GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2024

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS090064224
Investigation #:	2024A0123030
	Georgetown

Dear James Pilot:

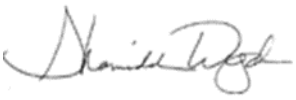
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090064224
Investigation #:	2024A0123030
Complaint Receipt Date:	03/20/2024
Investigation Initiation Date:	03/20/2024
Report Due Date:	05/19/2024
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Georgetown
Facility Address:	4784 Zielinski Lane Auburn, MI 48611
Facility Telephone #:	(989) 662-7047
Original Issuance Date:	07/11/1995
License Status:	REGULAR
Effective Date:	12/09/2023
Expiration Date:	12/08/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has recently made statements of harm toward Resident B. Resident A stated they were going to kill Resident B and the other housemates.	Yes
Resident A opens their bedroom window at night and makes the room very cold. This is affecting Resident B.	Yes
Resident A keeps food and drink in a personal refrigerator. Resident A has a very serious choking/aspiration risk which is outlined in Resident A's care plan. Resident A is only to eat and drink in front of staff in the kitchen area/table.	Yes

III. METHODOLOGY

03/20/2024	Special Investigation Intake 2024A0123030
03/20/2024	Special Investigation Initiated - Letter APS referral completed.
03/20/2024	APS Referral
03/21/2024	Inspection Completed On-site I conducted an unannounced on-site at the facility.
03/22/2024	Contact - Telephone call made I spoke with home manager Taylor Janik.
03/25/2024	Contact- Document Received Requested documentation received.
04/04/2024	Contact - Telephone call received I received a voicemail from staff Taylor Janik.
04/04/2024	Contact - Telephone call made I spoke with Staff Janik.
04/04/2024	Contact - Telephone call made I spoke with Resident A's case manager.
04/09/2024	Contact- Document Received I received an incident report via email from the facility.
04/19/2024	Contact - Telephone call made I spoke with Resident B's case manager.

04/25/2024	Contact- Telephone call made I made a follow-up call to the facility. Requested additional documentation and spoke with home manager Taylor Janik.
04/30/2024	Contact_ Document Received Requested documentation received via email.
05/06/2024	Contact- Telephone call made I made a follow-up call to the facility. I interviewed assistant home manager Stacy Staudacher.
05/07/2024	Exit Conference I spoke with licensee designee James Pilot via phone.

ALLEGATION:

- **Resident A has recently made statements of harm toward Resident B. Resident A was found with a sharp tool that fell out of his pocket. Resident A stated they were going to kill Resident B and the other housemates.**

- **Resident A opens their bedroom window at night and makes the room very cold. This is affecting Resident B.**

- **Resident A keeps food and drink their bedroom. Resident A has a very serious choking/aspiration risk which is outlined in Resident A's care plan. Resident A is only to eat and drink in front of staff in the kitchen area/table.**

INVESTIGATION: On 03/21/2024, I conducted an unannounced on-site at the facility. I interviewed staff Ashley Stevens. She stated that Resident A verbally is aggressive and makes threats but does not act on it. Resident A has not been physically aggressive. Resident A will say they'll hit Resident B, but she has never seen Resident A hit Resident B. Resident A will open the bedroom window every night. The window situation is a day and night issue. When the temperature in the room gets to 68 degrees Fahrenheit, staff have to close the window. Resident A will then re-open the window. It is a back-and-forth struggle between staff and Resident A. Resident B is cold all of the time and will yell and scream about being cold. Staff Stevens stated that they provide Resident B with blankets and tells Resident A that Resident A cannot freeze Resident B out. Staff Stevens stated that she believes Resident A's end goal is to have their own room. Resident A has a problem with authority and does not like to be told what to do. There have been about 20 or more incident reports written about the window situation, with two to three written daily. Staff Stevens stated that she was not at work when the object/weapon Resident A had was found. Staff Stevens stated that Resident A's behavior appears

unprovoked. Staff Stevens reported hearing threatening comments from Resident A to Resident B such as killing, stabbing, and "*cold cocking*" Resident B.

