GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

Thomas Quakenbush
Community Homes Inc
3925 Rochester Rd.
Royal Oak, MI 48073

RE: License #: AS630390444
Investigation #: 2022A0465043
Greer Home

Dear Mr. Quakenbush:

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630390444
Investigation #:	2022A0465043
Complaint Receipt Date:	08/04/2022
Investigation Initiation Date:	08/08/2022
Report Due Date:	10/03/2022
Licensee Name:	Community Homes Inc
Licensee Address:	3925 Rochester Rd. Royal Oak, MI 48073
Licensee Telephone #:	(248) 336-0007
Administrator:	Thomas Quakenbush
Licensee Designee:	Thomas Quakenbush
Name of Facility:	Greer Home
Facility Address:	2035 Lochaven Rd. West Bloomfield, MI 48324
Facility Telephone #:	(248) 336-0007
Original Issuance Date:	12/11/2018
License Status:	REGULAR
Effective Date:	06/11/2021
Expiration Date:	06/10/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A has been found wandering the streets by the police on multiple occasions.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/04/2022	Special Investigation Intake 2022A0465043
08/04/2022	APS Referral Adult Protective Services (APS) referral, assigned to Taniesha Sims for investigation
08/08/2022	Special Investigation Initiated – Telephone Spoke to Complainant via telephone
08/10/2022	Inspection Completed On-site I conducted a walk-through of the facility, reviewed Resident A's file, observed Resident A and interviewed direct care staff, Jo Kennard and Nicole Loafman
08/10/2022	Contact - Telephone call made I spoke to licensee designee/administrator, Tom Quakenbush, via telephone
08/10/2022	Contact – Telephone call made I attempted to contact Guardian A1, but the phone only rang with no voice mail system available
08/19/2022	Contact - Document Sent Email exchange with CMH ORR Officer, Kathleen Garcia
09/02/2022	Contact - Telephone call made I spoke to CMH ORR Officer, Kathleen Garcia, via telephone
09/02/2022	Contact – Telephone call made I attempted to contact Guardian A1. The phone number is not in working order

09/08/2022	Contact - Telephone call made I spoke to CMH ORR Officer, Kathleen Garcia, via telephone
09/22/2022	Contact - Document Received Email exchange with APS Worker, Taniesha Sims
09/08/2022	Contact - Document Received I received copies of the police reports via email
09/29/2022	Exit Conference I conducted an Exit Conference with licensee designee/administrator, Tom Quakenbush, via telephone

ALLEGATION:

Resident A has been found wandering the streets by the police on multiple occasions.

INVESTIGATION:

On 8/4/2022, a complaint was received, alleging that Resident A has been found wandering the streets by the police on multiple occasions. The complaint indicated the following: Resident A has a cognitive impairment and is non-verbal. Over the last six months, Resident A has eloped from the facility at least three times. Resident A has been found wandering the streets with no shoes on and has been found in the middle of busy streets, at risk of being hit by a car. Resident A lives at a group home that does not have door alarms, which is the reason that Resident A continues to elope from the facility without staff knowledge.

On 8/8/2022, I spoke to Complainant via telephone. Complainant confirmed that the information contained in the complaint is accurate.

On 8/4/2022 and 9/22/2022, I spoke to Adult Protective Services Worker, Taniesha Sims, via email exchange. Ms. Sims stated that she has completed her investigation of this complaint and will be substantiating for neglect due to the lack of supervision provided by the facility to ensure Resident A's safety needs were met.

On 8/10/2022, I conducted an onsite investigation at the facility. The facility cares for the developmentally and cognitively impaired population. I was unable to interview any residents for purposes of this investigation due to their medical diagnosis of cognitive and/or memory deficits. I conducted a walk-through of the facility, reviewed Resident A's file, observed Resident A, and interviewed direct care staff, Jo Kennard and Nicole Loafman.

