GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2022

Kimberly Nolan
Progressive Alternatives, Inc
P.O. Box # 20054
Kalamazoo, MI 49019

RE: License #: AS390016162
Investigation #: 2022A0462022
Progressive Alternatives

Dear Ms. Nolan:

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

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

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

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

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390016162
Investigation #:	2022A0462022
Complaint Receipt Date:	03/03/2022
Investigation Initiation Date:	03/04/2022
Report Due Date:	05/02/2022
Licensee Name:	Progressive Alternatives, Inc
Licensee Address:	400 S. Second Street Kalamazoo, MI 49019
Licensee Telephone #:	(269) 207-0091
Administrator:	Kimberly Nolan
Licensee Designee:	Kimberly Nolan
Name of Facility:	Progressive Alternatives
Facility Address:	10476 West U Ave Schoolcraft, MI 49087
Facility Telephone #:	(269) 207-0091
Original Issuance Date:	02/05/1996
License Status:	REGULAR
Effective Date:	08/08/2020
Expiration Date:	08/07/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 03/01/2022, facility staff members did not provide Resident A with supervision as specified in her written assessment plan and Behavior Treatment Plan when she was left alone with a visitor at the facility.	No
On 03/01/2022, direct care worker Thynosha Harris-Collins slapped Resident A in face, causing her glasses to break.	No
Additional Finding.	Yes

III. METHODOLOGY

03/03/2022	Special Investigation Intake 2022A0462022
03/04/2022	Special Investigation Initiated – Telephone interview with Resident A's Clinical Rehabilitation Worker Mackenzie Geisen. Contact- Requested and received documentation. Contact- Email exchange with Ms. Geisen.
03/07/2022	Unannounced investigation onsite. Face-to-face interviews with Resident A, DCWs Danna Smith and Meghan Overacker, and home manager Vicky Maguire. Requested and received documentation.
03/18/2022	Contact - Telephone interviews with DCWs Paige Nall, Thynosha Harris-Collins, and Jason Gains.
04/11/2022	Contact- Conducted an exit conference with licensee designee Kim Nolan via telephone.

ALLEGATION: On 03/01/2022, facility staff members did not provide Resident A with supervision as specified in her written assessment plan and Behavior Treatment Plan when she was left alone with a visitor at the facility.

INVESTIGATION: On 03/03/2022 Adult Protective Services (APS) dismissed the above allegation for investigation and referred it to the Bureau of Community and Health Systems (BCHS), via a written complaint. According to the written complaint, Resident A suffered from a traumatic brain injury (TBI). According to Resident A's "plan", she was to be supervised at all times. On 03/01 Resident A met a man, Individual A1, on the social media platform Facebook. Resident A asked direct care worker (DCW) Thynosha Harris-Collins if Individual A1 could visit with her in the

facility that evening and Ms. Harris-Collins said no. However, during the facility's "shift change" Individual A1 showed up at the facility anyway. According to the written complaint, Resident A was allowed to visit with Individual A1 in the facility's garage, unsupervised. Shortly after Individual A1 arrived, DCW Paige Nall reported to the facility to relieve Ms. Harris-Collins. When Ms. Nall went to check on Resident A and Individual A1 in the garage, she observed Resident A pulling her pants up. Ms. Nall left the garage and allowed Resident A and Individual A1 to spend more unsupervised time together. The written complaint indicated that at this time, Resident A and Individual A1 "had sex again." Individual A1 was then allowed into the facility where he visited with Resident A, supervised, for an additional 45 minutes before leaving the facility. According to the written complaint, after Individual A1 left, Resident A texted her mother and reported being raped by Individual A1. A police officer responded to the facility to question Resident A. However, Resident A denied being raped and told the police officer she had consensual sex with Individual A1 in the facility's garage.

