GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 11, 2025

Thurman Taylor
PO Box 888247
Grand Rapids, MI 49588

RE: License #: AF410317511
Investigation #: 2025A0467031
Taylor's Home Care

Dear Mr. Taylor:

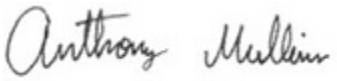
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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.

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,



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

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
This report contains quoted profanity

I. IDENTIFYING INFORMATION

License #:	AF410317511
Investigation #:	2025A0467031
Complaint Receipt Date:	03/18/2025
Investigation Initiation Date:	03/18/2025
Report Due Date:	05/17/2025
Licensee Name:	Thurman Taylor
Licensee Address:	PO Box 888247 Grand Rapids, MI 49588
Licensee Telephone #:	(616) 247-1412
Administrator:	Thurman Taylor
Licensee Designee:	Thurman Taylor
Name of Facility:	Taylor's Home Care
Facility Address:	1505 Morewood Dr. SE Grand Rapids, MI 49508
Facility Telephone #:	(616) 247-1412
Original Issuance Date:	07/27/2012
License Status:	REGULAR
Effective Date:	01/27/2025
Expiration Date:	01/26/2027
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/13/25, Margaret Taylor stated “fuck you and your mother” to Resident A during an argument outside the home.	Yes
Resident A was discharged from the home without being served a discharge notice in a timely manner.	Yes

III. METHODOLOGY

03/18/2025	Special Investigation Intake 2025A0467031
03/18/2025	Special Investigation Initiated - On Site
03/18/2025	Contact - Face to Face Spoke to Resident A at Corewell Health - Blodgett Hospital
03/18/2025	Contact - Document Received Received video evidence via text message of an argument between Resident A and AFC co-owner, Margaret Taylor
03/18/2025	Contact - Telephone call made Spoke to Margaret and Thurman Taylor via phone
03/20/2025	Police report received from GRPD.
03/24/2025	Contact – telephone call made to Thurman Taylor.
03/25/2025	Contact – telephone call made to Lee Storch, guardian for Resident A
03/25/2025	Contact – telephone call to Kristen Stillwell, supports coordinator for Resident A through Northern Lakes CMH
03/26/2025	Contact – telephone call made to Mr. and Mrs. Taylor
04/10/2025	APS referral completed.
04/10/2025	Exit conference with licensee, Thurman Taylor.

ALLEGATION: On 3/13/25, Margaret Taylor stated “fuck you and your mother” to Resident A during an argument outside the home.

INVESTIGATION: On 3/18/25, I received two complaints from LARA-BCHS online complaint system. The complaints stated that on 3/13/25 at 7:24pm, the licensee's wife, Margaret Taylor and Resident A were arguing in the front yard. Resident A said to Mrs. Taylor "fuck you bitch", and Mrs. Taylor reportedly responded to Resident A by stating, "fuck you and your mother." Resident A then became tearful and told Mrs. Taylor that her mother is dead. After the verbal altercation, approximately 4 police cars arrived at the home to address the concern. It is believed that Resident A tried to burn a plate inside the home.

On 3/18/25, I made an unannounced onsite investigation to the home. Upon arrival, staff member Karen Brooks answered the door and allowed entry into the home. Ms. Brooks stated that Resident A has not been at the home since this past Thursday (3/13/25). Ms. Brooks stated that she worked at the home last Thursday from 9:00am to 3:00pm and there were no incidents involving Resident A and the police while she was on shift. Ms. Brooks stated that when she works, Resident A is typically on her best behavior. When Resident A does have behavioral issues, Ms. Brooks stated that she tries to talk with her and encourage her to use some of her coping skills. Ms. Brooks stated that a staff member informed her that "police were called and (Resident A) was gone," but she does not know any specific information regarding what occurred.

While onsite, Ms. Brooks called the licensee's wife, Margaret Taylor and informed her that I was at the home. I then spoke to Mrs. Taylor over the phone and informed her that I was at the home due to a complaint that was received involving Resident A. Mrs. Taylor informed me that Resident A is currently at Corewell Health Blodgett Hospital in East Grand Rapids. I informed Mrs. Taylor that I would call her back after I left the home.

