several decades worth of standard annual and complaint survey experience, the processes undertaken by representatives of OLTC were remarkable in their respective lack of investigatory depth and comprehensiveness.

- Brookfield at Fianna Oaks' ownership/operating group provided little oversight over facility operations with regard to staff and executive training, resident and family communication processes, and compliance. This conclusion is drawn from the apparent absence of any leadership involvement above the facility administrator in any of the events, feedback, or dialogue involving Maurice Brigance, Dorothy Brigance, Steve Brigance or Peggy Brigance. During an extended period where several negative events occurred and state officials were involved as a routine matter, it is noteworthy that there was no apparent intervention by senior officials or members of ownership in the areas listed above.

**David R. Devereaux and Patrice K. Acosta**
323 East Wisconsin Avenue
Neenah, WI 54956

August 8, 2011

Rex W. Chronister, Attorney at Law
Chronister Fields & Flake, PLLC
309 N. 7th Street
P.O. Box 66
Ft. Smith, AR 72902

Dear Rex,

Attached please find an annotated copy of our original management report reflecting additional commentary based on review of the depositions of officials from the Office of Long Term Care and the state Ombudsman's office.

We reviewed the depositions of Sherril Proffer-Feyen (SP), James Hicks (JH), Jane Pessa (JP) and Betty Wheeler (BW) from OLTC and the depositions of Kathie Gatley and Debbie Medley (DM) from the Ombudsman's office. Within each relevant category, we have highlighted in red, comments attributed to the individual from their deposition testimony, further supporting our original findings.

Please let us know if you have any questions regarding the report.

Sincerely,

David R. Devereaux

Patrice K. Acosta

**Management Report Overview**

For ease of review, the detail of this management report is broken down into four areas:

- Office of Long Term Care Survey Information
- Brookfield Incident and Accident Reports
- E-Mail Correspondence
- Additional Items for Consideration

As the volume of notes, reports and exhibits was extensive, our thoughts are organized in this fashion to help build a chronology by topic area, and provide a trail of sequential information to a series of documents that originate from a wide variety of sources.

**Office of Long Term Care Survey Information**

OLTC Survey Checklist – Complaint #927

Complaint visit #927 took place at Brookfield on 2/26/09. Visit checklist is remarkable as the complaint was found to be substantiated, though no deficiencies were cited. In the opinion of the OLTC representatives, there are no comments regarding which complaint elements were found to be substantiated. This information could only be found buried in the text of an e-mail from Jim Hicks to Carol Shockley on 3/19/09.

SP States that 'substantiated, no deficiencies' means that 'the door did fall, but deficiencies weren't written because the—it wasn't a facility failed practice'.

BW States that 'substantiated, no deficiencies' means that yes, the door fell, but was the facility aware or should they have been aware of problems. Apparently, she felt that they should not have been aware, despite prior complaints and concerns. She also states that they looked at maintenance records, but did not look at quality assurance records. (While there is some protection afforded to QA records, in our experience, it would not have been unusual for the surveyors to ask if there was any QA activity related to the doors.) She states that they "didn't find the facility knew there were problems with the doors", which Rex contradicted with showing her the maintenance records that did in fact show two problems with the doors.

OLTC Survey Checklist – Complaint #930

Complaint visit #930 took place at Brookfield on 2/26/09. Visit checklist is noteworthy as it indicates that the complaint was 'SUB-NO DEF, then the indicator was changed to 'UNSUB'. This is questionable on its face, as it appears that the indication was changed. What caused the decision change here?

JH Says that he doesn't know who changed the document from 'substantiated, no deficiencies' to 'unsubstantiated' and that he said a secretary probably wrote 'substantiated, no deficiencies'.

OLTC Complaint Narrative Report – Complaint #930

In Nancy Jeffers' report, she indicates that the 'employee stated that the facility administrator asked her to redo her incident and accident report dated 1/7/09 on resident #1', and that a record review was conducted. A few follow up questions that surfaced in reading this documentation are the following:

- Where is the first incident and accident report?
- Why did it need to be redone?
- Is the first report available to be compared to the second one?
- On what date was the second report created?

If the first report was destroyed, this behavior ought to be enough to generate a deficiency for medical records retention.

The concern that prompted an investigation of the incident/accident report was generated by Steve Brigance via email to Jim Hicks on 3/3/09, when he uses specific language to express the concern regarding pressure to falsify an incident report. The *exact same* language is used in the OLTC narrative information, however, the surveyor refers to her investigation being conducted via telephone interview with an employee on 2/26/09. How could the surveyor thoroughly investigate the complaint when it had in fact not been made?

During the telephone interview, it appears that the employee that recreated the incident and accident report stated that she 'did not change a thing', and this response was accepted as fact. Without the questions listed above being included in the investigation process, the complaint investigation appears very incomplete. (Where is the first report, etc.)

When the surveyors investigated the allegation regarding the possible falsification of the incident report, they failed to personally interview the employee who completed the report. Instead, a phone interview was conducted. This employee was still employed by the facility and arrangements for a personal interview could have been made. An investigation involving falsification of records would warrant and in-person discussion to ascertain body language, nervousness, and other signs that someone is or is not being truthful.

The surveyors did not document an interview with Mitzi Bailey in regard to this matter even though the employee acknowledged that she had been asked to re-write the report by the Administrator.

SP-Admits that falsification complaint was not investigated in person, since complaint was made 3/3/09 and visit was 2/26/09; admits that "they should have asked administrator" about the allegation and document that in the file; says they investigated by phone and spoke to employee but states that based on the info in the file "it does not state that she asked the facility administrator".

JH-When asked about falsification complaint made on 3/3/09 could be investigated on 2/26/09 visit to the facility states "I don't know, I didn't work it."

BW-States that she "can't think of an instance when it is appropriate to destroy records". She also states that this concern could have been incorporated in the visit of 2/26/09 since that was within 7 days of the prior visit. This is clearly not something that would be allowed since the activities of the 2/26 investigation did not include any evaluation of the incident report's integrity. She states that she would have asked the administrator about the altered report. (We are curious about how the State Operating Manual views the 7-day window and how it would apply in this instance.)

