GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2019

Marcia Curtiss
Homestead Management
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #:	AL410092341
Investigation #:	2019A0356020
	Alzheimer's Center of W Mi #8

Dear Mrs. Curtiss:

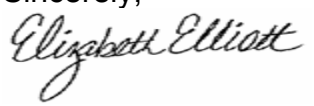
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410092341
Investigation #:	2019A0356020
Complaint Receipt Date:	02/19/2019
Investigation Initiation Date:	02/19/2019
Report Due Date:	04/20/2019
Licensee Name:	Homestead Management
Licensee Address:	Suite 115, 21800 Haggerty Rd., Northville, MI 48167
Licensee Telephone #:	(616) 949-9500
Administrator:	Kat Hartley
Licensee Designee:	Marcia Curtiss
Name of Facility:	Alzheimer's Center of W Mi #8
Facility Address:	3948 Whispering Way, SE, Grand Rapids, MI 49546-5804
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	12/01/2000
License **Status:**	REGULAR
Effective Date:	08/07/2017
Expiration Date:	08/06/2019
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's 24-hour discharge was not issued properly.	Yes
Incident Reports pertaining to Resident A do not document accurate information regarding the incidents, nor do they reflect any corrective measures taken to remedy the issue.	Yes
Incident Reports pertaining to Resident A were not made available in a timely manner to Resident A's designated Representative.	Yes

III. METHODOLOGY

02/19/2019	Special Investigation Intake 2019A0356020
02/19/2019	Special Investigation Initiated - Telephone Relative #1
02/19/2019	Contact - Document Received Docs received from Jaime Williams for Resident A.
02/21/2019	Contact - Telephone call received Audra Rein re: resident discharge.
02/25/2019	Contact - Face to Face Audra Rein, Nurse.
03/10/2019	Contact-Document sent Relative #1 re: Resident A's placement @ Metron of Belding.
03/14/2019	Contact - Face to Face Audra Rein, Nurse and Kat Hartley, Administrator.
03/15/2019	Contact - Telephone call made Relative #1
04/05/2019	APS Referral
04/08/2019	Contact - Document Received Documents from facility for Resident A.
04/08/2019	Contact - Document Received-APS denied for investigation.

04/18/2019	Exit Conference-Licensee Designee, Marcia Curtiss

ALLEGATION: Resident A's 24-hour discharge was not issued properly.

INVESTIGATION: On 02/19/2019, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complaint documented a dialog of text information back and forth between Audra Rein (facility nurse), Katina Reid, DCW (Direct Care Worker) and the complainant about Resident A attempting to leave the facility, Resident A being sent to the hospital via ambulance and the facility not being able to accept Resident A back due to safety issues.

On 02/19/2019, I contacted Relative #1 via telephone to discuss the allegations made in this complaint. Relative #1 explained that Resident A was admitted to this facility on 02/01/2019. Resident A went to the hospital a few times due to exit seeking behavior and Audra Rein, facility nurse, said if Resident A continues with these behaviors, she will not be able to return to the facility, but the facility did not issue a 30-day notice or a 24-hour notice in writing at that time. Relative #1 stated Resident A has physically gotten out of the building twice, she has kicked and hit staff and on 02/03/2019, Resident A kicked her foot through a double pane glass door at the facility and climbed through it and ran out into the parking lot with staff chasing her. Resident A was transported to the Emergency Room and sent back to the facility. Relative #1 stated most recently, on 02/15/2019, Resident A locked herself in her room at the facility. The maintenance staff unlocked her door to gain entry and Resident A "bolted" from the room and ran into the medication room and locked herself in. Relative #1 stated Resident A called 9-1-1 from inside the locked medication room and Resident A reported to the police she was being held hostage. Relative #1 reported Resident A is currently at St. Mary's hospital and Ms. Rein and Kat Hartley, Administrator have said upon Resident A's discharge from the hospital, Resident A will not be allowed to return to the facility. Relative #1 stated they (the family and Resident A) were texted that Resident A cannot return due to safety issues but they did not receive a 24-hour notice in writing,