Prior to leaving the home, Ms. Brooks confirmed that Resident B was at the home and called her down to the main floor to be interviewed. Introductions were made with Resident B, and she stated she remembered me from a recent investigation. Resident B confirmed that she was at the home last week Thursday, 3/13/25 and she believes the police were at the house. When asked why, Resident B stated, "let me try to remember this. I think it was for something severe." Resident B stated that Resident A was turning on the stove and tried putting "something metal or aluminum foil" on it. Resident B stated that she was in her room during this incident, so "I can't be a witness. I heard this from staff or one of my roommates." Despite not witnessing the incident herself, Resident B was adamant that the incident was "something severe." Resident B was unable to provide any further details regarding 3/13/25, including information pertaining to Resident A arguing with anyone. Resident B stated that she has no idea as to Resident A's whereabouts at this time. However, she thinks that she's likely in the hospital. Without being prompted, Resident B stated that she doesn't feel safe around Resident A due to the threats she and others have received. Resident B was thanked for her time as this interview concluded.

On 3/18/25, I spoke to Thurman and Margaret Taylor via phone regarding the allegations. Mrs. Taylor confirmed that on 3/13/25, Resident A did say “fuck you” to her. However, Mrs. Taylor denied saying “fuck you and your mother” to Resident A. Mrs. Taylor stated that there was a lot going on while she was on the phone trying to call her husband/licensee, Thurman Taylor. Despite this, Mrs. Taylor remained adamant that she never said the degrading words to Resident A, especially knowing the history/trauma that Resident A struggles with surrounding her mother. Mrs. Taylor shared that this incident stems from Resident A throwing items around the living room. Mrs. Taylor stated that she and staff left Resident A alone until she tried putting something on the stove while saying she was going to burn the house down. Mrs. Taylor stated that Resident A was also trying to burn herself by putting her hand on the stove. Mrs. Taylor stated that her employee, Ms. Millie intervened and stopped Resident A from burning anything. Resident A then made her way outside and Mrs. Taylor followed after her. Mrs. Taylor stated that she told her staff to lock the door to prevent Resident A from coming back inside because she didn’t know what items she had on her person. Mrs. Taylor stated that she believed the paramedics arrived at the home and Resident A was taken to Corewell Health Blodgett hospital and placed with a 1:1 sitter. It is unknown exactly who contacted emergency services. Mrs. Taylor stated that Resident A will confirm that she (Mrs. Taylor) did not make any negative statements towards her. Mrs. Taylor also stated that Resident A told her that she was going to try to get the home shut down.

Mr. Taylor stated that he was not at the home on the day in question. He said that he was on the phone with Mrs. Taylor during the incident but there was a lot of “chaos in the background”, making it difficult to hear and understand words being exchanged between the involved parties. Mr. Taylor added that Resident A thrives off attention, regardless of what is discussed with her. Mr. Taylor informed me that after I spoke to Resident A during a previous investigation, she later had an “escalated episode,” but staff were able to calm her down.

Mrs. Taylor was informed that this verbal altercation between she and Resident A was reportedly caught on video camera. In addition to that, there are also 2 witnesses who observed this. Mrs. Taylor stated she was angry and the incident was busy. However, she does not remember making any negative statements to Resident A.

On 3/18/25, I reached out to the first complainant requesting video footage of the incident between Resident A and Mrs. Taylor. The complainant provided me with a copy of the video via text message. In the video, Resident A is seen storming out the home wearing a blue top. Mrs. Taylor was observed coming out of the home shortly after Resident A wearing a pink top and bottom. Resident A was observed saying, “fuck you bitch, fuck you.” Mrs. Taylor was observed saying “fuck you and your mother.” Resident A then stated, “my mother’s dead, thank you very much.” Mrs. Taylor was observed saying, “I don’t give a fuck” as Resident A continued yelling at her while walking down the street saying she is going to call licensing.

