GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2023

Lisa Springett
30744 White Oak Drive
Bangor, MI 49013

RE: License #: AS800379702
Investigation #: 2023A1031029
Engedi AFC

Dear Ms. Springett:

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 (616) 356-0183.

Sincerely,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

WARNING THIS REPORT CONTAINS EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS800379702
Investigation #:	2023A1031029
Complaint Receipt Date:	03/31/2023
Investigation Initiation Date:	03/31/2023
Report Due Date:	05/30/2023
Licensee Name:	Lisa Springett
Licensee Address:	30744 White Oak Drive Bangor, MI 49013
Licensee Telephone #:	(269) 217-9359
Administrator:	Lisa Springett
Licensee Designee:	Lisa Springett
Name of Facility:	Engedi AFC
Facility Address:	12 E. Arlington Bangor, MI 49013
Facility Telephone #:	(296) 427-5879
Original Issuance Date:	01/06/2016
License Status:	REGULAR
Effective Date:	07/06/2022
Expiration Date:	07/05/2024
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff are sleeping and not providing appropriate supervision.	Yes
Residents are verbally abused by staff.	No
Additional Findings	Yes

III. METHODOLOGY

03/31/2023	Special Investigation Intake 2023A1031029
03/31/2023	Special Investigation Initiated - Email sent to ORR Director Candice Kinzler.
04/03/2023	APS Referral
04/03/2023	Contact - Telephone Interview held with ORR Director Candice Kinzler.
04/11/2023	Inspection Completed On-site
04/11/2023	Contact - Face to Face Interviews completed with Resident A, Resident B, Resident C, Glenbee Tillery, and Lindsey Hall.
04/18/2023	Contact - Email exchange with APS worker Mike Hartman.
04/20/2023	Contact - Telephone Interview with Julie Zecklin and Admerilla Tillery.
04/26/2023	Contact - Telephone Interview held with Diana Kindig.
04/26/2023	Contact - Documents Requested.
04/28/2023	Contact - Email exchange with Licensee Lisa Springett.
05/01/2023	Contact – Review of Documentation
05/01/2023	Contact – Telephone Interviews completed with Daniel Waite, Linda Davis, and Tammy Dykstra.
5/01/2023	Contact – Email sent to Linda Davis.

05/02/2023	Exit Conference held with Licensee Lisa Springett.

ALLEGATION:

Staff are sleeping and not providing appropriate supervision.

INVESTIGATION:

On 4/3/23, I interviewed Van Buren Recipient Rights Director Candice Kinzler via telephone. Ms. Kinzler reported she was informed that staff are sleeping during the night. Ms. Kinzler reported residents in the home should be receiving specialized care due to the home being contracted with Van Buren Community Mental Health for Special Certification. Ms. Kinzler reported Resident D requires additional supervision according to his individual plan of service.

On 4/11/23, I interviewed Direct Care Worker (DCW) Glenbee Tillery in the home. Ms. Tillery reported staff are allowed to sleep during the night once the residents go to bed. Ms. Tillery reported staff have been allowed to sleep at night since she has been employed at the home for the past eight years. Ms. Tillery reported there is a bed located in the office for staff use. Ms. Tillery reported Resident A is “very restless at night” and will wake up often. Ms. Tillery reported Resident A does require redirection to go back to bed.

On 4/11/23, I attempted to interview Resident A, Resident D and Resident E. Resident A was not able to be interviewed due to being nonverbal. Resident D and Resident E did not engage in the interview process.

On 4/11/23, I interviewed Resident B in the home. Resident B was not able to fully engage in the interview process due to a speech impairment. Resident B acknowledged that staff sleep throughout the night, but she is able to wake them up if needed.

On 4/11/23, I interviewed Resident C in the home. Resident C reported staff sleep throughout the night. Resident C reported she is able to wake staff up if needed.

