GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2020

Thomas, Robert and Susan
2915 Linda Court
Port Huron, MI 48060

RE: License #: AF740271686
Investigation #: 2020A0604022
RST AFC

Dear Mr. and Mrs. Thomas:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF740271686
Investigation #:	2020A0604022
Complaint Receipt Date:	09/24/2020
Investigation Initiation Date:	09/24/2020
Report Due Date:	11/23/2020
Licensee Name:	Thomas, Robert and Susan
Licensee Address:	2915 Linda Court Port Huron, MI 48060
Licensee Telephone #:	(810) 982-2802
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	RST AFC
Facility Address:	2915 Linda Ct. Port Huron, MI 48060
Facility Telephone #:	(810) 982-2802
Original Issuance Date:	12/16/2004
License Status:	REGULAR
Effective Date:	01/12/2019
Expiration Date:	01/11/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident G passed away on 08/03/2020 after being sick for two days. It is unknown why she was not taken to the hospital.	Yes
Licensee, Sue Thomas, has made inappropriate comments to residents about suicide.	Yes
Residents are caring for other residents. Resident H found another resident in the shower nude, sitting on the shower stool in the dark.	No
Sue Thomas stated that she has issue with Resident H because she does not wipe her “hoo ha”.	No
Additional Findings	Yes

III. METHODOLOGY

09/24/2020	Special Investigation Intake 2020A0604022
09/24/2020	Special Investigation Initiated - Telephone Left message for Complainant 1
09/24/2020	Contact - Telephone call received Received message from Complainant 1’s husband. I returned the call. I returned the call.
09/25/2020	Contact - Telephone call received Received message from Complainant 1’s husband. I returned the call. I returned the call.
09/25/2020	Contact - Document Received Email from Adult Services Worker, Rachel Jacobson
09/25/2020	Contact - Telephone call made TC to Rachel Jacobson. Interviewed by phone.
09/27/2020	Contact - Document Sent Email to and from Adult Services Worker, Rachel Jacobson

09/27/2020	Contact - Document Received Received Intake #175118 regarding RST AFC
09/29/2020	Contact - Telephone call made TC to St. Clair County Public Guardian's Office. I interviewed Tim Quirk from Guardian's Office.
09/29/2020	Contact - Telephone call made TC to Licensee, Sue Thomas. Interviewed by phone.
09/30/2020	Contact - Telephone call received Received copy of death certificate by text from Complainant 1
10/05/2020	Contact - Telephone call made I sent a text to Complainant 1
10/22/2020	Contact - Document Received Received intake #175659 regarding RST AFC
10/23/2020	Contact - Telephone call made TC to Complainant 3
10/26/2020	Contact - Telephone call received TC to Complainant 3. I left a message.
10/27/2020	Contact - Telephone call received Received message from Complainant 3
10/28/2020	Contact - Telephone call made TC to Complainant 3. Interviewed by phone.
11/05/2020	Contact - Document Received Email from APS Worker, Marnie Debell. Ms. Debell emailed denied APS referral re: Resident G's death that was received on 08/03/2020. I sent a return email.
11/13/2020	Contact- Document Sent Sent police report request to Port Huron Police Department.
11/14/2020	Contact- Document Received Received police report from Port Huron Police Department by email.
12/07/2020	Contact- Telephone call made TC to Sue Thomas. Interviewed Ms. Thomas, Resident D, Resident F, Resident J and Resident K.

12/15/2020	Exit Conference Completed exit conference with Sue Thomas by phone.

ALLEGATION:

Resident G passed away on 08/03/2020 after being sick for two days. It is unknown why she was not taken to the hospital.

INVESTIGATION:

An onsite investigation was not completed due to COVID-19.