The State kept this complaint open until 3/5/09, but still failed to investigate the violation of residents' rights regarding visitation with an ex-employee communicated by Steve Brigance on 3/1/09. The State surveyed the facility on 3/24/09 as a follow up to the annual survey from 10/08 and also did not investigate those allegations at that time. Further, a Life Safety Code survey was conducted on 4/13/09, and given the incident involving Mr. Brigance could certainly be addressed as a "life safety" issue; there was no further investigation of the matter at that time. Based on conversations had regarding this matter, it would appear as though the solid core closet doors were still in place at that time.

OLTC Survey Checklist – Follow-Up Health Survey – 3/24/09

As a follow up to a Health Survey conducted on 10/13-14/08, OLTC found all previous deficiencies to be cleared. What is noteworthy are the original deficiencies cited in the 10/08 survey, as all were cited prior to Mr. Brigance's injury, and all were noted as being corrected by Ms. Bailey, also before Mr. Brigance's injury. Additionally, Brookfield received eight deficiencies in its survey, which appear to be a very high number, given the resident census and the relative lack of complexity of the facility. It would be important to determine how this number of deficiencies compares to the state average for like facilities.

The most relevant deficiencies cited during the 10/08 survey are the following:

- 504.4 – Orientation and Training – areas cited included incomplete or improper education and training in the areas of Abuse, Neglect and reporting requirements; Incident Reporting; Residents' Bill of Rights, particularly involving Dementia and Cognitive Impairment. Of particular note, a review of Mitzi Bailey's personnel file or related information indicated that she had not indicated completion of training on Abuse, Neglect and reporting requirements. For a key leader, and the person most responsible for creating an environment free of abuse and neglect, this is disturbing.

- 506 – Quality Assurance – based on the citation language, it appears that there was no legitimate formation or function of a Quality Assurance Committee at Brookfield, and no formal attention paid resident quality of care or quality of life. The lack of this structural component illustrates a lack of oversight on the part of the facility's ownership or operating group, a lack of experience on the part of its Administrator, or a lack of interest on the part of both parties. A properly functioning Quality Assurance program would have been a significant tool in identifying and correcting hazards or processes needing improvement in the facility.

As there were other areas cited, including Dietary Services and Medication Administration, there is reason to believe that attention to detail and leadership were lacking at Brookfield, based on the remarks above, and those to follow.

BW-She states that with an initial licensure visit (the 10/08) is a "free" survey and it is not expected that all is in compliance. She does state that if it's a chain home then they should have "ironed out the kinks". She appears unaware that Brookfield is part of a chain. (We question whether or not the State Operating Manual allows this survey result to not go down as permanent deficiencies, per BW.)

OLTC Survey Checklist – Complaint #1008 – 11/23-24/09

The date sequence of this complaint raises some questions as to what behind-the-scenes discussions may have taken place at OLTC in regard to this complaint: It was opened on 11/17/09, visit conducted on 11/23-24/09, but not closed until 1/5/10, with letter emailed to Steve Brigance on 1/26/10, more than two months after the file was opened.

The first paragraph of the surveyor's narrative report is confusing. It appears as though they are assuming that the complaints made by Steve Brigance (11/17/09) are repetitive as to the complaints made after Mr. Brigance's injury, and therefore, as they state, "that another visit may be in order". Or, perhaps they visited the facility another time in addition to the visit of 11/23 -24/09. Either way, it is clear that Steve Brigance's complaint addresses additional issues specific to his mother's care and it was OLTC's obligation to investigate.

Complaint #1008, Visit by Hicks and Proffer

SP-Says that she and Jim Hicks went to the facility in 12/09 and that report is a blending of the investigation by Pessa and Wheeler and the additional visit by Proffer and Hicks. Says she did not take any field notes, but that she made copies of forms. States that their info is blended with Ms. Pessa's by whom? "It appears Jim did." She states that she did not do it. Of interest, she states that she went to facility and made copies, looked into the compliance agreements, left message for Mr. Brigance, spoke with the administrator and also says they were there for SIX HOURS. She has no field notes (just forms she copied and initialed) from that time. She admits that there should have been one blended report but broken down as to signatures of who actually did the work. Under cross from Dossett, she states that facility did not receive deficiencies because there was not "substantial failure" of the facility. (Is "substantial failure" the threshold per the State Operating Manual for the OLTC for a deficiency, or is it "deficient practice".)

JH-Says that he, Proffer and Kenneth Hanft from OLTC went to the facility. Proffer does not mention that Hanft was a part of this visit, nor does Wheeler or Pessa, who were also involved with Complaint #1008. He also states that Proffer reviewed paperwork while Hicks and Hanft did rounds. He also provided a lot of confusion and double talk regarding who did what on the 11/23/09, 11/24/09 and 12/3/09 visits to the facility. States that Proffer would

have been the lead and she would have incorporated his notes. This conflicts with her testimony when she says their info is blended with Pessa's and that it appears Hicks did that.

JP-Says she was aware that Proffer and Hicks went to the facility after she and Wheeler conducted their investigation.

BW-States that the Ombudsman was there during this investigation. The Ombudsman's report does not specify the date in which she was in the building, but we can presume it was between 11/16/09 (date she spoke with Steve) and 11/25/09 (date she closed case). She states she spoke with Mrs. Brigance, which would further narrow the time frame to 11/16/09 to 11/19/09; however, state visit was 11/23/09 and 11/24/09. If Ombudsman went to facility more than once, it is not documented that way on her report.

One aspect of the complaint dealt with call lights. Typically, when there is a call light complaint, surveyors will enter a sampling of rooms on different wings or units, unobserved, press the call light and then time the amount of time it takes the staff to respond. This practice was not followed during this complaint investigation. Instead, residents were asked about how the staff met their needs, not specifically about call lights (although some residents addressed this in a favorable manner). There is no evidence in the Surveyor Narrative Report if the surveyor was accompanied by staff while questioning residents, or if this was a confidential one-on-one process.

During the complaint investigation, the surveyors note the position of the call light cords wrapped or tied around the grab rail in the bathroom and the side rail of the bed in Mrs. Brigance's room. This is 4-5 days after her fall and subsequent hospitalization; however the surveyors accept the Ms. Bailey's words that this was how the lights were in the room while the resident was there. There was no corroboration of this with any of the caregivers.

The surveyors also cite the Resident Council minutes as evidence of no call light complaints; however there is no indication as to the number of residents in actual attendance at the meetings, and whether or not feedback to that specific issue was sought.