On 4/11/23, I interviewed DCW Lindsay Hall in the home. Ms. Hall reported overnight staff are allowed to sleep after the residents go to bed. Ms. Hall reported Resident A does wake up throughout the night and he is redirected to his bedroom. Ms. Hall reported she will wake up every 2 hours throughout the night and do bed checks.

On 4/20/23, Ms. Kinzler and I interviewed DCW Julie Zecklin via telephone. Ms. Zecklin reported staff are allowed to sleep and can “sleep whenever”. Ms. Zecklin reported staff have been allowed to sleep since she’s been employed at the home.

Ms. Zecklin reported staff are supposed to get up every 2 hours to complete bed checks as Resident A has incontinence needs at night.

On 4/20/23, Ms. Kinzler and I interviewed DCW Admerrilla Tillery via telephone. Ms. Tillery reported staff are allowed to take “small naps” at night. Ms. Tillery reported staff are required to wake up every hour and a half to check on Resident A due to him wetting the bed at night.

On 4/26/23, I interviewed DCW Diana Kindig via telephone. Ms. Kindig reported staff are allowed to sleep throughout the night. Ms. Kindig reported it is expected that staff wake up every 2 hours to check on Resident A and assist him to the bathroom if needed due to him wetting the bed at night.

On 4/26/23, I sent an email to licensee Lisa Springett requesting the home’s sleeping protocol. Ms. Springett replied via email on 4/28/23 and 5/1/23 reporting the residents in the home do not have treatment plans that require staff to be awake during the night. Ms. Springett reported staff will check on the residents before they lie down for the night and will attend to Resident A’s toileting needs at that time as well. Ms. Springett reported staff are not required to do bed checks throughout the night, but they will if a resident is ill or not feeling well. Ms. Springett reported where staff lie down is close to the bathroom and staff can hear when a resident uses the bathroom or is walking around in the common area.

On 5/1/23, I interviewed Resident A’s case manager Daniel Waite via telephone. Ms. Waite reported that due to the level of need Resident A has, he does not feel that it is appropriate for staff to be sleeping at any time. Mr. Waite reported Resident A is nonverbal and wakes up often in the middle of the night. Mr. Waite reported he is concerned that if staff are sleeping, they may not realize Resident A needs assistance due to being nonverbal. Mr. Waite reported he is also concerned that Resident A could leave the home throughout the night without supervision. Mr. Waite reported he believes Resident A requires 24/7 supervision.

On 5/1/23, I interviewed Resident D’s case manager Linda Davis via telephone. Ms. Davis reported she did not have any concerns regarding the care Resident D receives in the home. Ms. Davis reported Resident D sleeps well during the night and does not see a need for 24/7 supervision. Ms. Davis reported Resident D is able ask for help or assistance when needed.

On 5/1/23, I reviewed the resident’s *Individual Plan of Service* completed by Van Buren Community Mental Health. Resident B, Resident C, and Resident E plans do not specify that additional supervision is needed throughout the night. Resident A’s plan dated 3/8/23 indicates that he is “dependent on others for his basic need and provide a safe environment with proper supervision”. Resident D’s plan dated 7/21/22 indicates that he is to be prompted every 2 hours to use the bathroom and staff are to wake Resident D up at 9pm and 11pm to prompt him to use the bathroom. Resident D is reported to require monitoring and protection for health and

safety due to having limited safety awareness skills and unintentionally placing himself in danger. The plan notes that “staff should know [Resident D’s] whereabouts at all times”. Resident D also requires monitoring when accessing areas such as the kitchen due to a history of removing items to hide in his room for later consumption such as raw hamburger or a 5-pound bag of sugar.

On 5/1/23, I reviewed the staff schedule for the home. The schedule indicated from February to March 2023, there was one staff scheduled from 11pm to 7am.

On 5/1/23, I reviewed the Original Licensing Study Report dated 1/6/16. The report indicates within the program description that the “applicant intends to provide 24-hour supervision, protection, and personal care for adults who are developmentally disabled/ and/or mentally ill. The applicant also intends to provide specialized care to the mentally ill and developmentally disabled populations”. The report also indicates “awake staff will be provided if a resident’s assessment plan requires it”.