On 03/04 I conducted a telephone interview with Behavior Analyst and Clinical Rehabilitation Worker Mackenzie Geisen, who worked for the agency Behavior Consultants Inc. According to Ms. Geisen, due to Resident A's TBI diagnosis, Resident A had a history of unsafe behaviors and making poor decisions. Subsequently, public guardian Janice Clark was appointed Resident A's legal guardian. Ms. Geisen stated Resident A was to seek permission from facility staff members prior to receiving visitors at the facility and was to be supervised at all times. Therefore, Resident A should not have been left alone with Individual A1. According to Ms. Geisen, Resident A had a Behavior Treatment Plan, which was previously provided to facility staff members. Ms. Geisen stated she also "went over" the details of this plan with facility staff members. According to Ms. Geisen, she was not sure if Resident A's specific supervision needs were outlined in her Behavior Treatment Plan. Via email, Ms. Geisen provided me with a copy of this plan.

Via an email exchange between me and Ms. Geisen on 03/04, Ms. Geisen informed me it was her understanding Resident A would receive 24 hour supervision while at the facility. I explained to Ms. Geisen that according to Act No. 218 of the Public Acts of 1979, "supervision" was defined as being aware of a resident's general whereabouts. Specific supervision needs, and methods for providing those needs, were to be identified in Resident A's written assessment plan and Behavior Treatment Plan.

According to Resident A's Behavior Treatment Plan, Resident A had full access to the Facebook application on her personal cellular telephone. In order to consistently monitor Resident A's engagement and behaviors online, Resident A's case managers had access to Resident A's Facebook login and password. Documentation on Resident A's Behavior Treatment Plan indicated that among several issues, Resident A had difficulty with the "*understanding of and ability to engage in appropriate steps to obtaining a romantic relationship with someone of interest*".

According to Resident A's Behavior Treatment Plan, Resident A also had difficulty with "*demonstrating functionally appropriate ways to get attention from others*." Documentation on Resident A's Behavior Treatment Plan read, in part; *"on several occasions, Client has engaged in contacting others (her mom, family on social media, staff at the home, the BCBA and people she just introduced herself to on Facebook messenger) and expressing that she is experiencing pain, is injured, she fell or other examples that she has explained to be of a medical emergency.*

According to documentation on Resident A's Behavior Treatment Plan, Resident A was to have "1:1 supervision" while on outings. There was no documentation in Resident A's Behavior Treatment Plan including specific supervision needs for Resident A while at the facility. While documentation on Resident A's Behavior Treatment Plan indicated *"the BCBA does have a plan developed for Client to have the opportunity to go on dates with specific criteria she will need to meet before she can be unsupervised with a man, for safety reasons",* her plan did not include any specific restrictions on Resident A's right to receive visitors in the facility at a reasonable time, nor did it include restrictions on Resident A's ability to spend time with visitors in the facility without constant 1:1 enhanced supervision. Documentation on Resident A's Behavior Treatment Plan read in part; "*for a period of 45 consecutive days, Client will not give out personal information away [sic], send inappropriate content, make threats or suicidal statements, request money from others or give out inappropriate information about someone else on social media or text messaging.*

On 03/07 I conducted an unannounced investigation onsite and interviewed Resident A. Resident A requested DCW Janna Smith be present during our face-to-face interview. According to Resident A, it was her understanding she had no restrictions on private visits with individuals at the facility. Resident A confirmed that on 03/01 she met Individual A1 on the social media platform Facebook. According to Resident A, she spoke with Individual A1 via telephone and he asked to take her to dinner. Subsequently, she gave Individual A1 the address to the facility. Resident A stated she asked Ms. Collins-Harris, who was working at the time, if she could go out to dinner with Individual A1, to which Ms. Collins-Harris stated "no". According to Resident A, she made the same request to Ms. Geisen via text message. Resident A stated Ms. Geisen responded back, via text message, and informed Resident A she could not leave the facility with Individual A1 and needed to wait 45 days before she was allowed to go out on dates unsupervised. Resident A confirmed Individual A1 came to the facility anyway. Resident A stated Ms. Collins-Harris, Ms. Nall, and DCW Jason Gains allowed her to visit with Individual A1 in the garage unsupervised for approximately 20 minutes, and during this time, she had sex with Individual A1. According to Resident A, after engaging in sexual intercourse with Individual A1, Ms. Nall came into the garage and observed Resident A pulling up her pants. Resident A stated Ms. Nall asked, "what's going on?" and Resident A stated she was "honest with her (Ms. Nall)". According to Resident A, Ms. Nall told her and Individual A1 to "be responsible" and then left the garage, leaving her with Individual A1 unsupervised for a second time. Resident A stated she immediately told Individual