SP-Admits that no one asked Mrs. Brigance about the call lights or being allowed to be wet, and doesn't know why Ms. Pessa or Ms. Wheeler did not talk to Mrs. Brigance, even though at the time it was indicated she might be returning to the facility. Says that if she were in good enough condition, "they could have" spoken to her at the hospital, which is not an uncommon practice.

JP-Regarding call light investigation states that people at an ALF are supposed to be fairly self-sufficient and that response could take some time if the person was doing medications, needed to lock the cart, etc. States that she "timed call lights" and located one instance of testing the light during the day shift and receiving a 3 minute response. This was AFTER they had been in the facility beginning the evening before and staff was aware they were in the building. This methodology was not used during their night shift visit. Of course, the complaint had to do specifically with Mrs. Brigance who they did not visit or speak to about this matter.

BW-When asked about a 20" wait for a call light to be answered, she states that ALF Level 1 regulations do not address that. She states that if that happened more than once that it would not be acceptable. When asked about call lights and resident council complaints about such, she says "QA and Resident Council don't necessarily coincide at all." (This statement is not understandable to us.) She does state that call light problems are a QA issue. She states that the use of private sitters does not relieve the facility staff of their duties, and acknowledges role of companion. On cross from Dossett, she says that "we'd always expect if they were aware that sheets were soiled...they would be to change them immediately". BW states in response to question if a person's bed clothing and sheets are not changed after being soiled, is that abuse and neglect? "That is a problem."

Ombudsman-DM-States in her report that she met with Mrs. Brigance who told her that the "girls did not answer her light as soon as she turned it on"-quotes are for the report, she did not quote Mrs. Brigance verbatim. She investigated the med error allegation, unanswered call lights, bed being made with wet sheets and toilet unrepaired by speaking with Mrs. Bailey, ONLY. We believe that the investigatory standards to which the Ombudsman are

held would include more than a session with the administrator and a brief conversation with the resident. Additionally, how can the Ombudsman find the call light complaint "unsubstantiated" per her report, when the resident herself tells her it is a problem? It is clear from her deposition that there is confusion about phone calls, dates and timing of visits, and in general her testimony seems unreliable.

Steve Brigance's concerns were articulated prior to his mother's fall on 11/19/09 and the surveyors conducted their investigation of his complaints after the fall, however, even though they note that Mrs. Brigance was "in the hospital", there was no in depth investigation of the incident during this visit. One would expect that there would have been more narrative commentary in their notes about the incident, including whether or not Mrs. Brigance was a fall risk, review of the facility's investigation of the incident, interview of the staff present at the time of the incident and more focus on this event.

Most interestingly, in reviewing the 11/19/09 Resident Progress Note for Mrs. Brigance written by Debra Swaim, which was effectively lined out and replaced with another note, there is documentation that can be identified in this entry. The notation, as reviewed, appears to indicate the following:

'11-19 ~~3-11 Resident was resting at 8PM. Resident was sleeping at 10PM. Found her on floor Restroom. She said no~~ thank you.
~~Checked on her at 4, 6. She had her sitter and she refused. Said her sitter will help her.~~ ERROR'

The word 'Found' is partially detected at the end of line 2 in the 11/19 entry; it is written over another word, as are the words 'her on floor'. As this re-written entry would be difficult to explain, additional effort was made to destroy the entry, and replace it with another Resident Progress Note, which appears on another sheet of paper.

This is the second instance of incorrect handling of resident/medical record information; it speaks to a pattern of behavior, and legitimately raises concerns involving the integrity of the individuals involved. That OLTC did not address this entry, or appear to make any effort to determine the text contained, is a less than half-hearted attempt to deal with a serious matter.

Although there was a copy of this in the State file, there was no mention of this anomaly in the record by the surveyors and it does not appear as though they investigated it. Upon review of the crossed-out documentation, it certainly appears possible that the staff member may have charted in advance of the shift with the assumption that Mrs. Brigance would refuse to be toileted as she had often times in the past.

It is also customary that when a medical record has a handwritten error, it is to be crossed out with a single line and noted as error and initialed by the staff member doing so. This record entry was basically obliterated and rendered illegible for the most part, however there is enough visible to think the charting in advance may have been the cause of the entry. The crossed out entry is initialed by the same staff member that signed the incident report and that initialed the subsequent documentation about finding Mrs. Brigance. It is puzzling that the state investigators did not address this matter, or question this employee about this, especially given the fact that one of the complaints filed after Mr. Brigance's injury (Complaint #930) was specific to records falsification in regard to an incident report. This type of progress note false entry would be a serious violation on the facility's part, and failure of the state to investigate it seems negligent.

SP-Asked if this anomaly where record is scratched through is something that state should have investigated further or asked questions about says, "Could be, yes." States this is an incorrect way of scratching through. Says she did not look at progress notes until her deposition. By the time of her visit (12/3/09) the state was aware that Mrs. Brigance had an incident at the facility and was not well enough to return to the facility. The absence of looking at the chart is an incredible defect in their investigation.

JP-Says she is not concerned about the gap in the records, but rather why there was high frequency in charting prior to 10/22/09. She did not state that she investigated that, but she also was not asked. She is dismissive of the documentation issue by saying that CNA's are the "lowest paid and ill-educated" employees in a facility and that there is no reason they have to know how to correct an erroneous entry, nor should they be trained. It would appear

that this State official is willing to overlook or rationalize incomplete performance that is in direct conflict with OLTC's standards. She offers the conclusion that "she charted on wrong person", did not ask about this and doesn't think she should have. She does not believe it is an example of "charting ahead".

BW States that "this is the first time I've been able to really read that" and "I would have questioned that". She agrees the progress note is cause of concern and "did not see it until just now". She says that it is very difficult to read the scribbled out entry. Even on cross from Dossett, she admits that she "didn't catch that documentation".

It is also interesting to note that the progress notes show routine entries up until 10/22/09 and then no entry again until 11/12/09. The OLTC surveyor did not make note of this large gap in charting which occurred at the same time as a number of issues with Mrs. Brigance were being brought to the attention of the facility staff. This does not provide the impression that the staff was being attentive to Mrs. Brigance at that time.

