GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 19, 2020

Tracey Hamlet
MOKA Non-Profit Services Corp
Suite 201
715 Terrace St.
Muskegon, MI 49440

RE: License #: AS410069045
Investigation #: 2020A0357006
MOKA - Amanda

Dear Ms. Hamlet:

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

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410069045
Investigation #:	2020A0357006
Complaint Receipt Date:	12/13/2019
Investigation Initiation Date:	12/13/2019
Report Due Date:	02/11/2020
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201, 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(231) 830-9376
Administrator:	Tracey Hamlet
Licensee Designee:	Tracey Hamlet
Name of Facility:	MOKA - Amanda
Facility Address:	5102 Amanda Drive, SW Grandville, MI 49418-9766
Facility Telephone #:	(616) 719-2428
Original Issuance Date:	02/23/1996
License Status:	REGULAR
Effective Date:	08/26/2018
Expiration Date:	08/25/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was sent to the hospital and the home refused to take her back. There was no letter of Resident A's discharge provided.	Yes

III. METHODOLOGY

12/13/2019	Special Investigation Intake 2020A0357006
12/13/2019	APS Referral
12/13/2019	Special Investigation Initiated - Telephone Telephone with Kent County, DHHS, APS worker Katy Gee.
12/13/2019	Contact - Telephone call made To Brenda Preston the Home Manager.
12/13/2019	Contact - Telephone call made Spoke with Resident A's Legal Guardian, Melinda Veen
12/16/2019	Contact - Document Received Received e-mail from Katye Gee, APS.
12/16/2019	Contact - Document Received E-mail received from Katye Gee, APS.
12/17/2019	Contact - Face to Face Interview conducted face-to-face with Resident A into Gilead home.
12/19/2019	Inspection Completed On-site Announced inspection completed. Facility records reviewed.
12/19/2019	Contact - Face to Face Interviewed: Direct Care Staff Karla Erickson, Caitlin Koster and the Home Supervisor, Brenda Peterson.
12/19/2019	Contact - Document Received Including: Staff Schedule, Demographic Face Sheet, two Incident/Accident Reports, Resident A's Individual Plan of Service, Assessment Plan, DD Division Behavioral Treatment Plan, Residential PC/CLS Shift Notes, an unsigned letter to Resident A's guardian.

12/19/2019	Contact - Document Received Resident A's, information from MidMichigan Health, University of Michigan Health System, Behavioral Health MidMichigan Medical Center – Gratiot.
02/05/2019	Contact – Telephone with Case Manager, Kathy Johnson, network 180.
05/05/2020	Contact – Telephone made to Katye Gee, Kent County APS requesting her final decision.
02/07/2020	Exit conference was conducted by telephone with the Licensee Designee, Tracey Hamlet

ALLEGATION: Resident A was sent to the hospital and the home refused to take her back. There was no letter of Resident A's discharge provided.

INVESTIGATION: On 12/13/2019, I received a letter from the Department of Health and Human Services, Kent County, Katye Gee, Adult Protective Services, "REQUEST FOR JOINT INVESTIGATION." The letter read as follows: *"(Resident A) (43) is diagnosed with a developmental disability and diabetes. She lives at Amanda AFC. On November 27, 2019, (Resident A) was transported to Metro Health Hospital with allegations that she was being aggressive. The AFC home alleges that (Resident A) was being aggressive with staff and other residents. When asked to clarify about the aggressive behaviors, the manager refused to elaborate. (Resident A) was see by medical professionals and cleared for discharge. (Resident A) was transported back home to Amanda AFC and the staff refused to allow her back into the property. The staff slammed the door on EMS and (Resident A). (Resident A) was waiting in the ambulance and the Wyoming Police were contacted. Officers knocked at the home and staff also slammed the door on officers. Staff again stated that (Resident A) could not return to the home. (Resident A's) belongings and medications are still at the AFC home where she is not being allowed to return. (Resident A) needs an assessment to determine her ability to continue living at the current placement. Melinda Veen is the guardian for (Resident A), and she was contacted but is out of state and unable to act in (Resident A's) best interest. (Resident A) is currently at Metro Health Hospital and in need of placement. Additional Information: I interviewed (Resident A) in the hospital. She is cognitively impaired and was not able to provide details of the incident. She did want to go back to the AFC and denied she was hurt by anyone there..."* This concluded by noting that Resident A's guardian, Melinda Veen, has since moved her to Hope Network Gilead House.