On 02/25/2019, I interviewed Ms. Rein, facility nurse. Ms. Rein stated Resident A went back and forth from the facility to the hospital 4 times in a matter of 15 days and each time, she was accepted back except for the last time when she was placed elsewhere upon discharge. Ms. Rein stated she gave Relative #1 a 24-hour verbal discharge for Resident A on 02/03/2019 when she was in the hospital (which was one of her 3 hospitalizations while living at this facility) because they could not keep Resident A safe at the facility. Ms. Rein stated they ended up accepting Resident A back into the facility after the verbal 24-hour discharge was given. Ms. Rein stated it was not until after the last admission to the hospital on 02/15/2019 that Resident A did not return to the facility. Ms. Rein stated she does not know whether a 24-hour emergency discharge notice was issued in writing or not, but Ms. Rein stated she did verbally tell Relative #1 on 02/15/2019 that Resident A could not return to the facility. Ms. Rein stated they could not handle Resident A at the facility as she would not acclimate and attempted to elope every chance she could. Ms. Rein stated they

scheduled extra staff in the building (increased staff from 2 staff to 5 staff on 02/03/2019), but they could not continue to keep Resident A safe and for the safety of Resident A, she could not remain at this facility.

On 03/14/2019, I interviewed Ms. Rein and Kat Hartley, Administrator at the facility. Ms. Rein and Ms. Hartley gave an outline of the events leading up to Resident A's discharge from the facility:

- On 02/01/2019, Resident A tried to get out of a window, was yelling and fighting with staff. Resident A went to the hospital and was returned to the facility. Ms. Rein stated she increased the staff from 2 to 5 staff at the facility.
- On 02/03/2019, Resident A kicked and broke through a 2-pane door, climbed through the door getting outside. Resident A went to the hospital and was returned to the facility. Ms. Rein stated it was at this time she issued a verbal 24-hour discharge because she had increased staff from 2 to 5 yet this serious incident still occurred. Ms. Rein stated she told Relative #1 if Resident A returned again, family is responsible for 1:1 supervision of Resident A and if the facility must provide that service until Resident A leaves, an additional fee will be charged to accommodate the level of care Resident A requires. Ms. Rein stated despite the verbal 24-hour notice to Relative #1, Resident A came back to the facility and 1:1 care was provided by the facility.
- On 02/04/2019, Resident A attempted to elope out the door and staff intervened. Resident A ran into her room and got out the bedroom window. Staff summoned Ms. Rein, they got into Ms. Rein's car and found Resident A on the street at the end of the property. 9-1-1 was called and Resident A taken to St. Mary's. Ms. Rein stated she filed a Petition for Mental Health Treatment through Probate Court and Resident A was admitted to St. Mary's PMU (psychiatric medical unit).
- On 02/09/2019, Ms. Rein stated Resident A came back to the facility after Ms. Rein completed an evaluation of Resident A at the hospital.
- On 02/15/2019, Ms. Rein reported Resident A locked herself in her room and then ran from her room into the medication room and locked the door. While locked in the medication room, Resident A called 9-1-1, summoned the police and Resident A was hospitalized. Ms. Rein stated she notified Relative #1 that Resident A could not return to the facility and Ms. Hartley followed up Ms. Rein's 24-hour verbal discharge with a verbal discharge on 02/15/2019.

Ms. Rein and Ms. Hartley stated they tried to keep Resident A three times after hospitalizations and discharges. Ms. Rein and Ms. Hartley stated a verbal 24-hour discharge was given to Relative #1 on 02/03/2019 and then again on 02/15/2019 but acknowledged that a written 24-hour notice was not issued to Resident A, Relative #1 or any other member of Resident A's family.

