GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 25, 2022

Mike Dykstra
Golden Life AFC, LLC
4386 14 Mile Rd, NE
Rockford, MI 49341

RE: License #: AL590398548
Investigation #: 2022A1029042
Golden Life AFC #3

Dear Mr. Dykstra:

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.

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL590398548
Investigation #:	2022A1029042
Complaint Receipt Date:	05/24/2022
Investigation Initiation Date:	05/24/2022
Report Due Date:	07/23/2022
Licensee Name:	Golden Life AFC, LLC
Licensee Address:	4386 14 Mile Rd, NE Rockford, MI 49341
Licensee Telephone #:	(616) 307-7719
Administrator:	Mike Dykstra
Licensee Designee:	Mike Dykstra
Name of Facility:	Golden Life AFC #3
Facility Address:	8675 S. Grow Road Greenville, MI 48838
Facility Telephone #:	(616) 225-2649
Original Issuance Date:	07/22/2019
License Status:	REGULAR
Effective Date:	01/22/2022
Expiration Date:	01/21/2024
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident records do not include an updated *Health Care Appraisal.*	No
Resident records do not include an updated *Resident Care Agreement*.	No
AFC Accident / Incident Reports are not submitted to the department as required by Golden Life AFC #3.	No
Resident A was given the wrong medication which led to a hospital stay leading to him needing a ventilator.	Yes
Resident records do not include an accurate accounting of Resident Funds.	No
The food is stored on the floor and not protected from contamination at Golden Life AFC #3.	No
The oxygen is stored incorrectly because there are several tanks in a resident bedroom.	No
Additional Findings	Yes

III. METHODOLOGY

05/24/2022	Special Investigation Intake 2022A1029042
05/24/2022	Special Investigation Initiated – Telephone from Angie Loiselle MCN
05/25/2022	Contact - Face to Face with Angela Loiselle, MCN, Johanah Beech, Megan Lilly, and MCN nurse Missy MacLaren, Mike Dykstra was on the phone during conference.
05/31/2022	Contact - Document Sent New allegations reported
06/03/2022	Contact - Telephone call made to MCN Nurse Nicole Hanses
06/03/2022	Contact - Telephone call received from Nicole Hanses
06/09/2022	Contact - Face to Face with Megan Lilly, Resident A, reviewed resident records
06/17/2022	Contact - Document Received from Terry Frey CareLinc Medical Equipment Greenville regarding O2 storage

07/07/2022	Contact - Document Sent -Email to Megan Lilly requesting staff phone numbers.
07/08/2022	Contact – Telephone call to Sarah Crawford
07/13/2022	Exit conference with licensee designee, Mike Dykstra.

ALLEGATION:

Resident records do not include an updated *Health Care Appraisal*.

INVESTIGATION:

On May 31, 2022, a complaint was received via the Bureau of Community and Health Systems alleging the resident records did not include updated *Health Care Appraisals.*

On June 9, 2022, I interviewed home manager, Megan Lilly. Ms. Lilly stated the procedure for Golden Life AFC #3 is to obtain a *Health Care Appraisal* at move in and then have an updated one each year. She stated during the COVID pandemic it was harder to get an appointment to have them updated.

During the onsite investigation on June 9, 2022. I reviewed the resident records for Resident A, Resident, B, and Resident C. All three residents had a *Health Care Appraisal* in their file and one was updated within the last twelve months.

On July 8, 2022, Sarah Crawford, night manager for Golden Life AFC #3. She stated she is learning the procedure for *Health Care Appraisals*. She stated each resident receives a new *Health Care Appraisal* and these are schedule by the home manager. Golden Life AFC #3 always completed these regularly and she was able to see updated ones when she reviewed the resident records.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of

	an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	During the onsite investigation on June 9, 2022. I reviewed the resident records for Resident A, Resident, B, and Resident C. All three residents had an initial *Health Care Appraisal* in their file and one that was updated within the last twelve months as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident records do not include an updated *Resident Care Agreement*.