On 12/13/2019, I conducted a telephone interview with the Home Manager, Brenda Peterson. She explained that there has been a lot happening with Resident A in the last six months. Resident A had stopped caring about anything important to her including activities and important people in her life including her Aunt. She reported

that Resident A was evaluated at St, Mary's Hospital and they reported she could return to the AFC home (dates not provided). She reported that St. Mary's had changed her medications. When she did return to the home, she was paranoid that the house was going to catch on fire and "she went back down-hill." Resident A had a special relationship with her Aunt, and they talked regularly, but then Resident A became especially mean to her Aunt and the decided to "cut (Resident A) off." Ms. Peterson reported that Resident A was admitted to MidMichigan Health, University of Michigan Health System, Behavioral Health: MidMichigan Medical Center-Gratiot, In Alma MI at the end of October 2019. She reported that she was there for a period of time and then returned to the AFC home.

I asked Ms. Peterson about the incident of 11/27/2019. She said on 11/27/2019, Resident A was throwing things in the home and threatened to kill her peers and the staff several times. She said staff tried for two hours to redirect her with reading her Bible which she did often, but she refused. Ms. Peterson stated that they did everything to keep the other residents safe and no one was hurt. She said it was not safe for the residents with Resident A's behaviors, so they called for back-up by calling the police at their non-emergency number. The Officers arrived approximately 10:00 AM and they worked with Resident A, but her behaviors had not changed. At this point the police officers called for an ambulance. The ambulance took Resident A to the Metro Hospital. After Resident A was gone. DeAnn Hands, Clinical Coordinator, from MOKA arrived at the home. Ms. Peterson explained that Ms. Hands had told the staff that they could not take Resident A back into the home without the hospital completing an assessment of her. Ms. Peterson stated that she received a telephone call from Resident A's Supports Coordinator, Kathy Johnson. Ms. Johnson explained that the hospital nurse (unnamed) had called her and reported that they were sending Resident A back to the AFC home. Ms. Peterson told Ms. Johnson that they would not take her back unless she had been evaluated and assessed. Ms. Johnson said she would call the nurse back and tell them what they were expecting. Ms. Peterson stated that a lady with a shirt that had EMS on it arrived at the home with Resident A. Ms. Peterson explained to her that they would not take Resident A back unless the hospital had completed an evaluation/assessment. The lady asked to use their phone, and then walked Resident A back into her car, where they sat for approximately 15 minutes. Ms. Preston estimated the time was around 2:30 PM. She said the police arrived a short time later and the officer knocked at the door and asked her if the home had called them for help and she explained they had not. Then an ambulance showed up and Resident A was put into the ambulance and they left. Ms. Peterson said that she assumed that the lady that had transported Resident A had called the police, or their ambulance company, because they had not called the police.

On 12/13/2019, I conducted an interview with Resident A's guardian. She stated that she had learned that the home staff had called the hospital and that Resident A was sent back to the hospital because staff felt she was a danger to the other residents. She said Resident A sat in the hospital on Thanksgiving weekend which was very hard on her. She said the hospital staff reported to her that Resident A did not

exhibit any harm or threats to anyone while there. She said there was an emergency discharge from MOKA and that she had received a letter from the AFC home staff which she could not find, but she thought it was a notice that they were not going to take her back. She confirmed that Resident A has been in a psychiatric hospital for about two weeks not that long ago. She said the staff of the AFC home reported to her that Resident A had not changed her behaviors when she returned to the home and she knew the staff were beside themselves with her behaviors. She also stated that Resident A's Case Manager/Supports Coordinator told her that the home should have taken her back and that they should not have given her an emergency discharge. She said they ended up placing Resident A in a crisis home run by Hope Network after she left Metro hospital.

On 12/13/2019, I conducted an interview with Resident A's, Case Manager, Kathy Johnson, network 180. She stated that Resident A's guardian was out of town when this incident occurred. She said the AFC home had previously threatened to discharge Resident A (no date provided) but stated she had not received written notification of the 24-hour discharge until they (home staff) refused to take Resident A back into the home. The reported reason for this was that Resident A was aggressive and presenting as a danger to herself and other residents. She reported that she never actually saw the discharge letter, but her superiors did and informed her about the discharge letter. She stated that Resident A had behavior changes and she did not respond to redirection. She reported that she had had changes to her medications. She confirmed that Resident A spent the weekend at Metro hospital and then they found a placement for her at a crisis home. She also confirmed that Resident A went into St. Mary's hospital on 10/29/2019 and then was placed at the Behavioral Health Medical Center on 10/30/2019.