On 09/24/2020, I received a complaint regarding RST AFC. The Complainant stated that Resident G passed away on 08/03/2020. Licensee Designee, Sue Thomas, said that Resident G was sick for two days. She only ate a banana on one day and yogurt on the day after and then died the following day. Complainant does not know why Resident G was not taken to the hospital or why they did not call her family. Complainant just wants to know what happened.

A second complaint was received on 09/27/2020. It was alleged that Sue Thomas reported to Adult Service Worker that years ago she had a resident who said they were suicidal. Ms. Thomas asked the resident how they were going to commit suicide so that she could have the right cleaning supplies on hand. Sue went on to explain that she had a resident who thought she did not like her because she was black. This resident reported that they were suicidal and going to drown themselves. Sue filled up the bathtub for the client, and the client then told her that she was not actually suicidal. This resident has reportedly since moved out. It is unknown if the above incidents are both regarding the same resident. Sue indicated that she would never let anything happen to her residents. Sue's reasoning for her actions is that she knew the residents were not actually suicidal.

A third complaint was received on 10/22/2020. It was alleged that residents in the home are caring for other residents and the home has no staff. It should be noted that RST AFC is a family home with no staff. Complainant stated that on an unknown date, approximately one month ago, Resident H found another resident in the shower nude, sitting on the shower stool in the dark. Resident H turned on the light. Resident H went to find Sue in the main living room with friends. Resident H told Sue that resident was in shower and she said “oh yeah, I forgot”. Sue Thomas said that she only wants the easy people and does not want residents that need physical care. She has issue with Resident H because she does not wipe her “hoo ha”. It is unknown if Resident H will be returning to RST AFC. She is currently at the Medilodge following a hospitalization. The referral was denied by APS.

I received a fourth complaint from APS Worker, Marnie Debell on 11/05/2020. Ms. Debell stated that her manager asked her to send the denied APS referral from law

enforcement to licensing. The referral was made on 08/03/2020. The complaint indicates that Resident G resided at RST AFC with her roommate Resident D. Resident G had high blood pressure and a mental handicap of some sort. Resident G could also have had a rupture of some kind due to coughing up blood. Resident G passed away on 08/03/20 at 4:16am. The police were called by the AFC manager Susan Thomas at 3:28am. There are concerns of medical neglect for Resident G due to the timeline not matching up with the time of death. It is unknown if Susan is covering something up or not. Resident G had been sick since Friday (07/31/20). She was vomiting up blood today (08/03/20) and on 08/02/20, but Susan was not aware of that until she called for help on 08/03/20. Resident D was aware of Resident G vomiting up blood.

On 09/24/2020, I left a message for Complainant 1. I received a return call from Complainant 1's husband. I interviewed Complainant 1's husband on 09/25/2020. He stated that Resident G passed away on 08/03/2020. He believed that Resident G lived at RST AFC for a little over a year. She had cerebral palsy and was on blood pressure medication. Her guardian was the St. Clair County Public Guardian's office. Resident G was seen by a visiting physician at the home. He believes Resident G's cause of death was cerebral atherosclerosis and he has a copy of her death certificate. They never received copy of an incident report. Complainant 1's husband stated that Sue Thomas told them that Resident G was not feeling well for 2½ days before she passed away. He does not understand why Ms. Thomas did not take Resident G to a hospital. He is unsure if a doctor was called. He stated that they could have taken her if notified. Ms. Thomas also said that Resident G felt constipated, so she gave her a laxative. Resident G passed away at the home in the middle of the night and EMS was called. He also noted that the home always smells like cigarette smoke.

On 09/29/2020, I contacted the St. Clair County Public Guardian's Office. I interviewed Tim Quirk at the guardian's office. He stated that Resident G passed away on 08/03/2020. The Guardian's office does not have any concerns regarding her cause of death. Resident G had cerebral palsy. He stated that they still have residents placed at RST AFC. Mr. Quirk stated that they do not have any concerns regarding Resident G's medical treatment.