Staff Stevens stated that Resident A has a serious choking hazard and aspiration risk. Resident A's personal refrigerator is used for storing drinks. In the past, Staff Stevens stated that Resident A would shove food in Resident A's pants pockets and would eat and snack in the bedroom. Staff are supposed to watch Resident A eat and drink everything at the kitchen table. Staff Stevens stated she does not understand why Resident A has a personal refrigerator but was told it is Resident A's right to have it. She stated that Resident A has manipulative behaviors.

On 03/21/2024, I interviewed staff Sally Watson at the facility. Staff Watson stated that she is very concerned about Resident A's behavior. Resident A has verbally threated to harm Resident B. Staff Watson stated that she thinks one day Resident A may snap, and she does not want anyone to get hurt. When Resident B has schizophrenic episodes and yells, Resident A escalates. Resident B's behaviors aren't usually connected to others, it is just the schizophrenia. Resident A probably does not want to share a bedroom, and Resident A has a history of doing things to get rid of roommates. Resident A has poor hygiene, will defecate on themselves, and not wash their hands. Resident A also opens the bedroom window, and the room with get completely cold. The room has had a temperature reading of 64- or 65-degrees Fahrenheit before. Staff have to shut the window behind Resident A. There is a thermostat in the room because of Resident A's behavior. Resident B gets cold easily, and Resident A is trying to freeze Resident B out. Staff Watson stated that she does not know what the plan is to resolve these issues, and that other residents in the home have had increased behaviors. Staff Watson stated that she does not think she's heard Resident A threatened to kill anyone but Resident A has said "*If it keeps on, I'll snap*." Staff deescalates the best they can. Resident A was found with a metal tool that fell out of Resident A's pocket, that Resident A said they'd use against Resident B. Resident B is blind and can barely see.

On 03/21/2024, I interviewed Resident A at the facility. Resident A reported living at the facility for about a year. Resident A stated that things are good so far and Resident A gets along with staff. Resident A does not get along well with Resident B, and Resident A stated that other residents in the home want attention all of the time from staff and other residents in the home. When Resident A sleeps, Resident B yells. Resident A stated that they are not themselves with Resident B. Resident B triggers Resident A's behaviors. Resident A stated that Resident A likes the breeze that comes through the windows. Resident A admitted to threatening to harm other residents off and on because the other residents do not listen when told to stop. Resident A stated that the metal tool was a paper weight that was not sharp, and the home manager has it. Resident A stated that Resident A just wants quiet, peace, and solitude. Resident A wants their own room, and Resident A reported not having a roommate for a long time before Resident B moved into the room. Resident A reported feeling like they should have more options, and not feel restricted in the bedroom. Resident A stated that when staff close the windows, Resident A freaks

out and wants things their way. Staff do have to supervise Resident A with eating and drinking. Resident A denied eating and drinking in the bedroom, then stated that they only drink pop in the bedroom.

During this on-site, I observed Resident A and Resident B's bedroom. Resident A did have a personal refrigerator in the room. The inside of the refrigerator was observed to be empty.

On 03/21/2024, I attempted to interview Resident B at the dining room table. Resident B was observed sitting in a wheelchair, wearing a hooded sweatshirt, a hat, and was also covered in a blanket. Resident B stated that they like living in the facility and gets along with their roommate. Resident B complained that someone had the window open. Resident B stated that Resident B feels safe. During this interview Resident B appeared to mumble and speak in low volume.

Other residents present in the home were observed during this on-site. They appeared clean and appropriately dressed. No issues were noted.