Subsequent to the facility visit, the surveyors conducted telephone interviews with two private duty sitters employed by Steve Brigance for his mother. The sitters reference a "journal" that was used to communicate with the family and document issues or concerns during their time on duty. The State narrative indicates that they were e-mailed the journal with entries from 3/9/09 through 11/19/09, and that it is included with the survey paperwork. This journal was not provided in the materials provided for our review, which raises the question as to whether or not the State has withheld the journal. The surveyor's narrative states that the "journal is questionable due to the apparent lack of effective communication between sitter and staff". If the journal details issues with timeliness in response to call lights and other measurable observations, then this statement would appear to reflect bias on the part of the surveyor and an unreasonable discounting of the journal's contents. Even if the surveyor's assumption regarding sitter/staff communication was correct, it would not warrant a 100% discounting of the entire journal's contents.

Journal-Not reviewed by any of the OLTC surveyors that were deposed.

SP-Admits that Steve Brigance told her about the journal and suggested they get copies, but says "no, not to my knowledge" when asked if they obtained copies of the book. Later in depo, Rex has her read that it was emailed to them and says "Maybe Jim did receive a copy…" States that a journal "should be taken into consideration" but not 100%.

JH-Says that he did not review journal.

JP says that she never reviewed journal, but spoke with Debbie Upton on the phone who read portions to her. She states that she did not write the reference to the journal in the report, but she did sign the report. She states that sitters are "biased" because they are paid by the family.

BW-Says that she did not review the journal and that she never saw it. If she had seen it, it might have been helpful for specific dates. She says she would give "very little weight" to the journal, implying it is self-serving.

One of the complaint issues had to do with the toilet in Mrs. Brigance's room not working properly. The surveyors began their investigation at around 10:30PM of 11/22/09, and in keeping with traditional date documentation for night shift events, they labeled their visit as beginning on 11/23/09. Additionally, they mention that the plumber was in on 11/23/09 to look at the toilet and he indicated it was stuffed with wads of paper and pads. It appears as though once made aware of the OLTC's presence in the building and the nature of the concerns, the plumber was called in specifically to address this matter. In other words, the toilet was not in working order when the OLTC surveyors began their investigation. This is significant, as review of the email traffic between Steve Brigance and the facility administrator, "Mitzi" is written on 10/19/09 by Steve asking if "Blaylock been called about Mom's toilet that has been acting up", and she responds on 10/21/09 that "They will be here tomorrow". (Although it is not specifically documented that Blaylock did or did not come on the promised 10/22/09 date, it is documented, apparently by the facility that on 10/17/09 someone purchased a plastic plunger at Lowe's and that on 10/20/09

"Richard" came by and flushed toilet and it was not blocked.) This issue shows a lack of follow up on the part of the facility to address concerns brought to their attention by Mr. Brigance, because if it had been addressed in October when it was originally brought up, then why was it still clogged on 11/23/09. That is a long time for a resident to deal with an erratically operating toilet and further confirmation of the Quality Assurance deficits as cited by OLTC in 2008 and apparent when Mr. Brigance was injured in 2009.

Another aspect of the complaint dealt with an allegation that Mrs. Brigance was without her Aricept for 4 days in November. The state investigation narrative stated that she received the medication on the 12th and 13th of November, did not receive it on the 14th of November, and a pending problem with the pharmacy and the co-pay was subsequently addressed and the medication was delivered on the 15th. They go on to dismiss the complaint by saying, "Only one day was missed, not four" and then indicate, "The problem for this was with the pharmacy who failed to contact the facility in regard to the co-pay." In most cases, you would expect the facility to contact the pharmacy when a logged in pharmacy order is not subsequently delivered, and in most cases the facility would be held responsible by OLTC for assuring that the ordered medication was available. The surveyor's notes include copies of items from Mrs. Brigance's record, including a medication administration record for November, 2009. It is proper to document a missed dose of medication by initialing the box for that particular date and dose and to put a circle around the initials indicating that the medication was not given. This was done for 11/14/09 for the Aricept.

JP States she cannot answer about the Aricept issue because she did not do this part of the investigation, but Wheeler did. She acknowledges under questioning that the investigation **should have gone back prior to one month** in order to determine the timing of the medication running out. She is dismissive about the resident missing the medication by saying it is "not life threatening". Again, this attitude is at conflict with OLTC's expectations and the rules regarding medication administration.

BW States that Aricept is important to be given daily. She admits she **did not go back** to check the number of pills left over a number of months. She says it can't be proven.

Ombudsman DM-Her report says she substantiated the complaint regarding the medication because it was not available when the resident was supposed to receive it.

There are two medication order sheets for Mrs. Brigance for this time frame. The first one has medications ordered 10/5/09 up until the Aricept notation on 11/12/09, which is the last entry on the page, with no subsequent entries. The second medication order sheet has a medication ordered on 11/1/09 (no indication that it was received) and then a list of medications ordered on 11/19/09, which were received on 11/20/09. On the first sheet, Aricept was ordered on 10/7/09, received on 10/8/09 in the quantity of 30. The only other medication received on that date was Visine, and this may indicate that the Aricept was a new order although not having a complete record this really is unknown. However, if Mrs. Brigance received 30 on 10/8/09, it appears as though the missing days could have begun on 11/8/09 and that Mrs. Brigance did not receive Aricept again until 11/15/09.

It was also noted that there were 8 instances of pharmacy orders for Mrs. Brigance on the sheet ending with the Aricept order. Each one of those was ordered and then checked in by the same employee that documented the placed order, except for the Aricept order. It was the only medication documented as received by someone else other than the person who ordered the medication.

Given that this medication is prescribed to lessen symptoms of dementia and confusion, it would be worth evaluating in this matter as whether anywhere from a day to a week's worth of missing doses could have caused Mrs. Brigance to experience increased symptoms of dementia that would have made her less likely to remember to call for assistance when she got up to use the bathroom in the middle of the night.