On 09/29/2020, I interviewed Licensee Sue Thomas. Ms. Thomas stated that Resident G passed away on 08/03/2020. She does not know the cause of death. She stated that Resident G was not feeling good for two or three days before passing away, however, was "not that sick". Resident G did say she did not feel good and was slowing down eating. She asked Resident G each day if she wanted to go to the doctor or hospital and Resident G stated that she did not need to go. Ms. Thomas stated that Resident G's stomach was soft and she was up and moving. She was still smoking cigarettes and drinking water. Ms. Thomas stated that on 08/03/2020, Resident G started throwing up around 3:00 am and 911 was called. Police and EMS arrived at the home. Ms. Thomas stated that she tried for three hours to get a hold of guardian. She left messages for Resident G's guardian and sister. Ms. Thomas stated that all the residents are seen monthly by a visiting physician.

On 09/30/2020, I received copy of Resident G's death certificate from Complainant 1 by text. The death certificate indicates that Resident G passed away on 08/03/2020 due to cerebral atherosclerosis. Manner of death is listed as natural and an autopsy was not performed.

On 11/14/2020, I received a copy of the police report from Port Huron Police Department. The status of the case is closed. The report indicates, "Susan stated that (Resident G) has not been feeling well since approximately 07/31/2020. She said that she asked (Resident G) if it hurt to urinate which (Resident G) told her it did not and Susan said that she felt her stomach and it did not feel hard. She said that she tried to convince (Resident G) to go to the hospital but that (Resident G) refused to go, making mention that she cannot force her to go and seek medical treatment." The report stated that Susan said that this morning after 3 am she was informed by Resident G's roommate that Resident G was vomiting and did not feel well. She called for medical help at 3:28 am and a second time at 3:38 am. Police also interviewed Resident G's roommate who stated that she woke up to go to the bathroom at around 12:45 am and noticed Resident G was not feeling well. Resident G was vomiting in a small bucket next to her bed. She woke Susan up and informed her of Resident G's condition. The roommate stated that Resident G had been vomiting the day prior, believing that she first noticed the night prior, possibly in the early hours of Sunday morning. She said that Resident G had been using the bucket to vomit during that time and that she had not informed Susan of Resident G's medical issues. The police report indicates that EMS was interviewed. The EMS worker stated that Resident G's sheets were covered in vomit. There did appear to be slight rigor mortis in Resident G's arms and she was cold to the touch when they arrived on the scene so she was unsure if the timeline of Resident G's death matched what Susan had told medical staff or this officer.

I reviewed copy of an incident report completed by Susan Thomas dated 08/03/2020. The report indicates, "(Resident G) wasn't' feeling well. For 2½ days. Then during the night she started vomiting. Roommate came and got me the second time. I called 911 and (Resident G) wasn't responding very well by the time 911 got here she wasn't responding at all. They tried for over 40 minutes."

On 12/07/2020, I interviewed Licensee Susan Thomas by phone. She stated she received a subpoena and is being sued by Resident G's family. She believes the family's attorney is Geoffrey Fieger. Ms. Thomas stated that as a provider she cannot force a resident to eat.

On 12/07/2020, I interviewed Resident G's former roommate, Resident D by phone. She stated that she has lived in the home for 8 years. She stated that Resident G was sick for 2-4 days before she died. Resident D stated that they tried to get Resident G to eat but she did not want to. Resident G only wanted to sleep and go to the bathroom. Resident D stated that she was a witness when it happened. She stated that on the night of 08/03/2020 she went to get Resident G a washcloth and told Sue immediately that Resident G was getting sick. Resident D never heard Resident G ask to go to the doctor or hospital. She stated that Resident G said that she did not want to go to the