On 3/18/25, I spoke to Mrs. Taylor via phone again and informed her that I was able to obtain access to the video recording of the argument between her and Resident A. I informed Mrs. Taylor that the video confirms everything that is being alleged against her, including her saying “I don’t give a fuck” about Resident A’s mother being deceased. It is important to note that Mrs. Taylor was aware of Resident A’s mother being deceased. Mrs. Taylor stated, “oh my God, I can quit. That was not okay.” After sharing what I observed on the video, I asked Mrs. Taylor if she now recalls making the negative statements to Resident A. Mrs. Taylor stated, “honestly, that’s how she (Resident A) talks, and I probably did say that.” Mrs. Taylor stated that she has previously been able to calm Resident A down by stating, “I don’t give a fuck.” However, it’s still not an appropriate way to talk to her. Mrs. Taylor acknowledged that she knows how sensitive the topic of Resident A’s mother is to her. Mrs. Taylor stated that she plans to resign because “this doesn’t help.” Mrs. Taylor was unable to confirm if she was wearing a pink outfit on the day in question, “but if you say it was me, then it was me.” I also informed Mrs. Taylor that she has a video camera in her driveway that she can review as well. Mrs. Taylor stated that she is “speechless” and this was “unacceptable”. Mrs. Taylor stated that she is not effective in providing care if she’s exhausted, which has been the case for while trying to provide care and support for Resident A.

On 3/18/25, I made an unannounced visit to Corewell Health Blodgett hospital. Upon arrival, I spoke to security in the Emergency Department, and they provided me with Resident A’s room number. I made my way to Resident A’s room. Present in the room with Resident A was a 1:1 sitter. Resident A remembered me by name from a recent investigation and agreed to discuss the allegations. I asked Resident A to share what occurred at the home on 3/13/25 prior to her being transported to the hospital. Resident A stated that this incident stems from trying to burn herself because “I didn’t want to be at the home.” Resident A stated that Mrs. Taylor tried to push her out of the kitchen to stop her from burning herself. Resident A stated that Mrs. Taylor told her that she wanted her out of the house anyways because she was causing too many problems. Resident A stated that she asked Mrs. Taylor if she could call me or Adult Protective Services (APS) and Mrs. Taylor reportedly stated no. Resident A stated that she left the home in an attempt to get away from Mrs. Taylor to avoid being charged with assault.

While leaving the home, Resident A confirmed that she said “fuck you” to Mrs. Taylor. Resident A also confirmed that Mrs. Taylor responded by stating, “fuck you and your mother.” Resident A stated that she saw neighbors coming outside when she and Mrs. Taylor were arguing. Resident A recalled Mrs. Taylor wearing a “pink jumpsuit” on the day of the incident. I informed Resident A that the incident was caught on camera. Resident A then stated, “I’m glad it was caught on camera so no one thinks I’m lying.”

In addition to Mrs. Taylor making degrading statements to Resident A, Resident A also stated that Mrs. Taylor was carrying a pistol in her purse during this incident. Resident A could only describe the handgun as silver and stated that she believes

Mrs. Taylor intentionally showed her the gun in her purse to intimidate her. Resident A stated that her guardian, Lee Storch has been supportive of Mr. and Mrs. Taylor, despite the information she has shared with her. Resident A stated that she would like to get her knee brace from the home. Aside from that, Resident A stated, “I don’t want shit else from there.” Resident A was thanked for her time as this interview concluded.

On 3/20/25, I received a redacted police report (#25-015720) from Grand Rapids Police Department (GRPD). The police report did not list anyone by name but indicated that a caller alleged that she had been assaulted by staff. Police arrived at the home and a lady (likely Resident A) told officers that she self-harmed today due to having mental health issues. Another person at the home informed officers that a lady (likely Resident A) was making threats of harming herself, staff and other residents all day. Resident A also attempted to melt plastic Tupperware on the stove before staff intervened. Resident A was then transported to Blodgett Hospital for a mental health assessment. The report indicated that although the initial call was listed as an assault, the incident was found to be related to mental health.