On 02/19/2019, I received and reviewed several pages of text messages between Relative #1, Ms. Rein and Ms. Hartley. The text messages depict many interactions between Ms. Rein and Relative #1 regarding the incidents occurring with Resident A, her subsequent hospitalizations and what to do to make sure she is placed in a

safe environment. The texts document the following regarding the discharge of Resident A:

- On 02/03/2019, Ms. Rein texts; *'my executive director said she was going to do a 24-hour discharge and that if she does come back the guardian is responsible for one on one care until she leaves.'*
- On 02/09/2019, Ms. Rein texts; *'I just wanna make sure you know that she cannot come back to Whispering without me doing an evaluation and an okay from my boss' 'everyone is calling and saying (Resident A) is going to be discharged here without my assessment. If she is discharged to here, she will be sent back to hospital. At this moment she is not accepted back to whispering woods. If I find that she is not able to come back they will need to help you find her a placement.'*
- On 02/12/2019, Ms. Rein texts; *'I want to be clear, if I do my assessment and I do not feel like we can keep her safe I will have to decline her return. I have strict orders from my nursing corporate director.'* Ms. Rein completed the assessment on 02/14/2019 and accepted Resident A back into the facility.
- On 02/15/2019, Ms. Rein texts; *'she (Resident A) needs to go thru ER, but you need to tell them she cannot return to whispering woods. That we have tried three times now.'*
- On 02/15/2019, Relative #1 texts; *'are you now saying she cannot return permanently?'* Ms. Rein responded by text; *'Yes. We tried and it didn't work. We cannot keep her safe nor our staff safe from her.'* Relative #1 texts; *'I'm confused. Audra just said (Resident A) cannot come back to Whispering Woods.'* Ms. Hartley texts; *'Right, we cannot keep her safe. We stop billing as soon as the room is emptied out.'*
- In 02/16/2019, Relative #1 texts; *'I'm fighting again to get her help. You just made her homeless.'* Ms. Rein texts; *'I apologize if you think so. I simply told you we cannot keep her safe and secure and I cannot safely say I can keep the other residents and the staff safe as well. On my behalf I did try four times to keep her and work with her and you to make whispering a good place for her to be.'*

On 03/15/2019, I received and reviewed the Whispering Woods "House Guidelines" and the document reads: "The facility shall have the right to terminate the resident's occupancy upon giving twenty-four (24) hours advance written notice in the event that an emergency discharge is necessary. Emergency discharge of a resident may occur when it has been determined that any of the following exist:

a. substantial risk to the resident due to the inability of the facility to meet the resident's care needs.
b. Substantial risks or an occurrence of self-destructive behavior exist.
c. Substantial risk or occurrence of serious physical assault against self or others.
d. Substantial risk or an occurrence of destruction of properties."

On 04/18/2019, I conducted an Exit Conference with Marcia Curtiss, Licensee Designee via telephone. Ms. Curtiss stated she understands the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: (a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information: (i) The reason for the proposed discharge, including the specific nature of the substantial risk. (ii) The alternatives to discharge that have been attempted by the licensee. (iii) The location to which the resident will be discharged, if known.
ANALYSIS:	Relative #1 reported that Resident A was sent to the hospital and the facility would not accept Resident A back and did not give a written 24-hour discharge notice. Ms. Rein and Ms. Hartley stated a verbal 24-hour discharge was given to Relative #1 on 02/03/2019 and then again on 02/15/2019 but acknowledged that a written 24-hour notice was not issued to Resident A, Relative #1 or any other member of Resident A's family. A review of text messages between Ms. Rein, Relative #1 and Ms. Hartley between the dates of 02/03/19 & 02/16/19 document several instances where Relative #1 was told via text messages that Resident A could not return to the facility due to safety issues. The Whispering Woods House Guidelines document the facility has the right to terminate a resident's occupancy by giving a 24-hour advance written notice in the event that an emergency discharge is warranted. Based on investigative findings, there is sufficient evidence to support a rule violation that the elements specified in this rule regarding the written documentation of the 24-hour discharge of Resident A from the facility were not met.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Incident Reports pertaining to Resident A do not document accurate information regarding the incidents, nor do they reflect any corrective measures taken to remedy the issue.