The surveyors also examined the facility's bladder program. There were six residents receiving this service which included checking on the residents every two hours and offering to assist them to the bathroom. The care staff utilized monitoring sheets to document this and the state surveyors commented that they observed this care being performed at 11:45PM for three residents. There were 8 days of bladder monitoring checks for the residents

included in the State file: 11/11/09 through 11/19/09, with 11/14/09 being missing. There were numerous "holes" on the documentation sheets:

- 11/11/09 - nothing at all for resident #203; nothing for the day shift for resident #204;
- 11/12/09 - nothing for residents #305 and #203 on the night shift;
- 11/13/09 - no night shift documentation for anyone;
- 11/14/09 – no information available
- 11/15/09 - resident #305 was not on the sheet, but resident #306 was listed twice and actually documented twice on the day shift.
- 11/16/09 - staff documented (R) for Mrs. Brigance at midnight, 2AM and 4AM (assuming this meant she refused), they did the same for 11/17/09 and 11/18/09. On 11/19/09, the day of her fall, there was no documentation at all for the night shift (early morning of the 19th) and (R) documented for 4PM and 6PM. Initials were documented at 8PM, which would indicate that they indeed toileted Mrs. Brigance, but in the narrative progress note mentioned earlier the staff member writes that they did not awaken Mrs. Brigance at that time. Again, the sloppy documentation on the bladder forms and the inconsistency between the progress note (written under questionable circumstances already described) and the bladder forms point to another piece of evidence regarding falsification.

Another aspect of the complaint investigation involved the sitter's discussion with the surveyor about wet sheets left for more than 24 hours. The surveyor indicated in the narrative report in parentheses that "Laundry is set one time a week per occupancy agreement" perhaps as an "explanation" or excuse for this. However, three sets of linens are provided by the facility perhaps to account for the occasional need for a more frequent change and the ALF regulations under Linen and Laundry 700.2.2 (g) require the facility as part of its basic services to take care of bed linens. Under any circumstances it would not be acceptable for facility personnel to leave wet sheets in the room for more than 24 hours.

BW States that if staff were aware sheets were soiled they would expect staff to change them immediately.

In reviewing the Surveyor Notes Worksheets corresponding to this time frame, one of the remarks made by Cheryl Williams during the interview process indicated, 'If Ms. Brigance needs to go to a NH, maybe ½ of the other residents also do.'

Cheryl Williams' interview

SP Says she thinks it was done on 12/4 by Jim Hicks, but Pessa writes report, Profitt says Pessa shouldn't have signed it and "If Jim did the interview, Jim should have signed the form, too."

At this time, Brookfield was nearly 1 ½ years in operation, at an occupancy level of approximately 74%. During this time, the corresponding Profit and Loss statements for this facility were likely not showing a strong profit, due to slow fill rate and occupancy issues. It is possible, and not extraordinary, that Brookfield would go to extremes to protect its overall occupancy %, keeping residents that otherwise might have been better suited for a higher level of care (skilled nursing), in an attempt to protect its revenue sources. The contemplation of this operating strategy is a constant threat to assisted living facility residents, and on an individual level, it would be important to review the service level agreements and any assessment tools, to determine whether care needs are being assessed correctly and the resident(s) was placed in the most appropriate care setting.

**Brookfield Incident and Accident Reporting**

Our scope of work included review of three incident reports:

- The second Incident and Accident report involving Mr. Brigance, dated 1/7/09
- A memo, dated 10/30/09, involving an employee named Angela Ruckman and a resident in 411, who goes unnamed, but is believed to be Ms. Brigance.

- The Incident and Accident report involving Mrs. Brigance, dated 11/19/09

If the Incident and Accident Report involving Mr. Brigance is the re-written version, it is incorrect, as evidenced by the 1/7/09 date next to Amanda Broughton's signature. It should be dated as of the day it was re-written and designated as a replacement or second statement, as it is not an original and shouldn't be treated as such.

There are other areas of this report that raise serious questions, and they are listed below:

- We believe that this Incident and Accident Report was not fully completed by Amanda Broughton, PCA, and many of the sections were completed by Mitzi Bailey. In looking at the handwriting, particularly at the bottom of the form, there is a person other than Ms. Broughton who contributed to its completion.
- Under 'Type of Incident', there is documentation of this being a Fall. Unless someone witnessed the Mr. Brigance actually fall, this should be indicated as an incident of unknown origin, and that Mr. Brigance was found on floor.
- The question, 'Did incident result in death?' was answered 'YES', then amended to indicate 'NO'. It would be important to understand when and why it was answered in the affirmative, and when and why it was amended?
- There is an indication that Mr. Brigance was oriented to Time, Place, Person, and Events, and rated High on Mental Functional Level. At the same time, Mr. Brigance has a primary diagnosis indicated in several documented areas of Dementia, including the OLTC Complaint Narrative Report. There appear to be inconsistencies here.
- There is an indication that Mr. Brigance had no impairment and had a high physical functional level. In Mr. Brigance's Brookfield Pre-Admission Screen/Health History, it was indicated that he needed assistance with Mobility, ADLs, Medications, and Evacuations
- The 'Five Day Follow Up' question is completed by Ms. Bailey, who indicated that Mr. Brigance was a 'Resident at Sparks'. As she dated the form on 1/8/09, how is it that Ms. Bailey could have known this? Additionally, there is not an alternate location to place the date that the Five Day Follow Notation was provided.

In reviewing the memo-like incident report dated 10/30/09 involving Angela Ruckman, and care to the resident in Room 411, which is not named, yet would appear to be Mrs. Brigance, there are numerous questions, and some that speak to the inappropriate fashion that Brookfield administration handled documentation involving patient care, and treatment of medically related records.

Briefly, the questions that should be presented as a result of document review are the following:

- Why isn't the standard Incident/Accident Report used?
- Why is there no reference to Dorothy Brigance as the resident in Room 411?
- How, by whom and when was this determined to be an incident? The 'incident report' indicates a 10/30/09 incident date, yet there is evidence that it was not addressed on 10/30/09, or for four days afterward. Additionally, if Ms. Ruckman reported to a shift supervisor or Patient Services Coordinator, it is notable that there is no involvement in a person with direct supervisory responsibility.
- What made a four to five day delay appropriate in the documentation of a resident incident?
- Why is there no reference to time in this documentation?
- Why is there an employee statement to the Incident Report? This would be expected if it was an employee performance issue or a disciplinary notice, though the tone and word choice of Ms. Ruckman not customary with an Incident Report.
- If this is a performance or disciplinary notice, is there a corresponding investigation for abuse and neglect? Given the circumstances involving the care of an incontinent resident, making a resident's bed with urine soaked sheets, and allowing soiled evening wear to be made available for re-use, these each constitute reasons for investigating the possibility of resident abuse or neglect.