On 5/1/23, I interviewed Ms. Springett via telephone. Ms. Springett reported she was under the impression that the resident’s assessment plans and/or behavior plans needed to specifically state that an awake staff was required. Ms. Springett reported she understood the need for supervision as identified in Resident D’s assessment plan.

On 5/1/23, I sent an email to Ms. Davis requesting clarification regarding her verbal report and Resident D’s *Individual Plan of Service* as they differed. Ms. Davis reported “Those specific statements have followed [Resident D] as he moved from one Specialized Residential Home to another. His other Specialized Residential Homes prior to his current home, were in rural areas and [Resident D] enjoyed spending time outdoors. There was a concern at that time that [Resident D] would get into the trash outside. He does not go outside his current home unless staff is with him. He is very frightened of dogs and has seen large dogs roaming loose around the City of Bangor. I will ask his current staff if he gets into things in the kitchen, I have had no reports that he is taking any food items out of the fridge/pantry and taking them to his room at his current home. This was an issue in the past, but I don’t believe it to be an issue since he moved to this home. [Resident D] will be having an Annual Assessment/Annual Planning meeting coming up and his supervision needs will be reviewed and updated in his plan of service”.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on interviews and the review of supporting documentation, it has been determined that there is not sufficient staff on duty at all times to ensure the supervision, personal care, and protection of all residents. Although there is a 5:1 resident to staff ratio from 11pm to 7am, the one staff scheduled in the home is sleeping during the night. Staff are not able to meet the resident's supervision and personal care needs as identified in their plans when they are asleep. Resident A's plan indicates he is dependent on others for his basic needs and to provide a safe environment with proper supervision. Resident A's case manager expressed concerns regarding the lack of supervision and Resident A's overall safety and wellbeing while staff are sleeping. Resident D's plan requires staff to know his whereabouts at all times and monitor him in the common areas due to concerns of him having limited safety awareness skills and unintentionally placing himself in danger. The Original Licensing Report indicates within the program description that the licensee would be providing 24-hour supervision and ensuring awake staff are available per the resident's assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are verbally abused by staff.

INVESTIGATION:

Ms. Kinzler reported she was informed that Resident A and Resident B were verbally abused by staff. Ms. Kinzler reported it was alleged that Resident A was yelled at by DCW Admirrilla Tillery. Ms. Kinzler reported Ms. Tillery was sleeping and Resident A was standing over her which startled her. Ms. Tillery then got upset and redirected Resident A back to his bedroom. Other residents were woken up due to hearing yelling, cussing, and banging coming from Resident A's bedroom. Ms. Kinzler reported Resident C reported the incident occurred around 5am and she heard Ms. Tillery slamming doors. Resident C also heard Ms. Tillery tell Resident A to "shut the fuck up", "son of a bitch", and "what the fuck". Resident C reported to Ms. Kinzler that she did not want to get involved because she was afraid Ms. Tillery would do the same to her. Resident C also reported "I just felt bad for [Resident A]". Ms. Kinzler reported she was informed that it was alleged that Ms. Kindig called Resident B "fat fat fat". Ms. Kinzler reported she interviewed Resident B and she told her Diana was calling her names. Ms. Kinzler reported she interviewed Diana, and she

reported Resident B overheard a conversation she was having with her daughter, Glenbee Tillery. Ms. Kinzler reported she was informed that Ms. Kindig and Glenbee were referencing themselves and stating they were on a diet and trying to lose weight.

Glenbee Tillery reported Admirrilla Tillery informed her that she was laying in bed when Resident A woke her up. Glenbee reported Admirrilla told her she redirected Resident A back to his bedroom and there were clothes everywhere from him messing up his bedroom. Glenbee reported Admirrilla informed her that she stated "what the fuck [Resident A]" after Resident A hit Resident D. Glenbee reported Admirrilla has not worked at the home since the incident occurred. Glenbee reported she never called Resident B "fat" or any other derogatory name. Glenbee stated she and Ms. Kindig were having a conversation and Ms. Kindig were talking about losing weight for a wedding and Ms. Kindig did not want to be fat in the pictures. Ms. Tillery reported there were not any comments made related to any of the resident in the home being fat.