A1 to leave, which he did. According to Resident A, while Individual A1 did not physically force her to engage in sexual intercourse, she felt pressured to have sex with Individual A1 because “he drove all the way here to see me.” Resident A stated, “I don’t remember telling him no. I just remember being uncomfortable.” Resident A confirmed that after Individual A1 left, she texted her mother and reporting being raped by Individual A1. However, according to Resident A, her mother did not notify local law enforcement. Resident A stated that via the Facebook Messenger application on her personal cellular telephone, she also reported the allegation to her friend who lived in Georgia. According to Resident A, her friend notified local law enforcement. Resident A confirmed a police officer responded to the facility and interviewed her. According to Resident A she told the police officer the incident was a “misunderstanding” and a “false allegation.”

I conducted a separate face-to-face interview with home manager Vicky Maguire who stated that Individual A1’s visit at the facility on 03/01 was not “preapproved” by Resident A’s legal guardian, case managers and/or facility staff members. According to Ms. Maguire, on 03/01 facility staff members had no idea Individual A1 was coming to the facility until Resident A asked Ms. Collins-Harris if he could pick her up to go out on a date. Ms. Maguire stated that at approximately 5:00PM on 03/01, she received a telephone call from Ms. Geisen informing her that via text message, Resident A had asked her permission to leave with Individual A1 and that she told Resident A “no”. According to Ms. Maguire, she then called Ms. Collins-Harris, who was working at the facility, and together they decided that if Individual A1 showed up at the facility, Resident A and Individual A1 would be allowed to engage in a “supervised visit”. Ms. Maguire stated that Individual A1 arrived to the facility shortly after she spoke with Ms. Collins-Harris on the telephone, and Ms. Collins-Harris supervised Resident A and Individual A1 while they visited outside. According to Ms. Maguire, at approximately 6:00PM, Ms. Nall reported to the facility to relieve Ms. Collins-Harris. Ms. Maguire admitted Resident A and Individual A1 were left unsupervised in the garage for approximately 10 minutes while Ms. Collins-Harris provided Ms. Nall with a “shift report”. According to Ms. Maguire, after receiving shift report, Ms. Nall went out to the garage to continue supervising Resident A and Individual A1. Ms. Maguire stated that Ms. Nall later reported that when she went into the garage, she observed Resident A “adjusting her pants”. Ms. Maguire stated it was her understanding Ms. Nall did not leave Resident A and Individual A1 unsupervised for a second time, as indicated in the written complaint and reported by Resident A. According to Ms. Maguire, Individual A1 visited with Resident A at the facility for a total of 30-45 minutes before leaving. Ms. Maguire stated Resident A did not report the allegation to Ms. Nall, who was present at the facility after Individual A1 left. Ms. Maguire confirmed Resident A reported the allegation to her friend in Georgia who then called local law enforcement. Ms. Maguire also confirmed Resident A told a responding police officer that she was not raped but did feel pressured to have sex with Individual A1. According to Ms. Maguire, since the incident, Resident A reported different accounts of what occurred between her and Individual A1 on the evening of 03/01.