Evaluating the incident report document along with Ms. Ruckman's response demonstrates that no party was held responsible for this incident, and no leadership was demonstrated to protect resident health, safety or dignity. This is

not only tragic, but as it involves the facility Administrator, Ms. Bailey, tantamount to her allowing Ms. Brigance to be subjected to abuse and neglect.

The Incident and Accident Report for Mrs. Brigance is equally as troubling as the previous two reports cited above. Below are listed some of the reasons for this determination:

- It is incomplete.
- It is unsigned by anyone present the evening that Mrs. Brigance was found in her room.
- The Summary of Incident has an OVER -> indicator where it appears the person completing the form ran out of room, yet the information was not provided in the state file.
- It is dated as complete on the day following the date Mrs. Brigance sustained her injuries.
- There is evidence that there were two CNAs that found Mrs. Brigance on 11/19/09, yet the second person's name, signature or narrative is not available.
- As in the Incident and Accident Report, the Type of Incident is classified as a 'fall', rather than found on floor. At the same time, the Summary of Incident indicates that Mrs. Brigance was found on the floor.
- Under 'Steps Taken to Prevent Continued Occurrences', the notation indicates, 'She needs to pull cord.' There is no information in the file to indicate that an investigation, other than the Fort Smith Police Report, was conducted internally to determine the cause and effect of this event, particularly within a 24 hour period of the event.

Within the materials provided for our review, there is a single, unsigned, typed document dated 11/20/09 entitled, "Interview with Debbie Swaim". There is no way to tell who conducted this interview, however, it is a narrative description of a version of the events the evening of Mrs. Brigance's injury up until when she was found on the floor. The document refers to the fact that Peggy Brigance was present when Mrs. Brigance was being giving medication and that Peggy advised Debbie not to wake Mrs. Brigance up at 8PM or Midnight because "she had not been getting enough sleep". This is also referenced in the surveyor's narrative report from 11/23-24/09 and assumed as fact. The surveyor's narrative actually gives the impression that this was a standing request from Peggy Brigance. It does not appear as though either party, the facility administration or the state surveyors actually validated that this request was made by Peggy Brigance, which would be an important investigative action in this matter.

Given the weak documentation provided on Incident and Accident Reports at Brookfield, one has to inquire:

- Is this performance level a function of benign neglect by Executive Leadership, demonstrating a low priority for accurate and timely investigation and documentation?
- Is this performance level intentional, in order to provide incomplete, inaccurate, or misleading information to parties interested in root cause analysis of events?

In either case, the performance level is very poor. What is even more important to determine is the motivation behind these deficits.

**E-Mail Correspondence**

- The 2/19/09 e-mail message between Steve Brigance and Jim Hicks indicates that the doors had been a problem since the original walk-through. Is there any information to support this? Additionally, the message indicates that the doors were 'repaired a number of times'. There are records indicating that the doors were repaired twice. Does Steve have any recollection that the doors were addressed more than twice?

- The 3/1/09 e-mail message between Steve Brigance and Jim Hicks indicates that a caregiver was inexplicably fired, and was one of two individuals involved in completing the incident and accident report. Additionally, the message indicates that Ms. Broughton would be arrested for criminal trespass if she returned to Brookfield. Aside from the involvement in the completion of the incident and accident report, which was addressed earlier, it would appear that Brookfield violated Ms. Brigance's resident rights by barring Ms. Broughton from visiting the facility. As Brookfield was Mr. and Mrs. Brigance's home, they were allowed to have guests, including family, friends and others. Restricting Ms. Brigance's access to Ms. Broughton is likely to have caused undue and unnecessary distress to Ms. Brigance, and caused unnecessary isolation at a time when she recently experienced the loss of her husband, after six decades plus of marriage. It is incredible that this series of events, as referenced in the e-mail, was not investigated by OLTC. The defense of not getting involved in employment matters may be appropriate, yet does not excuse the disregard for investigating a violation of a resident's rights. This allegation clearly falls under Residents' Rights 603.1 L (visitation) and possibly 603.1 J (retaliation). Though Steve Brigance remarked about the employee termination, the nature of his complaint was not about the employee's termination, but rather his mother's desire to see this person and the fact that the facility barred visitation from occurring. OLTC not only failed to address this, but rather dismissed it as an employment matter not within their jurisdiction, which totally disregarded Mrs. Brigance's resident right to visit with guests of her own choosing.

**Retaliation and Residents' Rights**

SP: When asked if Steve Brigance's complaint contained some concerns regarding retaliation, then she says "We should have investigated that."

JH: When asked about Amanda Broughton, his reply was "I got sometimes's" and then he was showed emails and asked if he investigated the Resident Rights issue states, "I can't answer", and "If we don't have it here, it wasn't I'd say." When asked about visitation and residents' rights he said visitation can occur "if it doesn't cause hardship or problems with other residents". However the Arkansas regulations state that the resident must "Be allowed communication, including personal visitation with any person of the resident's choice, including family members, representatives of advocacy groups, and community service organizations." (603.1 L) On cross, Dossett has a line of questioning about this topic and he answers "yes" to Dossett's question that visitation should "consider the safety and comfort of all residents and employees." This is clearly not the law and there is nothing in the statute in regard to employees that would inhibit resident visitation. Dossett also gets Hicks to agree that when thinking about who is going to be allowed to supervise a visiting individual that "you'd have to consider... what their mental state is and their level of stability is." Again, the regulation is pretty clear about allowing visitors and there is nothing about supervision or mental stability. Dossett continues to pursue this line of questioning, getting Hicks to agree that OLTC would give a fair amount of leeway to the administration about restricting ex-employees from visiting. He also asks that when Hicks responded to Brigance, did he let him know that all he would be looking into was the falsification, and Hicks says "yes". Although, we now know that no one thoroughly investigated the incident report falsification allegation AND the residents' rights violation.

Ombudsman DM States that she spoke with Mitzi about the visitation issue and that Mitzi told her the employee had been fired. When asked if she asked why, she said no and that she never had another facility do this (prevent visitation). She also indicated that she never had a visit issue before, but that she felt it was not her position to tell the ALF who could come in and who could not. This is clearly a violation of her duty to advocate for the residents which includes upholding residents' rights.

- In Jim Hicks' 3/19/09 e-mail to Carol Shockley, he indicates that Complaint #927 was substantiated due to the closet door falling from its track, yet there was no deficiency cited as 'the facility had performed required maintenance when problems were reported.' This statement is factually incorrect, as the facility did not perform the required maintenance on one of the doors from the period 11/12/08 to 11/19/08, and also incredible to consider in a broader context, as it ignores any expectation or standard related to prevention or quality assurance.