On 3/24/25, I spoke to licensee, Thurman Taylor via phone. I informed Mr. Taylor that I spoke to Resident A at the hospital last week and she confirmed that Mrs. Taylor said the degrading statements to her that were alleged, including “fuck you and your mother.” I also informed Mr. Taylor that Resident A disclosed that Mrs. Taylor had a pistol in her purse while inside the home on 3/13/25 and made sure she saw it to intimidate her. Mr. Taylor stated that his wife has a CCW (also known as carrying concealed weapon). However, she does not carry her weapon at all. Mr. Taylor stated that Mrs. Taylor typically leaves her purse in her vehicle, and hardly ever takes it inside. Mr. Taylor stated that if Mrs. Taylor does have her purse inside the home, it is in the basement due to a history of residents stealing from her. Mr. Taylor confirmed that residents don’t have access to the basement. Mr. Taylor denied Mrs. Taylor attempting to intimidate Resident A with a gun.

On 3/25/25, I spoke to Lee Storch, guardian for Resident A. Ms. Storch stated that she was expecting a call from me regarding her, “pain in the ass client,” referring to Resident A. Ms. Storch stated that Resident A is a hard placement and this is not the first adult foster care home she has tried to disrupt. Ms. Storch stated, “I don’t think the Taylor’s did anything wrong, they were actually a lot of help for me.” Ms. Storch stated that Resident A’s behaviors are horrific, and she has been trying to get her to break bad habits that she’s had for years. Currently, Resident A is still in the hospital at Corewell Health Blodgett due to being a difficult placement. Ms. Storch stated that Taylor’s Home was the only home that would take her after she spent a total of 6 months between Forest View, jail, and then two months at Blodgett hospital. Ms. Storch stated that Resident A doesn’t care about anything and if she can’t have her way, “she will have a behavior.” Ms. Storch stated that prior to that, Resident A was at The Caro Center (state hospital) for 18 months, discharged January 12th, 2024, and was placed in an adult foster care home where she was allowed to pierce her tongue, sleep in other’s people room and do whatever she wanted. Due to this, Ms.

Storch removed her from that home and brought her to another home, where she only lasted for a few months. While there, Resident A was in and out of the hospital and was placed on probation after beating up her guardian. Ms. Storch confirmed that Resident A is now off probation. Ms. Storch confirmed that Resident A went to jail earlier this month for threatening staff at Taylor's Home. Mrs. Storch shared that Kent County seems to drop any charges against her like they did when she assaulted staff at Forest View Hospital, and just recently with the incident at the home. Ms. Storch stated that charges being dropped against Resident A only teaches her that she can get away with anything. Ms. Storch stated that Resident A being in Kent County has been helpful because people can see that her actions are all behavioral.

Ms. Storch has been Resident A's guardian for the past 3 or 4 years. Ms. Storch stated that "Taylor's Home and I have done nothing but fight for this girl." Ms. Storch stated that she hopes Taylor's Home is not getting in trouble for Resident A. At this point, I informed Ms. Storch that there is video recording, witnesses and Resident A admitting that Mrs. Taylor said "fuck you and your mother" to her. Ms. Storch stated that she understands that the owner of an adult foster care home can't say those things to a resident. However, she added that "we're talking about a girl that just would not stop." Ms. Storch stated that at times, Mrs. Taylor's only break would be to shower and then she would go right back to providing care for Resident A, "so I don't hold that against her at all."