hospital. Resident D stated that she heard Resident G say about a year and a half ago that she wanted to die.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all of the following qualifications: **(c) Be capable of handling emergency situations.**
ANALYSIS:	Resident G passed away at RST AFC on 08/03/2020. Ms. Thomas stated that Resident G was sick for about two to three days before she died. According to Ms. Thomas, Resident G was slowing down her eating but did not want to go to the doctor or hospital. Ms. Thomas said she asked Resident G each day if she wanted to go to the doctor or hospital and Resident G said that she did not need to go. Ms. Thomas reported that resident G's stomach was soft, and she was up and moving and she was still smoking cigarettes and drinking water. According to Resident G's roommate, Resident D, Resident G was sick for two to four days before she died. Resident D stated that they tried to get Resident G to eat but she did not want to. Resident G only wanted to sleep and go to the bathroom. The police report indicates that EMS was interviewed. The EMS worker stated that Resident G's sheets were covered in vomit. There appeared to be slight rigor mortis in Resident G's arms and she was cold to the touch when EMS arrived on the scene so they were unsure if the timeline of Resident G's death matched what Susan Thomas had told medical staff or the police officer. No medical attention was provided to Resident G was not eating and refusing to be seen by a doctor. Ms. Thomas did not contact Resident G's physician to inform them that Resident A was not eating and refusing to be seen. Also, Resident G's guardian was not contacted for emergency treatment.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(7) A licensee shall contact a resident's physician for instructions as to the care of the resident under the following conditions: **(b) If the resident requires the care of a physician while living in the home.**
ANALYSIS:	Resident G passed away at RST AFC on 08/03/2020. According to Ms. Thomas, she was sick for about two to three days before she died. Ms. Thomas reported Resident G was slowing down her eating but did not want to go to the doctor or hospital. No medical attention was obtained or provided to Resident G. Ms. Thomas indicated that she could not force Resident G to eat or go to the hospital. The police report indicates that there was uncertainty about the timeline Ms. Thomas reported, however, the police case was closed. The death certificate indicates that Resident G passed away on 08/03/2020 due to cerebral atherosclerosis. The manner of death is listed as natural and an autopsy was not performed. Despite Resident G's refusal, Ms. Thomas did not contact Resident G's physician and ask for direction when Resident G stopped eating and stated she did not want medical treatment.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by telephone, followed by a written report to the resident's designated representative and responsible agency within 48 hours of any of the following; **(a) The death of a resident.**

ANALYSIS:	There is not enough information to determine that Susan Thomas did not notify the appropriate individuals when Resident G passed away. An incident report dated 08/03/2020 was sent to licensing. Ms. Thomas stated that she also left messages for Resident G's sister and guardian. Police report also indicates that Ms. Thomas provided guardian and next of kin information to law enforcement.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Licensee, Sue Thomas, has made inappropriate comments to residents about suicide.**
- **Residents are caring for other residents. Resident H found another resident in the shower nude, sitting on the shower stool in the dark.**
- **Sue Thomas stated that she has issue with Resident H because she does not wipe her "hoo ha".**

INVESTIGATION:

On 09/27/2020, I received an email and telephone call from DHHS adult services worker (APS), Rachel Jacobson. Ms. Jacobson was concerned about statements Ms. Thomas told her regarding things she has said to suicidal residents. Ms. Thomas stated that she asked a resident what kind of cleaning supplies she needed. She also stated that she filled up the bathtub for a client who said they were going to drown themselves. Ms. Thomas said she knew they were not serious about committing suicide. Ms. Jacobson stated that Ms. Thomas reported this on 09/14/2020, but said it happened a few years ago. She did not give the resident's name but did say that one was a black female. It is unknown if the incidents are both regarding the same person.