INVESTIGATION:

On May 31, 2022, a complaint was received via the Bureau of Community and Health Systems alleging the resident records did not include an updated *Resident Care Agreement.*

On June 9, 2022, I interviewed home manager, Megan Lilly. Ms. Lilly stated the procedure for Golden Life AFC #3 is to obtain a *Resident Care Agreement* at move in and then have an updated one each year.

During the onsite investigation on June 9, 2022. I reviewed the resident records for Resident A, Resident, B, and Resident C. All three residents had a *Resident Care Agreement* in their file and one that was updated within the last twelve months.

On July 8, 2022, I interviewed Sarah Crawford, night manager for Golden Life AFC #3. She stated each resident receives a new *Resident Care Agreement* and these are scheduled by the home manager. Golden Life AFC #3 always completed these regularly and she was able to see updated ones when she reviewed the resident records.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care

	agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	During the onsite investigation on June 9, 2022. I reviewed the resident records for Resident A, Resident, B, and Resident C. All three residents had an initial *Resident Care Agreement* in their file and one updated within the last twelve months.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

***AFC Accident / Incident Reports* are not submitted to the department as required by Golden Life AFC #3.**

INVESTIGATION:

On May 31, 2022, a complaint was received via the Bureau of Community and Health Systems alleging direct care staff at Golden Life AFC #3 were not submitting *AFC Accident / Incident Reports* as required. There were concerns reported that a resident fell out of a wheelchair and no incident report was submitted.

On June 9, 2022, I interviewed home manager, Megan Lilly. Ms. Lilly stated the procedure is to notify licensing, Community Mental Health, and the resident's guardian, if there is one appointed, each time an incident occurs. Ms. Lilly was told she did not need to notify licensing by phone and she stated she wanted to ensure that the department was aware of concerns that occurred in the home. Ms. Lilly stated she calls and emails the *AFC Accident / Incident Reports* each time an incident occurred. I reviewed the facility file and there were no recent *AFC Accident / Incident Reports* submitted for a fall from a wheelchair. It was discussed with Ms. Lilly even if that incident did occur, unless the fall resulted in medical treatment at the emergency room or hospital, an incident report would not have been required.

I also reviewed the saved *AFC Accident / Incident Reports*, it is clear that Ms. Lilly and the rest of the direct care staff members at Golden Life AFC #3 are documenting incidents using the *AFC Accident / Incident Report* form and reporting these incidents within 48 hours as required.

On July 8, 2022, I interviewed Sarah Crawford, night manager for Golden Life AFC #3. She stated she has filled an incident report out many times. She stated if a resident falls and goes to the hospital, an incident report is completed and their management, guardian, and case manager are contacted. She does not remember a time when a resident fell out of a wheelchair, needed medical treatment, and a report was not done. Ms. Crawford stated newly hired direct care staff members are trained on how to complete an incident report must demonstrate how to correctly complete one as part of the training.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative,

	responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	After reviewing the saved *AFC Accident / Incident Reports* and interviewing Ms. Lilly, she and the rest of the direct care staff members at Golden Life AFC #3 are documenting incidents regularly using the *AFC Accident / Incident Report* form and reporting these incidents within 48 hours as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was given the wrong medication which led to a hospital stay leading to him needing a ventilator.

INVESTIGATION:

On May 24, 2022, an *AFC Accident / Incident Report* received by Golden Life AFC #3 regarding a medication error for Resident A which led to a hospital stay.

On May 24, 2022, I received a call from Angela Loiselle, Montcalm Care Network (MCN) Recipient Rights Advisor. She stated there was a medication error by direct care staff member Johanah Beech on May 22, 2022 with Resident A causing him to be admitted to Spectrum Greenville. After he was at the hospital, his oxygen was dropping and his tongue was blocking his airway. Ms. Loiselle stated he was placed on a ventilator because he has sleep apnea and the medication was causing him to not breathe on his own.