On 12/19/2019, I reviewed 28 of Resident A's Residential PC/CLS Shift notes from various shifts dated from 10/21/2019 through 11/27/2019. There were shifts that had no documentation indicating there had been any issues with Resident A's displaying behaviors. The documentation however does include the following summary of the events occurring on 11/27/2019; *"(Resident A) only wanted assistance from one staff. A peer became upset with (Resident A) and was screaming at her. (Resident A) then began perseverating about sitting in the chair and that the other peer was in and refusing to stay away from other peer. (Resident A) started throwing magazines, movies, shoes in the living room and then into the sensor room through the doorway and the window. She walked into the sensory room and several times and attempted to directly throw things at peer. She threatened to hit staff, raising her fists at and was cursing at staff and making rude comments. She was also kicking and punching walls and doors and the furniture. Staff stepped in between (Resident A) and peers several times for safety. (Resident A) refused any and all redirection to sue coping skills and to remove herself into a calmer area. She called Recipient Rights saying that staff were holding her hostage. After 2 hours of not being able to regulate staff called the non-emergency line for police assistance. She was taken to Metro for evaluation where she remained for the rest of the shift."*

On 12/17/2019, I went to the crisis home and conducted a face-to-face interview with Resident A. I have been the Licensing Consultant to the MOKA Amanda home since 2014. For each time I was in the home Resident A has always recognized me, called me by name and engaged me in conversation. When I met her at the crisis home, she did not recognize me and when I told her my name and reminded her of our past usual visits at the Amanda home, she showed no signs of recognition. I asked her about the incident on 11/27/2019. She said: "I was violent, and I have no idea why. I did not hurt anyone. I went to the hospital and then they brought me back to the home. I want to go back to the home they said I could not stay there." We talked about her behavior and her threats and she said; "It's a lie. I did not do that. I don't remember throwing things. I did not threaten to kill them." She did report that she had a doctor's appointment in a little while, which she had to get ready for. She also reported that she had been at St. Mary's hospital and at a home in Alma, MI. She said she was very agitated and 911 was called and the EMT's took her to the hospital. Then an EMT took brought her back to the home. She said, "We just walked right in and then the police came." She said they took her back to the hospital and that DeAnn Hands came to visit her at the AFC home. Then Resident A rambled about non-related topics and my interview was ended shortly thereafter.

On 12/19/2019, Ms. Katye Gee, APS and I made an announced inspection to the Amanda AFC home**.** We jointly conducted interviews with Direct Care Staff Karla Erickson, Caitlin Koster and the Home Supervisor, Brenda Peterson.

Ms. Erickson reported that she worked 1st shift on 11/27/2019 and Resident A was becoming agitated. She reported she went to purchase the groceries for the home and returned about one and ½ hours later. She stated that Resident A usually loves to bring the bags into the home and help with putting the groceries away but on this date, "She was very agitated and wanted nothing to do with it." She reported that Resident A was throwing things at other residents and verbally said she would kill the residents. She reported that the staff had worked with Resident A for two hours to calm her down and Ms. Peterson called the non-emergency number for the police for back-up. She said the police officers could not calm Resident A down, so the officers called for an ambulance. She said the EMT's arrived and said they had to take her to Metro. Hospital She thought the time was abound 10:00 or 10:30 A.M. She said they asked the ambulance staff to take her to St, Mary's but they reported that they had to take her to the closest hospital which was Metro Hospital. She stated that DeAnn Hands had come to the home after Resident A had left and told them that they could not take her back until the hospital had evaluated her. She stated that Ms. Koster took the call from Resident A's Supports Coordinator who had told her that the hospital was sending her back to the home. Then a car arrived at the home with Resident A. She estimated the time to be between 2:00 and 2:30PM. She said the driver came into the home with Resident A. She said Ms. Koster explained that they would not take Resident A back unless the hospital had assessed her. She stated that they left and sat in the white car. She said then the police arrived and asked if home staff had called for them. She said they had not.