On 03/22/2024, I made a call to home manager Taylor Janik. Staff Janik stated that Resident A has given staff a lot of issues. When Resident A first moved in, Resident A was not showering. Resident C moved in and was Resident A's roommate. There were issues. Resident A was making threats toward Resident C and accused Resident C of stealing. Resident C was moved to another bedroom. Later, Resident B moved into the facility. Resident A thinks staff baby other residents, but Resident A does not understand that other residents have less capabilities. Resident A does not like Resident B as a roommate. Resident A knew moving in that Resident A would have a roommate. Staff ask Resident A to close the bedroom windows. Resident A will respond to staff with "*it's my right*." A thermometer was purchased to put in Resident A and Resident B's room, and it is drilled to the wall, because the first thermometer that was purchased, Resident A hid it. Staff have to write incident reports every time Resident A opens the window. Staff are supposed to close the window if the temperature in the room falls below 72 degrees. Resident B is usually only in the bedroom at night. Resident A has started to tell a therapist that Resident A wants to choke and stab Resident B. Staff Janik stated that she reported the behavior to Resident A's behavior team which did not do much. The behavior team met with Resident A but Resident A's behaviors have not changed. A couple weeks ago, Resident A had a metal piece that Resident A says they took from Resident A's desk. Resident A stated that it was for protection, and that Resident A will get them before they get Resident A. Resident A said it's Resident A's right to protect themselves. Resident A takes Resident B's yelling personally. A behavioral specialist and Resident A's case manager had another meeting with Resident A after the weapon was found. After they leave, Resident A goes back to the same behaviors. Staff Janik stated that she touches base with Resident A's behavior team weekly. Staff Janik stated that there was talk about adding a medication for aggression. Resident A threatens all the residents in the home with words like "*I'll slap you. I'll hit you. I'll throw boiling hot coffee on you*." Resident A tells the

behavioral team what they want to hear. Resident A has not acted on the threats, but they are serious threats. Staff Janik stated that Resident A's refrigerator was empty as of yesterday. Staff have to encourage Resident A not to have food in the bedroom. A nursing care plan was changed to Resident A having to sit at the table to eat. Staff have asked Resident A's guardian to move the refrigerator out of the home, but the guardian has not done so. Resident A stores pop under Resident A's bed. They have had mice because Resident A has left sugar on the bedroom floor. Resident A's aggression started when Resident C moved into the home in May 2023.

On 03/25/2024, I received requested documentation from the facility including incident reports, *Bay Arenac Behavioral Health Plan of Services*, and assessment plans.

Resident A's *Assessment Plan for AFC Residents* dated 11/24/2023 has yes checked for "*gets along with others"* and "*controls aggressive behavior*." Under *eating/feeding* it states, "*prepping meals, uses a bowl at meals to spit in, eats very slow*."

Resident A's *Bay Arenac Behavioral Health Plan of Service* dated 11/13/2023 notes on page one that *"[Resident A] was also deemed a high choking risk by [Resident A's] physician. [Resident A] has agreed to work with staff on eating only in the kitchen and in places where staff can monitor [Resident A] for choking while eating. [Resident A] is not entirely happy with this change but does seem to understand that the consequences for [Resident A] choking in [Resident A's] room could result in death*." On page two it notes *"[Resident A] has had 2 increases in Prozac and was seen in the ER for making statements of causing harm to others*." "[*Resident A] can become verbally and physically belligerent at times. [Resident A] has supports in place that are helping [Resident A] to reduce agitation over others assisting [Resident A]. [Resident A] has a behavioral treatment plan, psychiatric supports and outpatient therapy to help [Resident A] address negative responses and [Resident A] is starting to show some improvements*." "*High choking risk and so must eat and drink with staff present*." Then on page four it says, "*Staff will give reminders and encouragement to [Resident A] to consume food and drink in the kitchen/main area of the home where staff can observe [Resident A] with intake to prevent and/or treat choking and encouragement*…."

Resident B's *Assessment Plan for AFC Residents* dated 02/23/2024 notes that Resident B "*still needs assistance from staff to know what is happening*" in regard to *Alert to Surroundings*. The assessment plan notes that Resident A gets along with others, and for controlling aggressive behavior, there is a "*behavioral plan in place with PRN protocol for anxiety/aggression*".