INVESTIGATION: On 02/19/2019, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reports Resident A has been removed from the facility via ambulance 4 times for having behaviors and there have been no corrective measures noted on the Incident Reports (IR's) for each occurrence.

On 02/19/2019, I contacted Relative #1 via telephone to discuss the allegations made in this complaint. Relative #1 explained that she should have received more IR's based on the texts she received regarding incidents occurring with Resident A. Relative #1 stated she received IR's for incidents on 02/01/2019, 02/03/2019, 02/04/2019 and 02/15/2019 and thinks there should have been more. Relative #1 stated once she received the IR's on 02/18/2019 and reviewed them, the information on the IR seriously "downplayed" the actual events that occurred. Relative #1 stated the IR's are not documented accurately.

On 03/14/2019, Ms. Rein and Ms. Hartley stated IR's were written after each incident by the staff who were there and witnessed the incident occur. Ms. Rein and Ms. Hartley stated IR's were written for each incident dated 02/01/2019, 02/03/2019, 02/04/2019 and 02/15/2019. Ms. Rein and Ms. Hartley stated Resident A was only at the facility from 02/01/2019 until 02/15/2019 and was in the hospital from 02/04/19 and returned on 02/14/2019, went back to the hospital on 02/15/2019 and did not return to the facility. Ms. Rein and Ms. Hartley stated the 4 IR's are the only IR's they have for Resident A.

On 02/19/2019, I reviewed the IR's and the following information is documented on the IR's:

- On IR 02/01/2019, written by DCW Keyauna Caston, 8:03PM and signed by Kat Hartley. '*Resident tried to escape from building, opened windows yelling out of window, fighting and yelling at staff.*' Action taken by staff: '*Sent to hospital for evaluation'* Corrective Measures taken to remedy and/or prevent recurrence: '*will follow hospitals instructions.'*
- On IR 02/03/2019, written by Ms. Rein, 10:00AM, signed by Kat Hartley and documents Porsha Day as the DCW involved/witness. '*Resident pushed on door until she got outside into outdoor courtyard where she walked through the snow and attempted to hop over the fence*.' Action taken by staff: '*Four staff members were able to talk to* (Resident A) *to get her to come back inside. When inside she started throwing furniture.*' Corrective Measures taken to remedy and/or prevent recurrence: '*911 called, sent to St. Mary's ER for eval and treat. Returned same day with no changes*.' *Note: 02/03/2019 is the date Resident A kicked through a glass door to exit the facility.

- On IR 02/04/2019, written by DCW/Med tech Debbie Hal, 2:00PM, signed by Kat Hartley. '*At 1:55, Kim, RA (*direct care worker*) was in pod 3 the door alarm was going off, I went over,* (Resident A*) was trying to get out, I stepped between (*Resident A*) & the door, (*Resident A*) said I'm a deputy sheriff, I said you cannot go out the door, she got in my face, yelling at me, Kim said I've got to do my rounds, I said ok, I'm ok, I'll watch (*Resident A*). (*Resident A*) kept up trying to get out, finally she went into her room & slammed the door, I texted Audra that she needed a one on one. I went to her room she had laid the bottom of the window down and was gone. I yelled to Courtney in activities to call, get help & I went out the window to find her, when I got to the office Audra came out and we got in her car and went after (*Resident A*), we found her on the street at the end of our property, called 911.*' Action taken by staff: '*Audra had eyes on resident at all times. Approached with caution. Friendly stander by pulled over and (*Resident A*) spent time talking to him while 911 was called and until police cruiser came.*' Corrective Measures taken to remedy and/or prevent recurrence: *'911 called ambulance and resident went to St. Mary's. Petition was turned in. Resident admitted to St. Mary's general population*.'
- On IR 02/15/2019, written by Katina Reid, 6:20PM, signed by Kat Hartley. '*Resident was observed exit seeking starting to push on doors, shove staff. Refused medication and then locked herself in bedroom and refused to open door. Then started to involve other resident in exit seeking.'* Action taken by staff: '*Tried redirecting resident. Also offered to watch a movie, offered to check vitals, resident refused*.' Corrective Measures taken to remedy and/or prevent recurrence: Nothing documented in this area. *Note: 02/15/2019 is the date Resident A locked herself in her room, then ran from her room into the medication room and locked the door. While locked in the medication room, Resident A called 9-1-1 and summoned the police. Resident A did not return to the facility because she went to the hospital.