On 09/29/2020, I interviewed Licensee Sue Thomas about the complaint received on 09/27/2020 regarding her comments made to residents about suicide. Ms. Thomas stated that she made a joke after the fact when former Resident A, was suicidal and CMH came out to the home. Ms. Thomas stated that she and Resident A both laughed about it. Ms. Thomas stated that the resident who was suicidal and said they were going to drown themselves was placed with her at her previous AFC home 20-25 years ago. The resident said Ms. Thomas did not like her because she was black. Ms. Thomas stated that she tried to call the guardian and case manager for hours when Resident I said she was suicidal. After 18 hours she was exhausted and said "come on, let's go to the bathroom and there's the water." Ms. Thomas stated that she knew Resident I was not serious and was not going to kill herself. I advised Ms. Thomas to not make any suicide jokes. Ms. Thomas was put on a provisional license on 07/12/2018 due to comments she made to Resident A and the Mobile Crisis Unit. Resident A is no longer placed in the home.

On 10/28/2020, I interviewed Complainant 3. She stated that Resident H was placed at the Mediloge. She stated that a nurse was having a phone conversation with Sue Thomas and Ms. Thomas made a comment that Resident H did not wipe her “hoo ha’”. Ms. Thomas said she wants to care for easy residents. The admissions director also heard the comment. Resident H also reported that one night she went to the bathroom and found another resident (Resident F) sitting naked on a shower chair in the dark. Resident H also stated that residents helped care for other residents. Complainant 3 stated that Resident H left the Medilodge on 10/23/2020 and is currently at the hospital. Her oxygen (O2) levels were dropped and she was verbally not responsive.

On 12/07/2020, I interviewed Susan Thomas by phone. She stated that one day she thought Resident F was in the living room. However, Resident F took her clothes off and got in the shower by herself. Ms. Thomas stated that Resident F did not turn on the water or anything but just sat there. Ms. Thomas was working on dinner and stopped to help Resident F immediately when she found out. She stated that she was not with friends in the living room. Ms. Thomas stated that Resident H did not say anything at first when she saw Resident F in the shower. She told Resident F’s daughter about the incident. Ms. Thomas stated that Resident F does require assistance with showering. Ms. Thomas stated that she does not make residents care for other residents. Sometimes Resident D will ask Resident F to go to the bathroom. Ms. Thomas stated that Resident F has dementia and will get mad if she asks her to go to the bathroom. Once Resident D asks Resident F to go to the bathroom, Ms. Thomas helps her. Ms. Thomas stated that Resident D has also held the shower head when she is showering Resident F. Ms. Thomas stated that Resident F turns her head and cannot see her. Both guardians know this occurs. Resident F also likes to help with chores around the house, however, it is her own choice.

Ms. Thomas stated that she does not want to accept residents that require lifting, walkers or wheelchairs. She stated that she is 62 years old and would like to care for residents that are more independent. Ms. Thomas stated that Resident H had many medical needs and was getting to the point she would require lifting. Resident H requires more help currently. Resident H got mad when she could not return to her home after going to the Mediloge. Ms. Thomas stated that she never said that she had issue with Resident H because she does not wipe her “hoo ha”. She stated that Resident H is able to wipe on her own and Resident F is the resident who requires assistance. Ms. Thomas stated that she might have said it but does not think she uses the term “hoo ha”.

On 12/07/2020, I interviewed Resident D by phone. Resident D stated that she likes living at the home. She helps by cleaning her room. Ms. Thomas does the laundry. Resident D stated that she does not help shower Resident F as it would not be allowed. She has only helped brush Resident D’s hair. Resident D stated that she offers to help out with simple things like doing the dishes because it is in her heart to help. Resident D stated that Ms. Thomas assists her when needed. Resident D stated that she does not provide care for other residents.

On 12/07/2020, I interviewed Resident F by phone. Resident F stated that she has lived in the home a long time. She indicated that she was not sure she was comfortable answering questions, however, said she would not answer if she was not comfortable. Resident F stated that she gets help in the home. She does not care for other residents and there is a good home care provider. Resident F stated that Ms. Thomas always helps with her shower. She did not recall and incident when she was left in the shower.