- In Carol Shockley's 3/19/09 e-mail to Jim Hicks, she makes an inquiry regarding the timeliness and depth of the maintenance being performed. It is apparent that this is not the case, as evidenced by the seven day lag (11/12/08 to 11/19/08) in time that the door(s) became non-functioning in the Brigance's room until being temporarily repaired. Based on the documentation provided, there appears to be no Quality Assurance practices or documentation in place at Brookfield, specifically in Maintenance. It would be interesting to review the Quality Assurance meeting documentation for Brookfield, and see what the meeting minutes indicate regarding door repair.

Memo Shockley to Hicks

JH Hicks says in his deposition that he does not recall doing any double-checking on the door issue when he received the email from Carol and that he "stood with the report."

- In Jim Hicks' 3/19/09 e-mail to Carol Shockley, he indicates that 'the problem is going to fall on the contractor in the 'possible' improper track being installed during construction per the investigators.' As it appears that this indeed did occur, it is remarkable that the facility, its operator, and its owner were not held to a very high standard of non-performance. Consider the following – a newly constructed facility is open for operation, and the resident room bath/shower mixing valve, responsible for mixing hot and cold running water, was installed with a grade of product that created a risk to resident health. At the time of the first resident shower, a resident is badly scalded and injured. Would the facility receive a pass on this occurrence, or would the contractor be solely responsible for the substandard product? In Mr. Brigance's situation, it is arguable that Brookfield be held to an even higher standard. The Brigances were tenured residents at Brookfield, the issues involving the bi-fold doors were historical and well documented, the company through its agents and owners, were operating the facility, and the State of Arkansas, through its agents and pre-occupancy inspection process, deemed the facility to be a safe living environment. That the facility was not held responsible for maintaining a safe living environment for its residents could be unprecedented.

- We reviewed the email correspondence regarding Mrs. Brigance's care which included a number of messages from Steve Brigance to Mitzi Bailey, several of which appear to be unanswered: 9/8/09, 10/2/09, 10/29/09, and 11/6/09. During this period, the one message that was responded to was the one in regard to the toilet repair issue, written on 10/19/09 and responded to on 10/21/09. There is also a handwritten notation on a 10/29/09 email, but it is unclear as to whether or not that is a note by Mitzi in response to the call light issue or not and whether that information was communicated to Steve Brigance.

- The next group of email messages between Mitzi Bailey and Steve Brigance are initiated when Mitzi advises him on 10/31/09 that she "has the invoices ready" and has prepared releases for him to sign in

regard to the sitters. The Brigance family had been utilizing sitters since June of 2009, so the motivation for requesting a release at this time appears to be self-serving. Nevertheless, Steve responds to this in a few days by signing the documents and clarifying his position regarding the release request. The fact that the facility Administrator ignored the care issues and responded in writing only for a plumbing problem, invoicing and requesting a release from liability, certainly sets the tone for why Steve Brigance's next email series beginning 11/15/09 are copied to the Ombudsman and the State OLTC official.

- The email of 11/15/09 from Steve Brigance to Mitzi Bailey outlines allegations of care problems and indicates the desire to have a meeting involving the Ombudsman and OLTC as well as the sitters and facility caregivers. This elicits a response from the Administrator at 5:46PM the next day, and she requests a written list and dates of occurrences. Steve Brigance's response is to advise Mitzi that he is turning this matter over to Peggy Brigance to limit his direct involvement and indicates again that the call lights are problematic and advises that the meeting could be held "anytime". Mitzi responds the next day, 11/17/09, at 12:20PM, acknowledges that Peggy will be involved, and discourages him from having the State and the Ombudsman in attendance. She goes on to suggest that the meeting be held 11/18/09 at 10:00AM. Within 45 minutes, Steve reiterates his desire to have the State officials in attendance. A few hours later, at 4:29PM, she responds saying "it's their decision to make and they are welcome to attend". Clearly, there has not been any direct communication to either official about their availability to attend the meeting and by communicating after 4PM she has virtually assured that there is no way they could attend the meeting for 10AM the next day, no matter who invited them.

**Brigance emails cc'd to State**

JH-During depo says that when he got concerns from Steve Brigance via email that he turned them over to his supervisor that the office and Brigance's would be better served if Sherri (Proffer) would start more or less communicating with him". This was not corroborated by Sherri Proffer's depo.

- After this exchange, at 4:34PM Steve Brigance informs Mitzi Bailey that there will not be a meeting at 10AM and expressly asks her to arrange a time that is convenient to the officials. She does not reply. The next morning, at 8:41AM on 11/18/09, Peggy Brigance writes Mitzi and she also asks her to "set up a care conference with Mr. Hicks and Ms. Medley at their earliest convenience", and she also advises Mitzi that she needs 24 hours notice to be able to attend the meeting. Mitzi Bailey does not reply until 4:12PM, advising that she has set up the meeting for 4PM on the 19th and once again ignoring the requests made by both Steve and Peggy to involve the State, says, "If you would like Ms. Medley and/or Mr. Hicks to attend, please feel free to invite them." Again, Mitzi Bailey appears to be going out of her way to ignore the request to invite the state officials, and to also schedule the meeting that they are anxious to have in such a manner as to make it very unlikely that either state official could attend.

**Additional Items for Consideration**

- Assisted Living Facilities have a mandatory reporting requirement in Arkansas, particularly in cases of suspected Abuse, Neglect, or Misappropriation of Resident Property. Why is there no evidence of an internal investigation by Brookfield of either abuse or neglect? Why is there no real evidence of an OLTC investigation regarding Neglect on the part of Brookfield? Briefly, it appears that Brookfield could be cited for the following issues:

    - Brookfield neglected to properly assess the resident living environment for risks, occurring on 11/11/08, 11/12/08, 11/19/08, and in the days following, as there is no evidence of follow up by Brookfield Maintenance or Administration after the intervention on 11/19/08, to determine the functionality or safety of the closet doors. In the OLTC Complaint Narrative Report, the Maintenance Person indicated that they planned to contact the General Contractor, Crawford Construction, if there were any more door issues. If there was a Quality Assurance program functioning, at even an elementary level, this communication would have occurred much earlier than after a significant resident injury, resulting in death. Based on the events between 11/12/08

and 11/19/08, there appear to be no rounds or walk-through tours being conducted by Administration, no evidence of a Quality Assurance process, or no elevation or communication of issues creating resident risk.