On May 24, 2022, I received a Corrective Action Plan for the medication administration error from Licensee designee, Mike Dykstra. There were ten steps that Golden Life AFC #3 managers were going to implement immediately as a result of this error. Those steps are listed below:

1. The staff who committed this med error was taken off meds effective immediately.

2. A message was sent to all management team members regarding what happened resulting in an emergency discussion on how this could happen and what needs to be done to prevent this from ever happening again.

3. A staff meeting was set up for 5/24/2022 to go over what happened and what actions need to be taken by staff.

4. All staff who work at the Grow Rd Location and the Montcalm location will be set up to be retrained in medications in person at Montcalm Care Network.

5. Management will go over this retraining with staff to ensure that each staff member fully understands how crucial it is to follow all rules of the med pass and to focus on one consumer at a time. The 5 rights of med passing need to be practiced when pulling the medication and then rehearsed again before administering the medication to the resident.

6. If the management finds any deviation or lack of ability from the staff when practicing what they have been trained to do this individual will be removed from meds until consistent and thorough follow through are observed.
   A resident's name will be written on the medication cup for that resident as a secondary way to double check.

7. Twice a week a member of the management team will do a surprise visit at med time to ensure compliance with all medication requirements.

8. Each med time we will have a dedicated staff inform the residents to go to them with any concerns or questions while another staff member focuses solely on the med pass.

9. Each resident will come to the med cart to receive medications so that the staff can double check the 5 rights before administering. If necessary, staff will facilitate resident to the med cart. Accommodations may be made for those temporarily confined to their rooms.

On May 25, 2022, I interviewed direct care staff member, Johanah Beech with Angela Loiselle from MCN Recipient Rights Advisor and Megan Lilly, Golden Life AFC #3 home manager. Licensee designee Mike Dykstra also participated in this interview on speaker phone.

Ms. Beech stated she was starting Resident D's medications and Resident E came out to the kitchen and wanted to give Resident A his muffin. Ms. Beech stated she was distracted by Resident E at the time she was passing medications. Ms. Beech stated she heard Resident A say he would take the muffin from Resident E "after the meds"

which reflexively caused Ms. Beech to put the medications down in front of him. Ms. Beech stated she then went back to her computer and saw Resident A's medications were not administered yet however by the time she realized the error; Resident A had already swallowed the Zocor 20 mg tablet which he and Resident D are both prescribed and Clozapine 275 mg which he is not prescribed.

Ms. Beech stated as soon as she realized what she had done, she called home manager Megan Lilly to tell her about the medication error. Ms. Beech stated she should have slowed down and paid attention to what she was doing instead of being distracted by Resident E wanting to give Resident A a muffin. Ms. Beech stated this is her first medication error since working at Golden Life AFC #3 since October 2021. After about 20-30 minutes, Resident A was taken to the emergency room. On the way to the hospital, Resident A was talking with Ms. Beech and holding her hand in the car. She stated he was talking the whole time and was not immediately affected by the medication. Ms. Lilly arrived at the hospital around 8:00 p.m. and he was talking in the waiting room.

Ms. Lilly stated his vitals were good when they first arrived at the hospital and when they got him to the room he laid down on the bed and his eyelids looked heavy. Ms. Lily stated approximately, 10-15 minutes later, Resident A was asleep and his oxygen levels were starting to go down. She stated the RN put oxygen on him at that point but his oxygen was dropping to the 80's. Ms. Lilly was told his tongue was blocking his airway and she was told by the doctor that the medication Clozapine would make him drowsy. However, when his oxygen levels went down, she was told they could not stop the effects of the medication and he was intubated. Ms. Lilly stated Guardian A1 met them at the hospital. Ms. Lilly and Licensee designee, Mr. Dykstra both stated Ms. Beech would be retrained to pass medications with a full medication training through Montcalm Care Network. Angela Loiselle also advised Ms. Beech that Montcalm Care Network offered free counseling through New Directions Counseling for direct care staff members which she could utilize during this time.

After the interview was completed As of May 25, 2022, I was also able to review the medication administration record (MAR) for Resident A at this time showing that he was not prescribed Clozapine 275 mg.