Resident B reported she heard Admirrilla "cuss a little" in Resident A's bedroom. Resident B did not have any further information to share. Resident A reported Ms. Kindig called her "fat, a lot". Resident B reported there was not anyone else around when this occurred. Resident B was not able to provide any further details.

Resident C reported there was an incident that occurred "the other day" involving "Addy" who was identified as Admirrilla. Resident C reported she was woken up in the middle of the night around 5am to yelling and banging noises. Resident C reported she heard Admirrilla say to Resident A "what the fuck", "shut the fuck up" and "hurry the fuck up". Resident C reported Admirrilla was very upset about something, and she heard loud banging noises coming from Resident A's bedroom. Resident C reported Admirrilla is "mean" to Resident A. Resident C reported she has never heard any staff call Resident B fat since living in the home. Resident C reported Resident B tends to lie when she is upset with staff.

Ms. Hall reported she had a conversation with Admirrilla the next day following the alleged incident. Ms. Hall reported Admirrilla told her "last night was rough" with Resident A but did not provide any specific details. Ms. Hall reported she has never heard staff call Resident B any derogatory names. Ms. Hall reported Resident B never made any reports about staff calling her names.

On 4/18/23, I received an email from APS worker Mike Hartman regarding the allegations of Resident B being called "fat fat fat". Mr. Hartman reported that as a result of his investigation, there was not a preponderance of evidence to support that Resident B was emotionally abused by staff.

Ms. Zecklin reported Resident B and Resident C informed her that Admirrilla yelled so loud in the middle of the night that it woke them up. Ms. Zecklin reported the residents were upset that they were woken up in the middle of the night but did not

provide any further details to her. Ms. Zecklin reported she has never witnessed any staff call Resident B any derogatory names.

Admirrilla reported Resident A was standing over her when she was sleeping which startled her. Admirrilla reported she redirected Resident A back to his bedroom and noticed his room was in disarray. Admirrilla reported she put his room back together and while doing so she heard a “slap noise”. Admirrilla reported she then said “what the fuck was that” and realized Resident A had slapped Resident D. Admirrilla reported she told Resident A that he cannot hit others. Admirrilla reported she did cuss but denied cussing directly at Resident A. Admirrilla reported Ms. Springett told her not to work at this home any longer because residents complained about her using curse words. Admerrilla reported she has never observed any staff call Resident B any names.

Ms. Kindig reported Admirrilla informed her that Resident A had woken up in the middle of the night and she redirected him back to his bedroom. Ms. Kindig was informed that Resident A had pulled all of his clothing out of his drawer and Admirrilla put them back. Ms. Kindig reported Admirrilla informed her that Resident A had hit Resident D and she stated “what the fuck”. Ms. Kindig reported she never called Resident B “fat fat fat”. Ms. Kindig reported she was having a conversation with another staff member about losing weight for a wedding. Ms. Kindig reported she said she did not want to be fat in wedding pictures. Ms. Kindig reported she said she was not losing fat in her arms and believes Resident B took her statements out of context because she was upset with her that day.

Ms. Springett reported she believes that Ms. Tillery did use curse words in the presence of the residents. Ms. Springett reported she does not believe the curse words were negatively directed towards Resident A. Ms. Springett reported she spoke to Ms. Tillery regarding the language being used in the home. Ms. Springett reported she does not have any concerns regarding Ms. Kindig speaking negatively to residents in the home.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**

ANALYSIS:	Staff admitted to using curse words while in the presence of residents in the home. Staff denied cursing directly at Resident A. Resident B and Resident C both reported hearing staff curse while in the presence of residents. However, there are conflicting reports made by involved individuals and a clear determination cannot be made whether staff used curse words in a general manner or directed it negatively towards Resident A. There is no evidence found to support that staff called Resident B “fat”.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Zecklin reported the home implements “quiet time”. Ms. Zecklin reported this involves staff directing the residents to their bedrooms at 10pm to go to bed. Ms. Zecklin reported the residents are allowed to watch TV in their rooms. Ms. Zecklin reported she has told residents in the home that they are not allowed to purchase items at the store such as caffeinated beverages or candy although they were purchasing the items with their own money. Ms. Zecklin reported she was not aware that she was not able to direct the residents away from buying needed items.