The *Face Sheet* stated that Resident A was admitted to the facility on 6/19/2015 and has a legal guardian, Guardian A1. The *Health Care Appraisal* lists Resident A's medical diagnosis as Dementia, Autism and Anxiety. The *Assessment Plan for AFC Residents* states that Resident A can move independently in the community, is non-verbal, has a limited alertness and awareness to his surroundings and needs assistance from staff for safety purposes, needs assistance with eating, toileting, bathing, grooming, dressing, personal hygiene and does not use assistive devices.

Upon entering the facility, I observed Resident A in the hallway area. Resident A was properly dressed and with adequate hygiene. Due to Resident A's non-verbal communication, I was unable to interview him for this investigation.

While walking through the facility, I observed three exit doors within the home: The front door, the side exit door off of the living room/kitchen area and a third exit door at the other side of the home, at the end of the hallway, next to Resident A's bedroom. Staff refer to the third exit door as the backdoor. I observed two wheelchairs and a Hoyer lift directly in front of the backdoor, blocking the exit door from being used. I opened and closed all of the exit doors within the home and determined that none of the doors have an alarm installed. I did not observe any alarms in use anywhere within the home.

I reviewed the *Staff Log Notes*, which indicated the following:

6/6/2022; Completed by Nicole Loafman (9am – 3pm shift): Fix door alarms.
6/6/2022; Completed by Jo Kennard (3pm – 11:30pm shift): Maintenance came and fixed door alarm.
6/8/2022; Completed by Nathan R.: Backdoor alarm needs to be checked because I found it on the ground and put it back up.
6/14/2022; Completed by Nathan R. (3pm – 9pm shift): Staff be careful to check doors as alarms have not been working properly.
6/14/2022; Completed by Jo Kennard (midnight shift): Only alarm door not working is backdoor.
6/15/2022; Completed by Nicole Loafman (9am – 3pm shift): Maintenance came and fixed both backdoor alarms.
6/28/2022; Completed by Rosa Glispie (3pm – 10pm shift): Resident A has been trying to escape throughout the day.
6/29/2022; Completed by Jo Kennard (10pm – 9am shift): Resident A tried to leave the house once.
7/17/2022; Completed by Roza Glispie (10am – 6pm shift): Resident A escaped three times.
7/20/2022; Completed by Jo Kennard (10pm – 9am shift): Resident A tried to leave out the backdoor once.
7/22/2022; Completed by Jo Kennard (4pm – 11:30pm shift): Resident A tried leaving most of the shift. Due to this, I did not have a chance to {give residents} showers.
7/24/2022; Completed by Jo Kennard (4pm – 11:30pm shift): Resident A constantly tried to leave.

7/27/2022; Completed by Rosa Glispie (3pm – 10pm shift): Resident A tried leaving around 5:25pm. I found him outside the backdoor. I didn't hear the alarm and that's because he knocked the sensor off the door (the sensor is on the office desk).
8/1/2022; Completed by Nicole Loafman (9am – 4pm shift): Resident A went out the back door while I was making lunch. He was brough back by the police. See IR in book. Maintenance should be coming out to fix back door alarm.

I reviewed the *Incident/Accident Reports* for Resident A, which indicated the following:

- 9/15/2021 at 3:30pm; Completed by Nicole Fenner: At 3:30pm, West Bloomfield Police notified staff member that they had Resident A in their custody. The police then returned Resident A back to the home. The police said they picked Resident A up about ½ mile down the road after receiving a phone call from someone stating Resident A was in their backyard. Corrective Measure: Continue to monitor for health and safety. Complete visual checks every 10 – 15 minutes.
- 3/3/2022 at 12:30pm; Completed by Quincy Kennon: Staff was in the back with other consumer and Resident A must have gone out the front door where the alarm is not working at the moment. The lady next door seen him walking and she brought him to me. I identified him. Staff brought him into the home and checked him to make sure he wasn't hurt. He had no injuries or bruises. He was ok. Notified the home manager of the incident. Corrective Measure: Continue to monitor for health and safety. Get door alarm fixed.
- 7/17/2022 at 3:10am; Completed by Roza Glispie: Staff was helping with other consumers take shower and shave. Resident A went out the back door. I could not hear while in the bathroom. Someone reported him three or four houses down and called the police. Police immediately brought him back. Corrective Measure: Continue to monitor health and safety.
- 8/1/2022 at 12:00pm; Completed by Nicole Loafman: Staff were in the middle of preparing lunch when the police showed up with Resident A. He had went out the backdoor. The door alarm was removed. Resident A made it two houses down, a neighbor noticed him and called police. Police brought Resident A home. He is safe and had no injuries. Corrective Measures: Company maintenance will be fixing the removed door alarm. Continue to monitor for health and safety.