On 04/18/2019, I conducted an Exit Conference with Marcia Curtiss, Licensee Designee via telephone. Ms. Curtiss stated she understands the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: (c) The effect of the accident or incident on the person who was involved and the care given. (e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.

	(f) The corrective measures that were taken to prevent the accident or incident from happening again.
ANALYSIS:	The complainant reported Resident A's IR information is not accurate. Relative #1 stated the information on the IR seriously "downplayed" the actual events that occurred. Relative #1 stated the IR's are not documented accurately. Ms. Rein and Ms. Hartley stated IR's were written after each incident by the staff who were there and witnessed the incident occur. On the IR dated 02/03/2019, the written information does not match the actual incidents that occurred per interviews with Relative #1, Ms. Rein and Ms. Hartley where Resident A kicked out a glass door and exited the facility. The IR documents Resident A pushed on a door and exited the facility. On the IR dated 02/03/2019, the corrective measures taken documents 911 was called and Resident A taken to the hospital and returned to the facility the same day with no changes. There is nothing documented in this section that would satisfy the corrective measures taken to prevent a recurrence of this incident. On the IR dated 02/15/2019, the written information does not match the actual incidents that occurred per interviews with Relative #1, Ms. Rein and Ms. Hartley where Resident A locked herself in her room then ran past staff and locked herself in the medication room where she called 911. The IR documents that Resident A locked herself in her room and refused to open the door with no mention she locked herself in the medication room and 911 was called. On the 02/15/2019 IR the corrective measures section of the report is left blank. Based on investigative findings, there is sufficient evidence to support a rule violation that the information documented on the 02/03/19 and the 02/15/2019 IR's submitted to licensing and to Resident A's designated representatives did not accurately document the actual events that occurred per information gathered from interviews with Relative #1, Ms. Rein and Ms. Hartley. The IR's did not elaborate on the effect of the accident or incident on the person who was involved. The IR's did not

	document the care given, a statement regarding the extent of the resident's injuries, the treatment ordered or the disposition of the person who was involved. The IR's did not document the corrective measures that were taken to prevent the accident or incident from happening again per this rule.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Incident Reports pertaining to Resident A were not made available in a timely manner to Resident A's designated Representative.

INVESTIGATION: On 02/19/2019, I received an BCAL (Bureau of Children and Adult Licensing) online complaint. The complaint reported that a request was made for a copy of the Incident Reports (IR's) covering the series of incidents that led to Resident A's hospitalizations and subsequent discharge from the facility. The complainant was told by staff at the facility the IR's would be available after 10:00am the following Monday, 02/18/2019, 2 ½ days after the final incident occurred.

On 02/19/2019, I contacted Relative #1 via telephone to discuss the allegations made in this complaint. Relative #1 reported on 02/01/2019, Relative #2 received a call from the facility regarding the incident involving Resident A on that day. Relative #1 stated on 02/03/2019 at 8:56AM, Ms. Rein contacted her via telephone and after this call, all other contact was done by texts on this date until Relative #1 called Ms. Rein at 1:24PM. Relative #1 stated on 02/04/2019, Relative #1 received a text at 3:02PM informing her of the incident on 02/04/2019 and Ms. Rein met Relative #1 at the hospital. Relative #1 stated on 02/15/2019 she received a text at 6:56PM from Ms. Rein and all contact from that point forward was done via text with Ms. Rein and Ms. Hartley. Relative #1 stated she placed two calls to the facility on 02/15/2019 at 8:07pm and 8:22pm and talked to staff, as Ms. Rein and Ms. Hartley were not at the facility. Relative #1 stated on 02/16/2019, she requested the IR's that document the 02/01/2019, 02/03/2019, 02/04/2019 and 02/15/2019 incidents involving Resident A at this facility. Relative #1 stated she received four (4) IR's on 02/18/2019.