I requested and received from Ms. Maguire a copy of Resident A's written *Health Care Appraisal* (HCA) and *Assessment Plan for AFC Residents* (assessment plan). Documentation on Resident A's HCA confirmed Resident A was diagnosed with a TBI. While Resident A's assessment plan indicated Resident A was at risk for elopement, there was no documentation on Resident A's assessment plan indicating any restrictions on Resident A's independent access in the community. There was also no documentation on Resident A's assessment plan indicating specific supervision needs for Resident A while at the facility (for example, "1:1 enhanced supervision" or "eyes-on supervision") if necessary, and/or documentation indicating Resident A's visits with individuals at the facility were to be supervised.

On 03/18 I conducted separate telephone interviews with Ms. Harris-Collins, Ms. Nall, and DCW Jason Gains, who also worked at the facility on 03/01. The statements Ms. Harris-Collins, Ms. Nall, and Mr. Gains provided me were consistent with the statements Ms. Maguire provided to me during my face-to face interview with her. According to Ms. Harris-Collins, Resident A and Individual A1 were left unsupervised in the facility's garage for approximately 5 minutes while she provided "shift report" to Ms. Nall. Ms. Harris-Collins stated she was still at the facility when Individual A1 left. According to Ms. Harris-Collins, Resident A appeared "fine" after Individual A1 left and did not report the incident to her either. Subsequently, Ms. Harris-Collins stated she was "shocked" to later learn of the allegation. Ms. Null stated Resident A and Individual A1 were left unsupervised in the facility's garage for approximately 10 minutes while she received "shift-report" from Ms. Harris-Collins. Ms. Null confirmed that following "shift-report", she went out to the garage to resume supervision of Resident A and Individual A1, and observed Resident A adjusting her pants, other clothing, and hair. Ms. Null stated, Individual A1 was fully clothed. Resident A appeared happy and not did not show any signs of distress and/or being uncomfortable. Ms. Null denied leaving Resident A and Individual A1 unsupervised for a second time. According to Ms. Null, she asked Individual A1 to leave and for Resident A to come inside for dinner. Ms. Null stated she observed Resident A hug and kiss Individual A1 goodbye. Ms. Null confirmed Resident A did not report the incident to her or Ms. Harris-Collins after Individual A1 left the facility. Ms. Null stated that at approximately 8:00PM, she received a telephone call from licensee designee Kimberly Noland, who informed her Resident A reported the allegation to her mother. According to Ms. Null, when a police officer responded to the facility that evening, Resident A expressed not wanting to speak to the officer. Ms. Null confirmed Resident A reluctantly spoke to the officer and told him the incident was a "misunderstanding". Mr. Gains stated on 03/01 Resident A and Individual A1 where only left unsupervised in the facility's garage on one occasion for a "brief amount of time", during "shift-report". Mr. Gains stated he found it difficult to believe Resident A and Individual A1 could engage in sexual intercourse in a such a short amount of time.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon my investigation, home manager Vicky Maguire and DCW Thynosha Harris-Collins agreed, via telephone conversation, that on 03/01 Resident A would be supervised while visiting with Individual A1 at the facility. However, Resident A and Individual A1 were left unsupervised in the facility's garage for a brief period of time while facility staff members conducted "shift-report". Resident A later reported that during this time, she was raped by Individual A1. Resident A later changed her statements and reported her sexual encounter with Individual A1 was "consensual." Resident A's assessment plan did not include specific supervision needs for Resident A while at the facility and/or any specific restrictions on Resident A's right to receive visitors in the facility at a reasonable time, nor did it include specific restrictions on Resident A's ability to visit with individuals in the facility unsupervised. Subsequently, there is not enough evidence to substantiate the allegation that on 03/01, facility staff members did not provide Resident A with supervision as specified in her assessment plan, when she was left alone with Individual A1 in the facility's garage for a brief amount of time while facility staff members conducted "shift-report."
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Resident A's Behavior Treatment Plan did not include specific supervision needs for Resident A while at the facility and/or any specific restrictions on Resident A's right to receive visitors in the facility at a reasonable time, nor did it include specific restrictions on Resident A's ability to visit with individuals in the facility unsupervised. Subsequently, there is not enough evidence to substantiate the allegation that on 03/01 facility staff members did not provide Resident A with supervision as specified in her Behavior Treatment Plan when she was left

	alone with Individual A1 in the facility's garage for a brief amount of time while facility staff members conducted "shift-report."
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 03/01/2022, direct care worker Thynosha Harris-Collins slapped Resident A in face, causing her glasses to break.