Then an ambulance arrived and took Resident A. She said the police arrived shortly thereafter. She said they had been advised by DeeAnn Hands, Clinical Coordinator for MOKA, to not take Resident A back into the home. Ms. Erickson stated that she left at the end of her shift at 2:30 P.M.

On 02/19/2020 we interviewed the Direct Care Staff, Caitlin Koster, She said "(Resident A) got up in a certain mood. She threw a magazine at a resident, but staff were able to protect her. She was throwing things and calling everyone names and threatened to kill everyone, and we had to actually body block her so she would not hurt any other resident. She would not calm down. I got her I-pad that usually calms her down and anther staff got her Bible because those are her favorite activities. None of these interventions worked. "She said I hate you. I will kill you. I will kill you both. I will kill your family members and your kids." She reported this went on for over two hours. She said staff called the non-emergency number for the police and the ambulance came to the AFC home. She said Resident A left the home and they called DeeAnn Hands. The Clinical Director, came the home and told them not to take her back into the home. She stated: "This situation with (Resident A) was not safe for me, the other staff or the residents living in the home. We could not walk away from her. She was yelling and not acting right. She stated that the officers arrived and when she saw the officers she started to cry." She stated that they have two different e-mails for Resident A's guardian, and Ms. Lee Ann Shedleski-Holmden, Regional Director of Kent County, for MOKA, sent the emergency discharge letter to both of the e-mails to let Resident A's guardian know that they could not meet her needs.

Ms. Gee and I interviewed the Home Supervisor; Brenda Peterson and she reported the same events as the other two Direct Care Staff.

On 12/19/2019 Brenda Peterson provided information and documents concerning Resident A: Staff Schedule 11/24/2019 through 11/30/2019 Demographic Face Sheet, two Incident/Accident Reports date 11/22/2019, and 11/27/2019, Resident A's Individual Plan of Service, dated 01/14/2019, Assessment Plan for AFC Residents, dated 10/11/18, DD Division Behavioral Treatment Plan, Residential PC/CLS Shift Notes 10/21/ through 11/27/2019, an unsigned letter to Resident A's guardian dated 11/27/2019 explaining a 24 hour discharge. She also provided copies of Resident A's, information from MidMichigan Health, University of Michigan Health System, Behavioral Health MidMichigan Medical Center, dated 10/31-11/2019.

On 12/19/2019, I reviewed the Incident/Accident Report (IR) dated 11/22/2019 regarding Resident A's aggressive behaviors. This IR documented: "…(*Resident A) began hitting and kicking various things such as walls and cabinets throughout various rooms in the home. Individual picked up items throughout the home such as remotes, and cups and tissue boxes and threw them on the floor as well as at peers. The duration of throwing various objects throughout the house lasted two hours with only moments between incidents. Staff advised her on proper decision making and*

recommended various coping skills. Staff followed individual's program plan. Individual had calmed herself for a period of time, staff had a meaningful conversation with individual at her request."

On 12/19/2019 I reviewed the IR dated 11/27/2019 at 9:00 AM, written by Direct Care Staff, Caitlin Koster and signed by Brenda Peterson. This report read as follows: "*A peer upset with (Resident A) and started screaming. Staff redirected peer to another area (sensory room) and got them busy doing other things. (Resident A) began to perseverate about sitting in the room where the peer was and staff asked (Resident A) to let peer have space and to go about her schedule. (Resident A) became upset and began slamming her fist into the furniture and the walls and walking around the house grabbing things to throw magazines, movies, her shoes and a pumpkin decoration that was sitting in the window. She whipped the pumpkin decorations and hit another peer that was sitting in the sensory room because they felt unsafe. She went for the monitor in the window, but staff was able to grab that before she could get ahold of it. Several times (Resident A) walked into the sensory room and threw things directly at a peer and threw items through the window attempting to hit a peer. One staff placed a chair and themselves in front of the peer that (Resident A) was threatening and attempting to hit for safety. The other staff several times blocked items being thrown from hitting the peers. (Resident A) made several threats to hit staff and was verbally assaulting the staff and the residents. Staff worked for two hours attempting to redirect (Resident A) to use specific skills and to go to an area of calm, but all redirection failed. Staff worked for two hours attempting to redirect (Resident A) to use specific coping skills and to go to an area of calm, but all redirection failed. Both staff agreed that for safety for everyone to utilize the non-emergency police number and receive assistance. Once the police had been contacted (Resident A) began to cry and got her I-pod and said the she would calm down. Staff followed BSP by redirecting to use coping skills and directed to calm area. All attempts made by staff to redirect (Resident A) failed. Due to safety to others the police were called for assistance."*