On June 9, 2022, I completed an onsite investigation at Golden Life AFC #3. The medication cart was kept in a room off of the kitchen and dining area. There were posters up explaining the process of administering medications safely. Ms. Lilly was able to give me a staff meeting sign in sheet from the May 24, 2022 where they discussed the medication error and retrained the direct care staff members on proper procedures.

On July 8, 2022, I interviewed Sarah Crawford, night manager for Golden Life AFC #3. She was still working at the time but not there when the incident happened. She did not have any concerns regarding Ms. Beech and her ability to pass medications. She stated during the time of the medication error the medication cart was in the medication

room standing off the kitchen. She stated after this incident she retrained some staff on medication training. When they are trained for medication, direct care staff member delivers the medications to the residents. She stated not all of the residents are mobile so they cannot all come to the medication cart to get their medications. The staff are trained to get one of the medication cups ready at a time and not do two medication cups at once.

I reviewed the Spectrum Health discharge paperwork for Resident A. According to the discharge paperwork, Resident A was admitted due to overdose of antipsychotic, accidental or unintentional, initial encounter on May 22, 2022, because there was an accidental clozapine overdose from the AFC home. According to the documentation sent by Spectrum Health, Resident A is also diagnosed with Anemia, congenital heart valve abnormality, diabetes mellitus type II, down syndrome, dysphagia (chronic), GERD, hypertension associated with diabetes, and hypothyroid. Resident A was brought to the hospital after the medication error on May 22, 2022 and was discharged from the hospital on May 29, 2022.

This is a repeat violation because 2020A0577022 dated 02/14/2020 also found a violation for R 400.15312 (2) after a resident did not receive their Seroquel medication as prescribed. The resident's medication was refilled as required and as a result the resident started vomiting and shaking due to not receiving medication as prescribed. The CAP was submitted for this incident on April 16, 2020 which implemented a new policy to ensure that medication refills are completely timely.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Resident A was not given his medication pursuant to label instructions. Ms. Beech administered the wrong medications to Resident A leading to his seven day admission to Spectrum Health. Resident A was placed on a ventilator as a result of difficulty breathing due to being given the wrong medication. According to hospital discharge paperwork for Resident A, he was admitted due to overdose of the antipsychotic medication Clozapine, accidental or unintentional, on May 22, 2022. Resident A was taken to the hospital immediately and Ms. Beech responded appropriately after the incident. Licensee designee Mike Dykstra submitted a corrective action plan and had the direct care staff members retrained within two days of the incident.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SPECIAL INVESTIGATION 2020A0577022 DATED 02/14/2020 and CAP APPROVAL DATED 04/16/2020].**

ALLEGATION:

Resident records do not include an accurate accounting of Resident Funds.

INVESTIGATION:

On May 31, 2022, a complaint was received via the Bureau of Community and Health Systems alleging the resident records do not include an accurate accounting of the Resident Funds for each resident.

On June 9, 2022, I interviewed home manager, Megan Lilly. Ms. Lilly stated the procedure for Golden Life AFC #3 is to maintain a *Resident Funds Part I and Resident Funds Part II* document in each resident record. Ms. Lilly stated all resident personal funds are maintained through a *Resident Funds Part II* form and the money is kept in a Funds II binder which she maintains and then subtracts these funds when a resident spends their personal funds. I observed that the resident funds for monthly room and board are also attached in this binder showing all funds the residents have paid monthly.

During the onsite investigation on June 9, 2022, I reviewed the resident records for Resident A, Resident, B, and Resident C. All three residents had both a *Resident Funds Part I and II* forms in their resident record. I counted the personal resident funds for Resident C and the amount matched the amount that was documented on her *Resident Funds Part II.*

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	During the onsite investigation on June 9, 2022. I reviewed the resident records for Resident A, Resident, B, and Resident C. All three residents had both a *Resident Funds Part I and II* in their resident record. I counted the personal resident funds for Resident C and the amount matched the amount that was documented on her *Resident Funds Part II.*
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The food is stored on the floor and not protected from contamination at Golden Life AFC #3.