INVESTIGATION: The above allegation was included in the written complaint APS forwarded to the BCHS on 03/03/2022. According to the written complaint, Resident A had a history of being aggressive.

During my face-to-face to interview with Resident A at the facility on 03/07, Resident A stated that on 03/01 she became angry when Ms. Harris-Collins told her she could not leave with Individual A1 to go out to dinner. According to Resident A, she pushed Ms. Harris-Collins, who then slapped Resident A in the face, breaking her glasses. I observed a small cut on Resident A's nose. Resident A stated the only witness to the allegation was Mr. Gains.

While at the facility on 03/07, I conducted face-to-face interviews with DCWs Janna Smith and Meghan Overacker who both stated the allegation would be "out of character" for Ms. Harris-Collins, who had been a long-time employee at the facility. Ms. Smith confirmed Resident A had a history of being physically aggressive with facility staff members.

During my face-to-face interview with Ms. Maguire at the facility on 03/07, Ms. Maguire also stated the allegation would be "out of character" for Ms. Harris-Collins. According to Ms. Maguire, it was her understanding that on 03/01, Resident A became angry and physically aggressive with Ms. Harris-Collins when she was told she could not leave with Individual A1 to go out to dinner. Resident A's glasses flew off and broke during Resident A's "fit of rage." Ms. Maguire stated Ms. Harris-Collins was extremely upset regarding the accusation against her. According to Ms. Maguire, Resident A also told Ms. Maguire the allegation did not occur.

Both Ms. Harris-Collins and Mr. Gains provided me with statements there were consistent with Ms. Maguire's statements, during my separate telephone interviews with them on 03/18. Ms. Harris-Collins denied the allegation. According to Ms. Harris-Collins, on 03/01 she attempted to discuss with Resident A the possibility that leaving the facility with an individual she just met might not be a good decision. Ms. Harris-Collins stated that initially, Resident A agreed and stated she understood. However, Resident A later became angry and started yelling at Ms. Harris-Collins. According to Ms. Harris-Collins, Resident A "raged towards" her and shoved Ms. Harris-Collins into the kitchen wall. Ms. Harris-Collins stated she protected her face with her hands and at some point, Resident A's glasses flew off her face and broke. Mr. Gains confirmed that on 03/01 he witnessed Resident A become physically aggressive with Ms. Harris-Collins. Mr. Gains denied the allegation and provided

statements that were consistent with the statements Ms. Harris-Collins provided to me. According to Mr. Gains, he intervened and escorted Resident A to another room. Mr. Gains stated that shortly after the incident, Individual A1 showed up at the facility.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility staff members and Resident A, there is not enough evidence to substantiate the allegation that on 03/01 DCW Thynosha Harris-Collins slapped Resident A in face, causing her glasses to break.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: During my telephone interview with Ms. Geisen on 03/04, Ms. Geison stated that due to destructive behaviors associated with her TBI diagnosis, Resident A was to seek permission from facility staff members prior to receiving visitors at the facility and was to be supervised at all times during these visits. Therefore, Resident A should not have been left alone with Individual A1 on 03/01. Ms. Geisen stated she was not sure if Resident A's specific supervision needs were outlined in her Behavior Treatment Plan.