During my onsite investigation, I interviewed direct care staff, Jo Kennard. Ms. Kennard stated, "I have been working here for nine months. We currently have four residents living here. Resident A has a history of elopement. Over the last month, Resident A has eloped several times. Resident A always elopes from the backdoor because it is the door closest to his bedroom. He ripped the door alarm off a few weeks ago and it hasn't been fixed yet. Resident A's bedroom is on the opposite of the home, so it is hard to hear or see him when he is in his bedroom area. We don't have door alarms. We only have door chimes, that only chime once when the door is opened. So, if staff are in the kitchen cleaning, running the blender or assisting a resident with dressing or bathing, we can't hear the chime and won't know that Resident A has eloped. I can't watch Resident A all the time. So, I had to block the door with two wheelchairs and a Hoyer lift.

This is the only way I can ensure that Resident A doesn't elope because I can't watch him all the time."

I interviewed direct care staff/home manager, Nicole Loafman, via telephone while onsite at the facility. Ms. Loafman stated, "Resident A elopes all of the time. This is normal behavior for him. Resident A usually tries to go out the backdoor. Resident A attempts to elope multiple times throughout the day. This is a constant behavior. We are unable to implement safety measures due to restrictions by Macomb-Oakland Regional Center (MORC). The door alarms were not working last time Resident A eloped, so we didn't know he left. He was gone for nine minutes before we knew he was gone because we do 15-minute checks. I was working the last time Resident A eloped. I was in the kitchen, and I had the blender running so I didn't hear anything. But the alarms on the doors were also not working that day because Resident A had ripped the door alarm down a few days prior. We are currently awaiting a new door alarm to be installed so right now we do not have alarms on the doors. But our door alarms are not actually alarms. They are chimes, like a doorbell ring. They ring once when the door is opened and then they do not chime again. I reached out to the Supports Coordinator at MORC to request approval for door alarms about 2-3 weeks ago and I'm still waiting to hear back. It's a long process to get things approved through MORC. I've texted the licensee, Tom Quakenbush and maintenance on multiple occasions regarding my concerns with not having door alarms. I don't know what else to do."

On 8/10/2022, I spoke to licensee designee/administrator, Tom Quakenbush, via telephone. Mr. Quakenbush stated, "I am aware of Resident A's elopements from the facility. We don't have alarms on the exit doors, only chimes. We did request approval from MORC to install door alarms, but the request was denied. We can't implement safety measures without approval from MORC. And we can't provide 1:1 staffing for Resident A. We don't have a sufficient number of staff available to provide increased supervision to Resident A. I am aware that staff have been blocking the backdoor with equipment and I have told all staff that they cannot do that. We have increased the frequency of checks on Resident A to every fifteen minutes. I can submit an emergency request to MORC for approval of alarms for the exit doors as soon as possible. I have not issued a discharge notice for Resident A because there are no other facilities that are going to take him. I don't believe he should be in a secured facility. I believe Resident A should be in the least restrictive setting and I feel he should remain at our facility." Mr. Quakenbush acknowledged that the facility does not have the necessary safety measures, including door alarms and increased supervision, to ensure the safety and protection of Resident A. During this phone call, I emphasized to Mr. Quakenbush the significance of risk to Resident A each time he elopes from the facility, and the responsibility of the facility to provide increased supervision to Resident A to ensure his safety and protection needs are met. Mr. Quakenbush responded that his facility cannot provide increase supervision nor 1:1 supervision due to limited staffing availability.

On 8/19/2022, 9/2/2022 and 9/8/2022, I spoke to Office of Recipient Rights Officer, Kathleen Garcia, via both telephone and email exchange. Ms. Garcia stated that she

has completed an investigation of this complaint and determined that the facility has not violated any resident rights rules.