I received copies of about 43 *AFC Licensing- Incident/Accident Reports* dated between 02/02/2024 and 03/25/2024. Each incident report notes that Resident A had opened the bedroom window, and the temperatures of the room was

documented on about 40 of the incident reports. The temperature of the room ranged from 60 degrees Fahrenheit to 67 degrees Fahrenheit. The action taken by staff was closing the window. It was noted that staff observed Resident A and Resident B's bedroom temperature to be below 68 degrees Fahrenheit during non-sleeping hours (between about 7:30 am and 7:40 pm) on about 24 of the incident reports.

An *AFC Licensing- Incident/Accident Report* dated 03/11/2024 written by home manager Taylor Janik in summary states that Resident A was getting into the van and a metal tool fell out of Resident A's pocket. Resident A stated that they "*pulled it off my desk*." The home manager asked Resident A what it was for, and Resident A said "*it's my weapon for protection, I will get the guys before they get me…the guys piss me off and I will get them before they get me. I'm not playing around anymore*." Staff asked Resident A if Resident A had feelings of hurting others, and Resident A replied "*yes*." Resident A replied "*you won't know*" when Resident A was asked if Resident A had any more weapons. A photo of the "weapon" appears to be a metal hinge with rounded ends. A note on the photos says the scratches on the metal are from [Resident A] claiming they sharpened the tool. Corrective measures noted include staff continuing to monitor Resident A's behaviors and actions, and to bring this incident to the attention of Resident A's team via email.

A second *AFC Licensing- Incident/Accident Report* dated 03/11/2024 written by home manager Taylor Janik in summary states that a search and seizure addendum for staff to search Resident A's bedroom was put into place. A search of the bedroom was done on 03/11/2024. Four plastic forks were removed from the room and disposed of in the kitchen garbage. A copy of the *Behavior Support Plan Addendum* was attached to the incident report, dated 03/11/2024.

The home manager reported this incident to Resident A's psychologist, case manager, behavioral specialist, and the facility's managers. It also notes that there will be continued follow-up with Resident A's team and a med review with a physician was scheduled for 03/13/2024.

On 04/04/2024, I made a return call to staff Taylor Janik. She stated that Resident B switched rooms with Resident C, and Resident C is now roommates with Resident A.

On 04/04/2024, I spoke with Resident A's Bay Arenac Behavioral Health case manager Jennifer DeShano via phone. She stated the following:

Resident A's behaviors are significant, but baseline for Resident A. Resident A uses threats to make things go Resident A's way. Resident A wants their own bedroom and Resident A is doing things to make their roommate uncomfortable. She cannot say yes or no to whether or not Resident A would ever get physical with someone else. Resident A has been informed that these behaviors can lead to a more restrictive setting. Resident A thrives in negativity and likes for others to be

uncomfortable. Resident C has moved back into the room with Resident A. Resident C can defend themselves better and not be bullied by Resident A. Resident B is really passive, and Resident A thought they could bully Resident B. There is one physically aggressive resident in the home who has a room with no roommate due to behaviors, so Resident A cannot have their own room. The metal object Resident A had was a hinge the size of a thumb from Resident A's desk.

On 04/09/2024, I received an *AFC Licensing Division- Incident/Accident Report* dated 04/08/2024. It states "[Resident A] was getting upset because other residents were interrupting [Resident A] while [Resident A] was trying to talk with staff. [Resident A] stated that [Resident A] would like to go somewhere to be put under observation because [Resident A] impulses are getting to be too much to control. ([Resident A] getting violent.) Staff calmed [Resident A], reassured [Resident A] that everything is going to be okay, that violence is never the answer, and that maybe going to [Resident A's] room would help. The incident report further states that Resident A's team would be contacted regarding this incident report and follow up with Resident A's physician.