On 02/19/2019, I received and reviewed several pages of text messages between Relative #1, Ms. Rein and Ms. Hartley. The text messages document on 02/16/2019, Relative #1 requested the IR's from "all interactions" with Resident A and Relative #1 requested; 'please send photos of incident reports to me by text or email today', stating she needed them for the hospital, namely the incident that occurred on 02/15/2019. Ms. Hartley and Ms. Rein responded telling Relative #1 that the earliest they could get the IR's to her would be on Monday, 02/18/2019. Relative #1 stated; '*I am politely asking for this and don't see why this cannot be done. There has to be someone there who can get it and snap photos of it to me. I'm fighting to get her help. You just made her homeless. This is the least you can do to help.*' Ms. Rein replied that she is out of town until Sunday night and; *'the reports are in my office. I will gladly send them to you Monday.'*

On 02/19/2019, I reviewed the documented notification times on the IR's for when Resident A's designated representatives were notified of incidents that occurred with Resident A. The IR dated 02/01/2019 documents Relative #1 was notified on 02/01/2019 at 8:05PM. On 02/03/2019 the IR documents that Relative #1 and Relative #2 were contacted at 10:15AM. The IR dated 02/04/2019 does not have a time that Relative #1 was notified of the incident. The IR dated 02/15/2019, Relative #1 is contacted and notified of the incident at 7:20PM. There is no indication on the IR's that a written notice of the IR was provided to Relative #1 or Relative #2.

On 03/14/2019, I interviewed Ms. Rein and Ms. Hartley at the facility. Ms. Rein and Ms. Hartley stated the incidents were reported to Relative #1 via telephone calls from staff. Ms. Rein and Ms. Hartley stated they provided Relative #1 with the IR's written for the incidents dated 02/01/2019, 02/03/2019, 02/04/2019 and 02/15/2019. Ms. Rein and Ms. Hartley stated Relative #1 requested the IR's on 02/16/2019, the business office was closed on that day because it was a Saturday, so the IR's were made available to Relative #1 on Monday, 02/18/2019.

On 04/18/2019, I conducted an Exit Conference with Marcia Curtiss, Licensee Designee via telephone. Ms. Curtiss stated she understands the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (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 complaint reported that a request was made on 02/16/2019 for copies of Incident Reports covering the series of incidents that led to Resident A's hospitalizations and subsequent discharge from the facility. The IR's were made available on 02/18/2019, 2 ½ days after the final incident occurred. Relative #1 stated she received 4 written IR's on 02/18/2019 upon request on 02/16/2019.

	On 03/14/2019, Ms. Rein and Ms. Hartley stated they provided Relative #1 with the IR's written for the incidents dated 02/01/2019, 02/03/2019, 02/04/2019, 02/15/2019 on 02/18/2019 upon her request made on 02/16/2019. The text messages document Relative #1's request on 02/16/2019 for all of the IR's for Resident A "immediately" and Ms. Rein and Ms. Hartley responding the office is closed and the reports will be made available on 02/18/2019. A review of IR's dated 02/01/2019, 02/03/2019, 02/04/2019 and 02/15/2019 document Relative #1 was notified of the incidents but does not document Relative #1 was ever provided with the written IR. Based on investigative findings, there is sufficient evidence to support a rule violation that a written report was not provided to Relative #1 within 48 hours of the incidents occurring on 02/01/2019, 02/03/2019 and 02/04/2019.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Elizabeth Elliott

04/18/2019

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

Jerry Hendrick

04/19/2019

Jerry Hendrick — Date
Area Manager