On 9/8/2022, I reviewed the *West Bloomfield Township Police Reports*, which indicated the following:

- 3/3/2022 at 11:45am; Completed by police officer, M. Kelly: I was on patrol in the listed area when I observed a woman walking Resident A down the road. Resident A did not have a coat on and was not wearing shoes. I spoke to the woman, and she advised that she believes he is a walk-away from the group home at the listed address. I had Resident A get in the backseat of my vehicle to keep warm. I made contact with the caretaker, Quincy Kennon, who advised that Resident A is an elderly patient with Dementia who is non-verbal. I helped Resident A get back inside without incident. Resident A did not appear to need medical attention and Quincy stated that Resident A could only have been gone for 10 minutes.
- 7/17/2022 at 2:55pm; Completed by police officer, J. Frost: On 7/17/2022, I was dispatched to the area of Lochaven, between Willow and Cooley for a white male, bald, gray sweatpants, wandering the street. The public citizen advised that Resident A appeared disoriented. A second public citizen stopped to talk with Resident A, where I arrived on the scene. Resident A was non-verbal and had no ID on his person. I led him to my vehicle where he sat in the rear passenger seat. I began down Lochaven attempting to locate a group home. In the driveway of 2035 Lochaven, I observed a white 15-passenger van with a non-profit license plate. I made contact at the front door, with Rosa Glispie, a direct care worker. She advised that Resident A does live at this address and {that she} was unaware of Resident A leaving the residence. She advised he knows how to disable the alarm that chimes when someone enters or leaves. According to Glispie, this was a normal state of being and did not require medical attention.
- 8/1/2022 at 11:45am; Completed by police officer, T. Shepherd: Officer Shafto and I were dispatched to 2003 Lochaven Rd. on 8/1/2022 at approximately 1145 hrs. for a report of a nonverbal, elderly male walking on the side of the road, fully dressed and wearing only socks, no shoes. Upon arrival I observed an elderly male, later identified as Resident A, sitting in a lawn chair near the road. The public citizen stated he was driving SB on Lochaven and observed Resident A walking very close to Lochaven rd. He Resident A appeared to be unsteady walking and he was concerned for Resident A's safety. He said he stopped his vehicle and attempted to ask if Resident A needed assistance. He said Resident A was not responsive to his attempted verbal communication. He said a neighbor brought a chair for Resident A to sit in until police arrival. The public citizen stated that she believes Resident A lives at the group home 2 homes north of Resident A's current location. I assisted Resident A walking back to 2035 Lochaven. I was met at the front door by Group home manager, Nicole Loafman. Nicole stated that Resident A did in fact live at the 2035 Lochaven address. She stated that she does resident checks every 15 minutes, and Resident A must have been gone approximately 12 minutes. She stated that the group home has alarms on all doors. She said that Resident A had "ripped" off the alarm on a rear door recently (unknown date) and that is the door he walked out of. She said she has a work order to have the alarm replaced and has

contacted the group home maintenance team today (8/1/2022) to check the status of the repair. The group home was clean and orderly, Resident A appeared to be in relatively good physical health. Resident A was dressed in what appeared to be clean clothes, and socks. The group home currently has 4 residents. I requested that Nicole and staff be aware of the potential for Resident A and other residents to exit from that door. I requested she contact maintenance again to have the door alarm repaired. A CLEMIS check has 2 additional reported walk-aways by Resident A from this address.