On 12/07/2020, I interviewed Resident J by phone. Resident J stated that she has lived in the home since June 2020. She likes living there and has a big bedroom. She stated that the food is good and she gets lots of it. Resident J stated that she does not need a lot of help. Ms. Thomas helps with laundry, bus fair and does all the cooking. Resident J stated that she does not have to do much. She helps set the table. Resident J stated that she does not provide any care for other residents.

On 12/07/2020, I interviewed Resident K by phone. Resident K stated that she has lived in the home for 3½ months. The home has good food and she is treated well but she would like to move to an assisted living with more independence. Resident K stated that Ms. Thomas helps her with medications, meals and makes sure she does not fall as she is legally blind. She can dress, shower and feed herself. Resident K stated that she never cares for other residents and they are not allowed to do that.

I completed an exit conference with Licensee, Susan Thomas, by phone on 12/15/2020. I informed her of the violations found and that a copy of the special investigation report would be mailed once approved. I also informed her that a provisional license was recommended.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all of the following qualifications: **(b) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	Ms. Thomas did not respond appropriately when Resident A and Resident I stated they were suicidal. Ms. Thomas admitted that she made a joke to Resident A regarding suicidal thoughts. She also stated that she took Resident I to the bathroom and said “there’s the water” when she was having suicidal thoughts, however, it occurred 20-25 years ago. Ms. Thomas was advised not to make jokes about suicide. On 07/12/2018, Ms. Thomas’s license was placed on a provisional due to inappropriate inappropriate comments she

	made to Resident A and the Community Mental Health-Mobile Crisis Unit. Ms. Thomas was inappropriate when the Mobile Crisis Unit (MCU) arrived at the home to meet with Resident A. Ms. Thomas was frustrated and angry when the MCU visited the home and was yelling “curt remarks”. Ms. Thomas said, “You’re lucky I’m letting you in right now” and was “stand offish”.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2017A0604016 dated 12/08/2017; CAP dated 07/12/2018**

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Due to the need for privacy, Resident D should not assist with showering Resident F. According to Sue Thomas, Resident D has held the shower head when she is showering Resident F. Resident D turns her head and is not watching.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(1) A licensee shall not mistreat or permit the mistreatment of a resident by responsible persons or other occupants of the home. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm.
ANALYSIS:	There is not enough information to determine that Susan Thomas left Resident F in the shower. According to Ms. Thomas, one day she thought Resident F was in the living room. However, Resident F took her clothes off and got in the shower by herself. Resident F did not turn on the water or anything but

	just sat there. Ms. Thomas was working on dinner and stopped to help Resident F immediately when she found out. I was unable to interview Resident H about the incident as she was in the hospital and verbally unresponsive. Resident F stated that Ms. Thomas always helps with her shower. She did not recall and incident when she was left in the shower. None of the residents interviewed stated that they have to provide care for other residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(2) A licensee, responsible person, or any person living in the home shall not use any of the following methods of handling a resident for discipline purposes: **(e) Mental or emotional cruelty, including subjecting a resident to verbal abuse, making derogatory remarks about the resident or members of his or her family or making malicious threats.**
ANALYSIS:	There is not enough information that Ms. Thomas used verbal abuse or made derogatory marks about Resident H. According to the Complainant, Sue Thomas has issue with Resident H because she does not wipe her “hoo ha”. The Complainant stated that the admissions director also heard Ms. Thomas’ comment about Resident H not wiping herself. Ms. Thomas said that she might have said it but does not think she uses the term “hoo ha”. Ms. Thomas also indicated that she would be referring to Resident F who needs assistance with wiping. Ms. Thomas did not accept Resident H back into her home due to her level of care after she was placed at the Medilodge.
CONCLUSION:	VIOLATION NOT ESTABLISHED

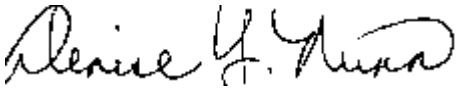
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

12/15/2020

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



12/15/2020

Denise Y. Nunn — Date
Area Manager