Despite Resident A's reported concerns with the home, Ms. Storch stated that Resident A called her today and asked to return. Ms. Storch stated that she told Resident A she put herself in this position and this is the first home that was fighting for her. Ms. Storch stated that Resident A was complaining about being in the hospital and she was straight forward with her and told that she is in the hospital because of her own actions. Ms. Storch stated that it would probably be a "cold day in hell" before she returns to Taylor's Home due to her ongoing behaviors. She also added that Resident A is threatening to have behaviors in the hospital because she no longer wants to be there. Ms. Storch stated that the local CMH (Network 180) was dropped from Resident A's case. As a result, Northern Lakes CMH is the only CMH involved. Ms. Storch added that part of the problem was that 2 CMH's (Northern Lakes and Network 180) were supposed to be working with her but they could not get anyone at Network 180 to help them. Ms. Storch stated that the hospital social worker told her that the two CMH's could not agree on anything related to Resident A's care/services. Ms. Storch stated that Resident A's behaviors started at Taylor's home on day 1. Ms. Storch confirmed that Resident A has a history of sabotaging her placements. Ms. Storch stated that she knows the other residents were not safe around Resident A due to her behaviors ramping up. Ms. Storch stated, "the girl knows what she's doing." Ms. Storch was advocating for Taylor's Home to remain open, despite the verbal altercation that led to this investigation. Ms. Storch stated that there is a home in Detroit with behavioral specialist that they are considering accepting Resident A. Ms. Storch was adamant

that Resident A needs a higher level of care. Ms. Storch was thanked for her time as this interview concluded.

On 3/25/25, I spoke to Kristen Stillwell, supports coordinator for Resident A through Northern Lakes CMH. Ms. Stillwell stated that every time Resident A has been in this same predicament, it has usually taken several months to get her an appropriate placement. Ms. Stillwell also confirmed that Resident A spent a few months at Blodgett Hospital in the past when she was unable to obtain placement. Ms. Stillwell confirmed that Resident A has a pattern of self-sabotaging behaviors that cause her to lose placement. Ms. Stillwell stated that Resident A lacks impulse control and this contributes to a lot of her behavioral concerns. Ms. Stillwell stated that she is hopeful that if Resident A can get her medication regimen corrected, it will decrease her behaviors.

Ms. Stillwell shared that Resident A is never anywhere long enough to develop the patient-doctor relationship to get medications continued. Ms. Stillwell stated that Resident A met with a psychiatrist through Network180 once, and she was due to meet with them again tomorrow, but this will not take place due to being in the hospital. Ms. Stillwell stated that Resident A was placed at Taylor's Home in November 2024 and it took until February 2025 before she could be seen by a psychiatrist. Part of this is due to Resident A being in and out of jail. Ms. Stillwell confirmed that the psychiatrist not being as familiar with Resident A has caused him to be hesitant to make any significant medication changes. Ms. Stillwell confirmed that Resident A has had the behavioral concerns at Taylor's Home since she arrived. Ms. Stillwell confirmed that she and Northern Lakes CMH does the searching for placement for Resident A. Once a place is found, Ms. Stillwell will get consent from Resident A's guardian and complete a referral. Ms. Stillwell stated that Resident A's guardian, Lee Storch has been great as she has found the last two placements for Resident A since discharging from the Caro Center (psychiatric hospital). Ms. Stillwell confirmed that there is a home in Detroit called Sparks Behavioral that they are considering for Resident A. They are currently awaiting a response back from the owner and that will determine the next course of action. Ms. Stillwell stated that she emails with the hospital social worker weekly and meets virtually once a week regarding updates on placement. Prior to concluding this call, I informed Ms. Stillwell of the verbal altercation between Resident A and Mrs. Taylor.

On 3/26/25, I spoke to Mrs. Taylor via phone and informed her that I did speak to Resident A at the hospital and she confirmed the verbal altercation as described above. Due to the disrespectful language used towards Resident A by Mrs. Taylor, she was informed that there will be a citation because of her actions. Mrs. Taylor stated that this has been bothering her physically, mentally, and spiritually, and this is not the kind of person she is. Mrs. Taylor apologized for her actions.

Mrs. Taylor was informed that Resident A mentioned that she had a gun in her purse during the day of this incident that she was using to intimidate Resident A. Mrs.

Taylor immediately denied this and stated that she has never taken a gun inside the home.