- Brookfield neglected to repair non-functioning doors timely, as evidenced by the seven day gap from 11/12/08 to 11/19/08. During that seven day period, Karen Brown's notation on the Maintenance Log form indicated that the unhinged closet door was kept in the Brigance room. This was also indicated in the OLTC Complaint Narrative Report, documenting the creation of a significant risk of injury to both residents. Joe Martin, Maintenance Person stated that the doors were too heavy, and it took him and another person to safely carry a door out of a resident room. Additionally, Mr. Martin indicated that he only worked at the facility one day per week, and there is no evidence of an on-call process for maintenance related issues.
- Brookfield neglected to fully repair a set of doors, that had been an issue historically, resulting in an injury to a resident, as evidenced by the 11/19/08 repair (shims) being less than satisfactory.
- Brookfield neglected to investigate internally, even if to rule out abuse or neglect
- Brookfield neglected to communicate or report an instance of resident neglect
- Brookfield neglected to remove the doors from the resident living area, as the OLTC Complaint Narrative indicates regarding Complaint #927. Brookfield did exactly this with resident Connie Bianchi's door. Why did this not occur with the Brigances?
- Brookfield neglected to offer to replace the unrepaired doors, even if it were at resident's expense

- On the OLTC Facility Data Sheet, it indicates that the Initial Life Safety Code inspection was held on 5/22/08. Is that inspection report available, and what does it indicate about the doors and hardware? In reviewing the comments of Rich Rapin, Project Manager, Crawford Construction Company, he indicates that the Brigance's door had hardware different than that of other resident rooms. If this were the case, the Project Manager should have known, or been alerted to this during construction, and if this were an oversight (intentionally or unintentionally), it could have been detected in the initial LSC walk-through. And if it were not detected during the initial LSC walk-through, it should have been not only detected, but addressed during the period that Brookfield operated the facility. The Brigances were tenured residents, the resident room was in use, the Maintenance Person was familiar with the issues in the resident room and had knowledge of how the doors and hardware compared to other resident rooms, and could have done several things to achieve a more positive outcome.

  As an aside, the State File contained information from a Life Safety Code survey conducted at Brookfield on 4/13/09. In reviewing the survey document completed by Richard Daes, HFS, there is no survey element corresponding to the review of closet doors in Apartments, under Tag 905. In fact, the word 'door' appears only three (3) times in the entire survey document; once related to a single door serving as both entrance and exit, once related to keys, code or other operating device for a door, and another instance related to adjoining resident rooms.

- As OLTC Complaint #927 was found to be substantiated, but with no deficiencies, it would be important to access OLTC's records, and determine the number of cases where a complaint is found to be substantiated, yet no deficiency is cited. It is difficult to remember a single instance where Arkansas regulators, or regulators for any other state, substantiated a complaint involving a health care facility and found no deficiencies to be cited.

- Brookfield has a Grievance Policy and Procedure which states in its Policy section that grievances must be investigated, and solutions documented in writing, and available for review in the office of the Administrator. In the Procedure section, it states that when a grievance is given verbally to the Administrator, a written record will be made at that time. Based on the record review, there appears to be no evidence of a grievance process initiated, an investigation attempted, or any documentation provided by the Administrator involving any of the issues raised by the Brigances during the relevant time periods. Additionally, there is no evidence that OLTC performed any investigation into Brookfield's Grievance Policy or its execution.

- Brookfield has a Safety and Security Policy, which states, '5. Environmental safety is provided by keeping the facility clean and orderly and includes properly operating doors, protected stairs, and generally good repair of the entire facility; and 6. All equipment should be operated according to manufacturer's recommendations and repairs made as recommended by the manufacturer. Given the chain of events, it appears that neither #5, nor #6 was followed successfully.

  Additionally, in the preamble of this policy, it is stated that 'Every employee should perform every duty correctly and safely and should report safety hazards to the Administrator.' Nothing in this record would indicate that the spirit of this policy was being followed or encouraged, as evidenced by the behavior of the facility, staff and its Administrator from 11/11/08 through 1/7/09.

- On December 31, 2009, Marcelina Brigance, a nurse and Mrs. Brigance's daughter writes OLTC noting her concerns about call lights not being answered timely over a nine-day period in August of 2009 while she was visiting from Texas. Even though the OLTC complaint #1008 remained open during this period (after the visit on 11/26/09 until the letter sent to Steve Brigance in January of 2010), there is no evidence in the State file that would indicate that this was investigated.

- In reviewing the record and exhibits, it is reasonable to question the qualifications, experience and training of the Administrator, Mitzi Bailey. Given the deficits in oversight, communication, organization and execution, there is a demonstration of questionable capacity, commitment, interest or all of the above in the performance of her daily duties. At the same time, it would be interesting to understand what training and skills development interventions were being provided by Brookfield's operating group or ownership, as the performance gaps of this leader appears to be profound. Given the relative size and complexity of this operation, the performance issues should not have been as significant as appearances allow.

  Ms. Bailey appears to have taken the place of Paul Gilbert, who was the administrator of record when the facility was initially licensed on 6/11/08. At the time of licensure, Mr. Gilbert did not have experience in operating assisted living facilities in Arkansas, as he was awaiting the appropriate professional credentials. As Ms. Bailey has emerged as a central figure in a number of events, it would be important to understand her credentials and experience.

- It was interesting to see (via Steve Brigance's email traffic) that the primary owner of the facility, Robert Brooks was the individual that gave Steve the name and contact information for Jim Hicks, the OLTC executive in charge of following up on Steve's complaints, when Steve was initiating his search for an ALF for his parents. Is there a long-standing or friendly relationship between Mr. Hicks and Mr. Brooks that had biased the State in their investigations? Was there any ex-parte communication between Mr. Hicks and Mr. Brooks that took place? A second time the sound of familiarity stood out was on 11/20/09 when Mr. Brooks wrote Jim Hicks about an administrator absence in Bella Vista and stated, "Jim, I tried to call earlier this week to discuss the Brigance situation..." and Hicks answers him on Monday, 11/23/09 with "Bob, thank you for the information."