- 8/15/2022 at 11:33am; Completed by police officer, J. Frost: On 8/15/22, at 1133 hrs. I (Officer Frost) was dispatched to 1903 Lochaven for a welfare check of an older W/M, non-verbal wandering the area. I have been on a previous run, 22-13268, where I recovered Resident A from the side of the road, returning him to, 2035 Lochaven, which is a group home facility. I arrived at, 1903 recognizing Resident A. The public citizen stated Resident A was walking on the side of the road, nearly falling in the street. Not knowing his medical condition, she brought him into her yard, provided shade and water for him. I advised that he resides at the group home down the street. I escorted Resident A to my patrol vehicle, where I transported him back to, 2035 Lochaven w/o incident. I assisted Resident A back into the home and made contact with the facility manager, Nicole Loafman. She stated she is caring for four other patients, one of which requires constant attention. Resident A suffers from dementia and has a history of walking away from the facility, as WBPD has taken three other reports similar in nature. Loafman is concerned for Resident A's welfare, as she states she and the facility is ill equipped to deal with Resident A and his medical needs. Resident A has no family and is currently having his medical decision made by Oakland County (MOCI). Loafman provided me the case worker of MOCI contact information (Jim Stark). She also provided contact for the facility (MORC) coordinator. Loafman is concerned if Resident A is not relocated to a better equipped facility, he may get seriously injured or killed. I provided Loafman my card with this case number. The case will be forwarded to the state investigator for review. I also made contact with Jim Stark who is the county representative who make his medical and living facility decisions. He advised today was the first he had heard of Resident A's flight risk and stated he will begin looking for a more secure facility for transfer.

On 9/29/2022, I spoke to Guardian A1 via telephone. Guardian A1 stated that he was never contacted by, nor sent notification by the facility, that Resident A was eloping from the home. Guardian A1 stated that he believes Resident A requires more supervision than is being provided by the facility. Guardian A1 stated that there are efforts being made to determine the most appropriate and safest placement for Resident A.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be

	attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 8/10/2022, I completed a walk-through of the facility and observed two wheelchairs and a Hoyer lift directly in front of the backdoor, blocking the exit door from being used. According to the *Staff Log Notes*, Resident A has attempted to elope from the facility five times between the dates of 6/28/2022 and 7/24/2022. According to the *Staff Log Notes*, *Incident/Accident Reports* and the *West Bloomfield Township Police Reports,* Resident A successfully eloped from the facility eight times between 9/15/2021 and 8/15/2022, on the following dates: 9/15/2021, 3/3/2022, 7/17/2022 (three times), 7/27/2022, 8/1/2022 and 8/15/2022. According to Ms. Kennard and Ms. Loafman, Resident A has a history of elopement and attempts to elope on a daily basis. Ms. Kennard and Ms. Loafman stated that the chimes on the exit doors are ineffective in notifying them if Resident A has eloped from the facility due to their quiet and one-time only noise that is made when an exit door is opened. According to Ms. Kennard, she blocked the backdoor with wheelchairs and a Hoyer lift to restrict Resident A from leaving the facility due to not being able to provide the level of supervision that he requires to prevent elopements. According to Ms. Kennard, Ms. Loafman and Mr. Quakenbush, the facility is unable to implement safety measures due to restrictions by Macomb-Oakland Regional Center (MORC). According to Mr. Quakenbush, the facility does not have sufficient staff available to provide the necessary increased level of supervision that Resident A requires. Mr. Quakenbush stated that he has not issued a discharge notice to Resident A due to the belief that his facility is the best placement option for Resident A at this time. On 8/15/2022, approximately five days after my onsite investigation at the facility, Resident A again was able to elope from the facility for an unknown amount of time. When interviewed by law enforcement, Ms. Loafman stated that she is feels the facility is ill-equipped to care for Resident A. Ms.

	Loafman vocalized her concern that Resident A is at risk of serious harm if he continues to remain at the facility. Based on the information above, the facility does not have sufficient staff on duty, nor adequate safety measures in place, to provide the level of supervision that Resident A requires to ensure his safety and protection needs are attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to the *Staff Log Notes*, *Incident/Accident Reports* and the *West Bloomfield Township Police Reports,* between the dates of 9/15/2021 - 8/15/2022, Resident A has attempted to elope from the facility five times and has successfully eloped from the facility eight times. During this 11-month period of elopement history, the facility has only implemented 15-minute checks of Resident A, which has not prevented Resident A from continuing to elope from the facility.

On 8/10/2022, I reviewed the *Assessment Plan for AFC Residents*, which was dated 8/4/2022. The written assessment plan does not reference Resident A's elopement history, nor does it specify any safety measures in place to address the elopement risk.