Admirrilla Tillery reported the home implements “quiet time”. Ms. Tillery reported this involves directing residents to their rooms to go to sleep between 8pm to 9pm. Ms. Tillery reported “they take their pills and go to their room. They can’t be going around the house. Everyone stays in their rooms”. Ms. Tillery reported she turns the TV off at 9pm because that is what she does with her children and feels this helps the residents get ready for bed. Ms. Tillery reported Resident B must turn in her tablet at 9pm because she texts a lot at night. Ms. Tillery was not able to clearly identify if taking away Resident B’s electronics was a requirement of her behavior plan or assessment plan. Ms. Tillery reported the home telephone is located in the office and residents do not have free access to use the phone in the evening. Ms. Tillery reported residents can use the telephone at night “depending on who it is”.

Ms. Kindig reported the residents do not have a designated bedtime. Ms. Kindig reported by 10pm they ask the residents to have “quiet time” and they go in their rooms to watch TV. Ms. Kindig reported residents can watch TV in the main living area until 10pm. Ms. Kindig reported Resident B’s case manager suggested encouraging Resident B to turn in her tablet at night because she was complaining about not sleeping well. Ms. Kindig reported taking away Resident B’s tablet was not officially documented in her behavior plan. Ms. Kindig reported there was one

evening where she prompted Resident B multiple times to turn in her tablet and Resident B refused to do so. Resident B got upset and threw her tablet on the ground. Ms. Kindig reported she told Resident B to pick up the tablet. Ms. Kindig reported Resident B asked for assistance turning on her tablet and connecting it to internet. Ms. Kindig reported she told Resident B “no” and that it was “too late” for her to use her tablet. Ms. Kindig reported that residents are asked to not use the telephone past 10pm to make phone calls.

Ms. Springett reported residents typically go to their bedrooms after 8pm medications are passed. Ms. Springett reported the residents are not told they need to go to their rooms, but they have been doing this for several years. Ms. Springett reported if they wanted to stay up in the common area, they are welcome to do so.

Resident B’s *Individual Plan of Service* was reviewed and there is no documentation to support that Resident B needs to turn in her tablet at any time.

Ms. Dykstra reported Resident B does have a habit of staying on her tablet too late. Ms. Dykstra reported that she could not recall whether or not she directed staff in the home to take away Resident B’s tablet at night.

Ms. Springett reported that the home has locked up the resident’s tablets due to them using them late in the night. Ms. Springett acknowledged that taking away tablets or electronics was not identified in the resident’s plans or assessments. Ms. Springett reported she never directed staff to have the residents go to their room for “quiet time”. Ms. Springett reported residents tend to go to their rooms by individual choice after medications are given in the evening. Ms. Springett reported residents in the home do not have any dietary restrictions to prevent them from buying unhealthy food while at the store. Ms. Springett reported she has reminded staff to answer the home telephone and allow residents access to the phone when requested.