On 04/10/25, I conducted an exit conference with licensee designee, Thurman Taylor. He was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of this report. I also informed Mr. Thurman that it is recommended that the facility be placed on a provisional license due to the severity of the situation. Mr. Thurman is aware that he must indicate in writing if he wishes to contest or accept the provisional license. If he chooses to contest the provisional license, an administrative hearing will be scheduled.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions**
	(2) A licensee, responsible person, or any person living in the home shall not use any of the following methods of handling a resident for discipline purposes: **(e) Mental or emotional cruelty, including subjecting a resident to verbal abuse, making derogatory remarks about the resident or members of his or her family or making malicious threats.**
ANALYSIS:	In addition to a video recording, two complainants observed Mrs. Taylor stating, “fuck you and your mother” to Resident A on 3/13/25. Resident A also confirmed that Mrs. Taylor made this statement towards her. Mrs. Taylor initially denied the allegation but later apologized for her actions. Based on the information obtained, there is a preponderance of evidence to support this applicable licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was discharged from the home without being served a discharge notice in a timely manner.

INVESTIGATION: On 3/20/25, I received a LARA-BCHS online complaint stating that Resident A has been medically cleared for discharge by the hospital social work team, psychiatry team, and the local Community Mental Health (CMH), Network 180. It’s alleged that the licensee, Thurman Taylor is not returning calls from hospital staff or Resident A’s supports coordinator overseeing placement for Resident A. Resident A was not served with a discharge notice in a timely manner.

On 3/18/25 (prior to receiving this complaint), I spoke to Mr. and Mrs. Taylor via phone regarding a verbal altercation between Resident A and Mrs. Taylor. During

that call, Mr. and Mrs. Taylor were asked what their plans are for Resident A due to ongoing concerns for her at the home. Mr. Taylor stated, “I value my license, more than I value her.” Mr. Taylor stated that hospital staff are trying to discharge Resident A today. However, he has already told them that Resident A is unable to come back today due to not having two staff members available to meet her 2-to-1 staffing needs. Therefore, Mr. Thurman stated that he plans to serve an emergency discharge notice to Resident A today. Mrs. Taylor also added that hospital staff wanted Resident A to discharge this past Thursday (3/13) and Friday (3/14) and “we told them no.” I explained to Mr. and Mrs. Taylor that due to the severity of the situation with ongoing behaviors by Resident A that put herself and her peers at risk of harm, I support the discharge notice.

On this same day, I received a copy of the emergency discharge notice for Resident A on via email from Mr. Taylor. The discharge notice stated that Resident A was being served with this notice due to “serious self-injury & threats to other residents.” The discharge notice indicated that, “due to the recent events/actions, it makes it difficult to ensure the safety & health” of Resident A and others in the home.

On 3/24/25, I spoke to Mr. Taylor via phone and informed him that I received the additional allegation listed above. Mr. Taylor stated that he was in contact with Resident A’s supports coordinator, Kristen Stillwell throughout her hospital admission. Mr. Taylor stated that his last time he spoke to Ms. Stillwell via phone was on Tuesday, 3/18/25 at 12:18 pm. Mr. Taylor stated that there were 19 emails with all involved parties on 3/18/25, including Ms. Stillwell (CMH supports coordinator), Lee Storch (Resident A’s guardian) and Network 180 staff. Mr. Taylor was adamant that his email correspondence with all involved parties included communication regarding an emergency discharge notice for Resident A. Mr. Taylor also clarified that he does not get paid for 2-to-1 staffing for Resident A when she is not in the home. Mr. Taylor stated that he explained to hospital staff that he did not have two staff members readily available to provide care for Resident A as required when she was ready to discharge, and the home is not able to meet her needs.