On 04/19/2024, I spoke with Resident B's Bay Arenac Behavioral Health case manager Heidi Nixon. She denied having any concerns and stated that Resident A and Resident B are no longer roommates. She stated that it was fine how things were handled, and there have been no issues since, and that the problem was Resident A and Resident B sharing a room.

On 04/25/2024, I made a follow-up call to the facility and spoke with home manager Taylor Janik. Staff Janik stated that Resident A is still opening the bedroom window. Resident C has been wanting to sleep on the couch due to Resident A and Resident C's bedroom being dirty and smelling. Resident A defecated in their pants recently, and feces fell out of their pants while at the dining room table. Resident A is still verbally threatening other residents. Resident A refused to go to a therapy appointment the other day. Staff Janik stated that staff cannot force Resident A to stop bringing food and drinks into their bedroom. Resident A keeps pop in the bedroom, and staff encourage Resident A to not take snacks into the room.

On 04/30/2024, I received requested documentation from the facility. Resident A's *Residential Progress Notes* dated 04/01/2024 through 04/22/2024 were reviewed. The progress notes summarizes behavioral changes in Resident A, since Resident B and Resident C switched being roommates with Resident A. The progress notes indicate that Resident A has been purposefully keeping a messy room and defecating on themselves and refusing to shower and change clothing. Staff tried to redirect Resident A to address hygiene issues due to Resident A walking around the home and lying in bed with bowel movement in their pants, and dirty clothing. Resident A responded to staff by refusing to shower and letting staff know it's their right (to refuse). On 04/22/2024, Resident A also purposefully urinated all over the bathroom floor and refused to clean themselves and the bathroom up.

On 05/06/2024, I interviewed assistant home manager Stacy Staudacher via phone. Staff Staudacher stated that Resident A sneaks food into their room daily. Third shift staff have reported witnessing Resident A trying to sneak chips into the room at nighttime. Staff find food stuff under Resident A's bed. A pest control company has had to come out regularly for ants and mice due to Resident A having food in the bedroom. Resident A stores pop in their room. Staff finds empty cans in the bedroom as well as water bottles. Resident A is defiant but is aware of the risks. Resident A defecates in their clothing and walks around with feces under their nails in the home. Resident A will sit at the dining room table for meals with feces on them. Resident A tracks urine from room to room, laughs it off, and tells staff they have to clean up behind them. Staff have found feces in Resident A's bedroom. Staff are constantly wiping and cleaning up behind Resident A. Resident A refuses medical appointments. Resident C initially moved out of the room with Resident A because Resident C could not stand the smell in the bedroom. Now, Resident C is roommates again with Resident A. Staff Staudacher stated that she has witnessed Resident A tell Resident B they'd kill Resident B. Resident A opens the bedroom window daily, but lately due to warmer days, staff have not had to write any incident reports. She stated that there were times you could feel the change in temperature in the hallway of the home before even getting to the bedroom, due to Resident A having the window open.

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: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	On 03/21/2024, I conducted an unannounced on-site. Staff Ashley Stevens, staff Sally Watson, Resident A, and Resident B were interviewed. Staff Stevens, Staff Watson, and Resident A reported that Resident A has made verbal threats of harm towards Resident B and other residents. Staff Stevens and Staff Watson reported that Resident A opens the bedroom window making the bedroom Resident A shares with Resident B very cold. Resident A admitted to opening the window. During the course of this investigation, I reviewed about 43