Via an email exchange between me and Ms. Geisen on 03/04, Ms. Geisen informed me it was her understanding Resident A was to receive 24 hour supervision while at the facility. I explained to Ms. Geisen that according to Act No. 218 of the Public Acts of 1979, "supervision" was defined as being aware of a resident's general whereabouts. Specific supervision needs for Resident A were to be identified in Resident A's written assessment plan and Behavior Treatment Plan. To ensure everyone was "on the same page", I suggested to Ms. Geisen that Resident A's specific supervision needs, and the methods for providing these services, be clearly documented and agreed upon in Resident A's assessment plan.

I reviewed a copy of Resident A's *Behavior Treatment Plan*. According to documentation on Resident A's *Behavior Treatment Plan*, Resident A was to receive "1:1 supervision" while on outings. Resident A's *Behavior Treatment Plan* indicated

Resident A's responsible agency developed a plan for Resident A to earn the opportunity to go on dates with specific criteria she will need to meet before she can be unsupervised with a man, for safety reasons. For a period of 45 consecutive days, Resident A was to refrain from giving out personal information, sending inappropriate content, making threats or suicidal statements, requesting money from others, or giving out inappropriate information about someone else on social media or text messaging. There was no documentation in Resident A's *Behavior Treatment Plan* identifying specific supervision needs, and the methods for providing those needs to Resident A while at the facility (for example "1:1 enhanced supervision" or "eyes-on supervision"), if necessary. There was also no documentation in Resident A's *Behavior Treatment Plan* indicating Resident A's visits with individuals at the facility were to be supervised by facility staff members.

During my face-to-face interview with Resident A on 03/07, Resident A stated it was her understanding she had no restrictions on private visits with individuals at the facility.

During my face-to face interview with Ms. Smith on 03/07, Ms. Smith stated that prior to the incident between Resident A and Individual A1 on 03/01, Ms. Geison informed her and a "couple of other facility staff members" that if Resident A had visitors, they were to remain in a public area of the facility at all times so that they could be closely supervised. However, Ms. Smith stated she did not believe this was documented in Resident A's assessment plan.

During my face-to-face interview with Ms. Maguire on 03/07, Ms. Maguire stated that during her telephone conversation with Ms. Harris-Collins on 03/01, they both agreed Resident A and Individual A1's visit in the facility on 03/01 should be supervised by a facility staff member.

I reviewed a copy of Resident A's assessment plan, which indicated that due to a TBI diagnosis, Resident A had mental and physical limitations and poor safety awareness. While documentation on Resident A's assessment plan indicated Resident A was at risk for elopement, there was no documentation on Resident A's assessment plan restricting Resident A's independent access in the community, as indicated in Resident A's *Behavior Treatment Plan*. There was no documentation on Resident A's assessment plan indicating specific supervision needs for Resident A while at the facility, and the methods for providing this specific supervision (for example, "1:1 enhanced supervision" or "eyes-on supervision"), if necessary, nor did it include documentation indicating Resident A's visits with individuals at the facility were to be supervised by facility staff members. Resident A's assessment plan also did not include the signature of a representative from Resident A's responsible agency Behavior Consultants, Inc.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
DEFINITION:	**(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.**
ANALYSIS:	According to Resident A's *Behavior Treatment Plan*, Resident A was to be provided with 1:1 supervision while on outings. However, Resident A's restrictions on independent access in the community were not outlined in her assessment plan. Due to Resident A's history of unsafe behaviors and making poor decisions, both Resident A's responsible agency and facility staff members believed Resident A's visits with individuals in the facility should be closely supervised by facility staff members. However, this specific supervision need was not included and agreed upon in Resident A's assessment plan. Therefore, it has been established that Resident A's assessment plan did not accurately describe Resident A's current supervision needs, nor did it include the specific methods to provide these needs. It has also been established that Resident A's assessment plan was missing the signature of a representative from Resident A's responsible agency Behavior Consultants, Inc.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/11 I conducted an exit conference with licensee designee Kimberly Nolan and shared with her the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

04/05/2022

Michele Streeter Date
Licensing Consultant

Approved By:

04/07/2022

Dawn N. Timm Date
Area Manager