During my onsite investigation on 8/10/2022, Ms. Kennard and Ms. Loafman both stated that Resident A has a history of elopement and attempts to elope on a daily basis. Ms. Kennard and Ms. Loafman stated that the chimes on the exit doors are ineffective in notifying them if Resident A has eloped from the facility due to their quiet and one-time only noise that is made when an exit door is opened.

According to Ms. Kennard, Ms. Loafman and Mr. Quakenbush, the facility is unable to implement safety measures, such as door alarms, due to restrictions by Macomb-Oakland Regional Center (MORC).

On 8/10/2022, Mr. Quakenbush stated that the facility does not have sufficient staff available to provide the necessary increased level of supervision that Resident A requires. Mr. Quakenbush stated that he has not issued a discharge notice to Resident A due to the belief that his facility is the best placement option for Resident A at this time.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement, physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Based on the information above, the facility has continued to retain Resident A as a resident of the facility, without completing an up-to-date written assessment to determine Resident A's suitability to remain at the facility. The facility has not adequately assessed if the home has the amount of supervision, protection, and physical accommodations available in the home that Resident A requires.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 8/10/2022, I spoke to Ms. Loafman and Mr. Quakenbush via telephone. Ms. Loafman and Mr. Quakenbush stated that they have not submitted written reports to Guardian A1 nor the Department of Licensing & Regulatory Affairs pertaining to Resident A's elopements from the facility. Ms. Loafman and Mr. Quakenbush stated that they were not aware that there was a licensing rule requirement to do so.

On 9/29/2022, I spoke to Guardian A1 via telephone. Guardian A1 stated that the facility has not provided him with written reports each time Resident A has eloped from the facility. Guardian A1 stated, "I was not aware that Resident A was eloping from the facility until I received a call from a third-party service provider a few weeks ago. The facility has never contacted me directly nor sent me any written reports as of yet."

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted with 24 hours of each occurrence.
ANALYSIS:	Based on the information above, the facility has not submitted written reports to Guardian A1 for all instances in which Resident A was absent without notice.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my onsite investigation on 8/10/2022, I observed two wheelchairs and a Hoyer lift in front of the backdoor, blocking the exit door from being used.

While onsite at the facility, I interviewed Ms. Kennard. Ms. Kennard stated, "Resident A has a history of elopement. Over the last month, Resident A has eloped several times. Resident A always elopes from the backdoor because it is the door closest to his bedroom. He ripped the door alarm off a few weeks ago and it hasn't been fixed yet. Resident A's bedroom is on the opposite of the home, so it is hard to hear or see him when he is in his bedroom area. So, I had to block the door with two wheelchairs and a Hoyer lift. This is the only way I can ensure that Resident A doesn't elope because I can't watch him all the time."

On 8/10/2022, I spoke to Mr. Quakenbush via telephone. Mr. Quakenbush stated that he is aware that staff have previously blocked the backdoor with equipment as a way to prevent Resident A from eloping from the facility.

On 9/29/2022, I conducted an exit conference with Mr. Quakenbush via telephone. Mr. Quakenbush stated, "I feel we have provided the appropriate level of care for Resident A. I believe Resident A has the right to go in and out of the home as he chooses. Resident A is a grown adult male that sometimes doesn't want to stay in the house. I believe the door chimes and the 15-minute checks, now recently changed to 10-minute checks, are sufficient to meet Resident A's needs." Mr. Quakenbush stated that he is not in agreement with the recommendation of a 1st provisional license because he believes the facility is providing an adequate level of care to Resident A.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.
ANALYSIS:	Based on the information above, the facility is not ensuring that all means of egress are being maintained in a manner that provided free and unobstructed egress from all parts of the home. On 8/10/2022, I observed two wheelchairs and a Hoyer lift in front of the backdoor, blocking the exit door from being used.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend issuance of a 1st provisional license.

Stephanie Gonzalez

9/29/2022

_____

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn

09/29/2022

_____

Denise Y. Nunn Date
Area Manager