INVESTIGATION:

On May 31, 2022, a complaint was received via the Bureau of Community and Health Systems alleging the food is stored on the floor and is not free from contamination at Golden Life AFC #3.

During the onsite investigation on June 9, 2022, I observed the food storage both in the cupboards and the refrigerator. Golden Life AFC #3 does not have a separate pantry area for food storage. All food was above the floor and was not kept directly on the floor. The refrigerator had a thermometer which helps to ensure the food was free from spoilage.

On July 8, 2022, I interviewed direct care staff member whose former role was a third shift manager, Sarah Crawford. She denied she has ever observed any food stored on the floor at Golden Life AFC #3. She stated she bought shelves for the facility in the past so they would have more storage space. There is no pantry at the facility and all food is stored in the kitchen area. There has always been a thermometer in the refrigerator and freezer area.

APPLICABLE RULE	
R 400.15402	**Food service.**
	(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.
ANALYSIS:	During the onsite investigation on June 9, 2022, I observed the food storage both in the cupboards and the refrigerator. There was no food stored on the floor anywhere in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The oxygen is stored incorrectly because there are several tanks in a resident bedroom.

INVESTIGATION:

On May 31, 2022, a complaint was received via the Bureau of Community and Health Systems alleging there are ten full and empty oxygen tanks left in a resident bedroom.

On June 1, 2022, I received an email from Angela Loiselle, MCN, who stated she thinks Carelinc may supply the oxygen to Golden Life AFC #3. She stated one of the primary nurses involved with Golden Life AFC #3 is Nicole Hanses, RN.

On June 3, 2022, I interviewed Nicole Hanses, RN. She stated she has been to Golden Life AFC #3 several times and has had no concerns regarding the storage of extra oxygen tanks in the facility. She has never had any safety concerns regarding the use of oxygen at the facility either.

On June 9, 2022, I interviewed home manager, Megan Lilly. Ms. Lilly stated they store the oxygen tanks in a shed out in the yard. The extra tanks were observed to be standing in the corner of the shed along with racks they can sit in. Ms. Lilly stated the racks are used to transport the tanks and used when they are in the home. All resident bedrooms were observed during this visit by this consultant and there were no oxygen tanks observed in any of the resident bedrooms.

On June 17, 2022, I interviewed with Terry Frey from Carelinc Medical Equipment. Mr. Frey stated his team has delivered Oxygen to Golden Life AFC #3. Mr. Frey stated he has never heard reports of improper oxygen storage regarding Golden Life AFC #3. Mr. Frey stated he will send some literature by email that I can share with the home manager regarding proper storage of oxygen.

On July 8, 2022, I interviewed Sarah Crawford, night manager for Golden Life AFC #3. She stated the oxygen is stored in the shed when they are not using it. Ms. Crawford

stated the oxygen is standing upright and believes it is in a cart. She does not remember how many residents that needed oxygen but there were some residents that needed to have oxygen for a concentrator and Resident A who was on oxygen on a regular basis. Ms. Crawford has never observed oxygen tanks in any of the resident bedrooms.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On June 9, 2022, I interviewed home manager, Megan Lilly. Ms. Lilly stated they store the oxygen tanks in a shed out in the yard. During the onsite inspection on June 9, 2022, there were no oxygen tanks stored in the resident bedrooms.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on June 9, 2022. I reviewed the resident records for Resident A, Resident, B, and Resident C. All three residents had both a Resident Funds I and II in their resident record and one that was updated. Resident C had personal funds in the amount of $255.90 which was over the $200.00 maximum.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(6) Except for bank accounts, a licensee shall not accept resident funds of more than $200.00 for any resident of the home after receiving payment of charges owed.
ANALYSIS:	During the onsite investigation on June 9, 2022. I reviewed the resident records for Resident A, Resident, B, and Resident C. All three residents had both a Resident Funds I and II in their resident record and one that was updated. Resident C had personal funds in the amount of $255.90 which was over the $200.00 maximum.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan; I recommend no change in the license status.

_____7/19/2022_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

07/25/2022

_____

Dawn N. Timm
Area Manager

Date