	AFC Licensing- Incident/Accident Reports dated between 02/02/2024 and 03/2024, that documents the room temperature in Resident A and Resident B's room was recorded to be between 60- and 67-degrees Fahrenheit at least 40 times. Resident A admitted to having a "metal tool" that was not sharp that they planned to use as a weapon. Resident A stated that Resident B triggers Resident A's behaviors. An *AFC Licensing- Incident/Accident Report* dated 03/11/2024 summarizes that staff confiscated a "metal tool" that Resident A told staff was a weapon, and Resident A made verbal threats about using said weapon on others. As a result, staff had to search Resident A's room for other weapons. Nothing was found, but a *Behavior Support Plan Addendum* was added to Resident A's care plan giving staff permission to search Resident A's room. On 03/22/2024, staff Taylor Janik was interviewed and also confirmed Resident A makes verbal threats towards other residents, was opening the window making the bedroom cold for Resident B. Staff Janik stated that Resident A had also made threats towards Resident C in the past when Resident A and Resident C were roommates. During the course of this investigation, Resident B moved out of the room with Resident A, and Resident C was moved back into the room. Resident A's *Residential Progress Notes* dated 04/01/2024 through 04/22/2024 notes Resident A's behaviors since Resident C moved back into the bedroom with Resident A. Per the documentation, Resident A has been purposely keeping a messy room, urinating on the floor, and having bowel movements on themselves and refusing to shower and change out of dirty clothing. Resident B's case manager Heidi Nixon denied having any concerns regarding Resident B, stating that there have been no issues since Resident B moved into another room. Resident A's case manager Jennifer DeShano stated that Resident A's behaviors are significant, but baseline, Resident A makes threats to get their way, and Resident A did things to make Resident B uncomfortable. There is a preponderance of evidence to substantiate a rule

	violation in regard to Resident A's incompatibility in the home with other residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68- and 72-degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperature and requirements specified in this rule.
ANALYSIS:	On 03/25/2024, I received copies of about 43 *AFC Licensing-Incident/Accident Reports* dated between 02/02/2024 and 03/25/2024. Each incident report notes that Resident A had opened the bedroom window, and the temperatures of the room was documented on about 40 of the incident reports. The temperature of the room ranged from 60 degrees Fahrenheit to 67 degrees Fahrenheit. The action taken by staff was closing the window. It was noted that staff observed Resident A and Resident B's bedroom temperature to be below 68 degrees Fahrenheit during non-sleeping hours (between about 7:30 am and 7:40 pm) on about 24 of the incident reports. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

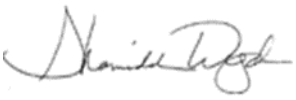
APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard

	to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	On 03/21/2024, I conducted an unannounced on-site at the facility. Staff Ashley Stevens stated that Resident A has a personal refrigerator for storing drinks, and that Resident A has shoved food in their pants pockets and would eat/snack in their bedroom. Resident A was interviewed and stated that they drink pop in their bedroom. On 03/22/2024 and 04/25/2024, Staff Taylor Janik was interviewed and stated that Resident A stores pop under their bed, and that the facility has had to hire an exterminator due to Resident A leaving sugar on the bedroom floor. Staff Janik also stated that Resident A stores pop in the bedroom, and staff cannot stop Resident A from being food and drinks into the room. Resident A's *Bay Arenac Behavioral Health Plan of Service* dated 11/13/2023 was reviewed during the course of this investigation. It notes that Resident A is a high choking risk that could result in death. It notes that Resident A must eat and drink with staff present. On 05/06/2024, I interviewed staff Stacy Staudacher. She stated that Resident A sneaks food into their bedroom daily. The facility has had to hire pest control services due to Resident A leaving food in the bedroom, and that Resident A stores pop in the bedroom. Staff have found empty pop cans and water bottles in the room. There is a preponderance of evidence to substantiate a rule violation. Staff and Resident A were interviewed and both reported that Resident A refuses to cooperate with Resident A's *Plan of Service* regarding eating and drinking under staff supervision due to Resident A being a high choking risk.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/07/2024, I conducted an exit conference with licensee designee James Pilot via phone. I informed James Pilot of the findings and conclusions.

IV. RECOMMENDATION

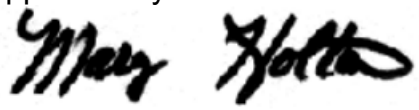
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



05/07/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



05/07/2024

Mary E. Holton Date
Area Manager