On 3/26/25, I spoke to the complainant via phone. The complainant confirmed that Resident A had a long stay at Corewell Health Blodgett in October of 2024 and hospital staff are familiar with her. The complainant confirmed that she is now aware that an emergency discharge notice was served to Resident A. However, she shared that hospital staff did not find out that Resident A was being served with a discharge notice until being at the hospital for three days, all of which were days that she was medically ready to discharge from the hospital. The complainant stated that for the entirety of Resident A’s hospital admission, Mr. and Mrs. Taylor would not answer calls from hospital staff. The complainant stated that Resident A was dropped off at the hospital with no plan in place until Mr. and Mrs. Taylor met with their licensing consultant. The complainant stated that “every day she (Resident A) was in the hospital, she had every right to be back at that home.” I informed the complainant that I am the licensing consultant that Mr. and Mrs. Taylor were referring to. I explained to the complainant that I understand that the hospital is not an appropriate

placement for Resident A if there is no medical reason for her to be there. However, Resident A poses a great risk of harm to herself and others if she were to return to the home. The complainant stated that she understands that. However, her concern is that Mr. and Mrs. Taylor avoided hospital staff by not returning calls and they could have told hospital staff that their intentions were to not have Resident A return to their home on day one. The complainant stated that this would have allowed hospital staff to work on coordinating with all involved parties on day one.

On 3/26/25, I spoke to Mrs. Taylor via phone. We discussed the additional complaint that came in on 3/20/25 regarding Resident A not being allowed to discharge home despite being medically ready. Mrs. Taylor stated that the discharge came from her husband, Mr. Taylor as this is primarily his role, including documentation. Mr. Thurman interjected and confirmed that the day that Resident A was admitted to the hospital (3/13), he had no intentions of discharging her from the home at that time, especially since he was not at the home on the day of the verbal altercation between Resident A and Mrs. Taylor. Mr. Taylor then stated that after evaluating the situation and consulting with me, he came to the decision of serving Resident A with a discharge notice. Mr. Taylor denied that he was not taking calls from the hospital staff. Instead, Mr. Taylor stated that hospital staff were primarily calling Mrs. Taylor and she reportedly returned all calls that were made to her. At this time, I reminded Mr. and Mrs. Taylor of our previous conversation on 3/11/25 at the home, which was to serve Resident A with a discharge notice to allow her guardian and CMH to start seeking placement elsewhere. Mr. and Mrs. Taylor were informed that if they had served the notice on 3/11, this additional complaint could have been avoided. Mr. Taylor expressed concern about receiving a recipient rights violation if he proceeded with the recommendation.

On 4/10/25, I conducted an exit conference with licensee designee, Thurman Taylor. Mr. Taylor was informed that due to Resident A being medically ready to discharge from the hospital as early as 3/13/25, it is the AFC's responsibility to allow her to return back home. Mr. Taylor stated that he would likely dispute this because he didn't have two staff available to provide care for Resident A like she requires. I informed Mr. Taylor that regardless of the staffing concerns, Resident A should have been allowed to return home on the first day she was in the hospital since a discharge notice was not served at that time. The emergency discharge notice was not served until day 5 of her hospital admission. It's also important to note that Mr. and Mrs. Taylor were encouraged to serve Resident A with a discharge notice on 3/11/25 under SIR #2025A0467030 due to significant behavioral concerns, which was well before this complaint was filed. However, Mr. Taylor was adamant on working with Resident A as he did not want to fail her. Mr. Thurman is aware that a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house**

	guidelines; fee schedule; physician's instructions; health care appraisal.
	(13) A licensee may discharge a resident before the 30-day notice when it has been determined that any of the following exists: **(a) Substantial risk or an occurrence of self-destructive behavior.** **(b) Substantial risk or an occurrence of serious physical assault.** **(c) Substantial risk or an occurrence of destruction of property.** **(14) A licensee who discharges a resident pursuant to subrule (13) of this rule shall notify the resident's designated representative and responsible agency within 24 hours before discharge. Such notification shall be followed by a written notice to the resident's designated representative and responsible agency stating the reasons for discharge.**
ANALYSIS:	Resident A has been medically ready to discharge from the hospital since the day of admission on 3/13/25. However, Mr. and Mrs. Taylor told hospital staff that she could not return despite a discharge notice not being served until 3/18/25. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a six-month provisional license is recommended for the above-cited quality-of-care violation.

Anthony Mullins

04/10/2025

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Anthony Mullins Date
Licensing Consultant

Approved By:

04/11/2025

Jerry Hendrick Date
Area Manager