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:	Staff in the home are not always treating the residents with dignity. It does not appear that staff are being malicious in how they are treating residents. It does appear that staff are treating the residents more as children and not recognizing them as adults with the right to make individual decisions. Staff are making decisions on behalf of the residents despite the resident's individual wants and requests. Staff have implemented "quiet time" which includes staff directing the residents to their rooms after medications are passed. Staff have reported they do not allow the residents to watch TV in the common area past a certain time. Staff prompt Resident B to turn in her tablet in the evening. Staff have refused to assist Resident B with the use of their electronics which prevented them from using their tablet when they wanted to. Resident B's individual plan of service does not indicate Resident B has to turn in her tablet and it does not indicate that staff can prevent usage of their personal items at any time of the day. Residents in the home do not have any dietary limitations that prevent them from purchasing or consuming caffeine or sugar. Staff are also dictating the use of the telephone in the home and residents are not always able to make phone calls when requested.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Kinzler reported she did not receive incident reports for concerning incidents that recently occurred at the home. Ms. Kinzler reported Ms. Springett did not submit an incident report regarding the alleged incident involving staff verbally abusing residents. Ms. Kinzler reported she spoke to Ms. Springett, and she handled the matter internally. Ms. Kinzler reported she did not receive an incident report regarding Resident B self-harming herself.

Resident B reported she self-harmed by using a CD on her wrist. Resident B was observed to have superficial marks on her wrist. Resident B reported she showed staff her wrist afterwards. Resident B was not able to identify what staff she informed.

Ms. Hall reported Resident B got off the bus recently and was visibly upset. Ms. Hall reported Resident B showed her marks on her wrist. Ms. Hall reported she observed Resident B to have superficial marks on her wrist. Ms. Hall reported she did not complete an incident report for the self-harming behavior. Ms. Hall reported when

she does complete an incident report, she puts it in a box and Ms. Springett submits them where they need to go.

Ms. Zecklin reported was aware of Resident B's self-harming behavior and did not complete an incident report. Ms. Zecklin reported she provided a verbal report of the incident to Ms. Springett. Ms. Zecklin reported she does not fully understand when and what to document regarding incident reports. Ms. Zecklin reported additional training would be helpful in this area.

Admirrilla Tillery reported she did not complete an incident report when Resident A slapped Resident D in the head. Ms. Tillery reported she started filling one out and then decided to provide a verbal report to Ms. Springett. Ms. Tillery reported when they complete an incident report, they notify Ms. Springett, and Ms. Springett will come to the home to discuss the issue.

Ms. Kindig reported she completes incident reports and submits them to Ms. Springett for review.

On 5/1/23, I interviewed Resident B and Resident D's guardian Tammy Dykstra. Ms. Dykstra reported she has not received any incident reports from the home regarding recent events. Ms. Dykstra reported the home could be better at reporting important information to her.

On 5/1/23, I reviewed the licensing file and there were not any incident reports located for the home.

Ms. Springett reported incident reports are kept in the home and she was not aware that they needed to be sent to LARA along with Community Mental Health. Ms. Springett reported there was not an incident report completed when Resident A hit Resident D. Ms. Springett reported this was a behavior of Resident A as when he gets in his moods he will charge people, throw things, and occasionally hit. Ms. Springett reported Resident D was not injured, so staff directed Resident A back to his own bed. Ms. Springett reported she was not aware that Resident B had engaged in self-harming behavior until she received a call from Ms. Kinzler. Ms. Springett reported Resident B has a history of breaking her CD's and scratching herself superficially when she gets mad. Ms. Springett reported she went to the home to see Resident B and talked with her about this after being made aware of this behavior.

APPLICABLE RULE	
R 400.14311	**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: **(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.**
ANALYSIS:	The home has not reported to the appropriate parties as required by this rule. There were recent incidents that included attempts at self-inflicted harm and harm to others that were not reported to AFC licensing, the responsible agency, and designated representative. Based on interviews with staff and the licensee, there is not a clear understanding of when reporting should be completed per licensing rules and who or where they should be submitted upon completion.
CONCLUSION:	**VIOLATION ESTABLISHED**

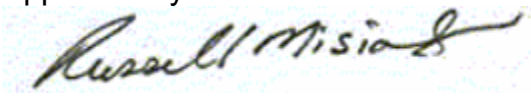
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

5/2/23

Kristy Duda Date
Licensing Consultant

Approved By:



5/18/23

Russell B. Misiak Date
Area Manager