On 12/19/2019, I reviewed Resident A's documents from MidMichigan Center Behavioral Health, Gratiot. Resident A was admitted on 10/30/2019. This document recorded their "IMPRESSION: 1. Schizoaffective disorder, depressed phase." The reports explained the physician's orders of increasing and decreasing her psychotropic medications. They monitored her for EPS, agitation, aggression and suicidal behaviors. On 11/02/2019 the report stated that the IMPRESSION: Major depression, severe, with psychotic features." The report also states that she will "zone out" without answering questions. She is developmentally delayed and has a public guardian, Medication on Vraylar." "She has Affect blunted, anxious mood." The documents provided did not indicate a discharge date from the facility.

On 12/19/2019, I reviewed Resident A's "Demographic Face Sheet," which recorded that she has been with MOKA since 08/09/2000 and was admitted to the Amanda Home on 01/13/2011.

On 12/19/2019, I reviewed Resident A's Assessment plan signed on 10/11/2018. This document indicated she becomes distracted and her safety skills become compromised when she experiences impulsivity and therefore is vulnerable in the community. She lacks appropriate interpersonal boundaries. In the community she requires visual supervision. The plan stated that she has a formal behavior plan in place to address maladaptive behaviors, putting herself in unsafe situations and she exhibits limitations in getting along with others. She also has a history of self-injury during bathing.

On 12/19/2019, I reviewed Resident A's Individual/Family Plan of Service dated 01/14/2019 and was signed on 05/17/2019. This report indicated she receives Supports Coordination and a nurse to manage her physical health and monitoring. She goes to the Greenwood Clinic, Dr. Mulderig, Psychiatric Services-behavioral health services and treatment with symptom monitoring and medication reviews. She has services form Wilson/Wynn Interventions to support and help manage/reduce behaviors of concern.

On 12/19/2019, I reviewed Resident A's Behavioral Treatment Plan, signed on 012/12/2019. This document recorded behaviors which included Perseveration with repeated questions, Aggressive behaviors with episodes of verbal aggression (yelling, swearing directed at or making derogatory comments towards others, or other physical aggression including hitting, kicking, biting, scratching or throwing items at others, or property destruction, breaking or disrupting items belonging to others). There were Proactive Measures/Teaching, Replacement Skills, Developing/Training, Reinforcement/Encouraging Appropriate Alternative Behavior, and Intervention for Target Behavior. There were interventions for her perseveration on topics, Inappropriate Boundaries, Interventions for Emotional Dysregulation, and a Token System. The Tokens will earn her 7 oz can of diet pop or decaf coffee as allowed on diet and she can earn outings with staff for shopping, out to eat or other activity, going out to McDonald's for an Iced tea and go out to return pop cans.

Upon review of Resident A's documents, it is evident that she requires close monitoring and interventions. She also has significant psychiatric challenges requiring many medications and a behavioral treatment plan. After interviewing the staff, they demonstrated that they did follow her behavioral plan and used the interventions provided but these interventions did not help Resident A calm down on this occasion.

On 12/19/2019, I reviewed the letter dated 11/27/2019, from MOKA to Resident A's guardian. The letter provided to me was not signed. The letter stated in part: *"(Resident A's) actions since her return from her recent psychiatric inpatient stay escalated today to a level that crated an extremely unsafe environment for her, her housemates and supports, limiting (Resident A's) ability to benefit from our residential services and limiting our ability to safely provide services to other individuals at the home. Unfortunately, there is a lack of compatibility with her housemates, and we cannot ensure safety for her and everyone in the home, as her*

current support needs exceed our available resources. Repeated multiple attempts were made by our team to help (Resident A) and to ensure safety for everyone in the home, including seeking assistance from local law enforcement when her behavior exceeded our ability to keep others safe. Our team's efforts included on-going consultation with her support coordinator and medical professionals. Our team fully followed all clinical and medical directions and training. Unfortunately, this did not lead to improvements in safety and (Resident A) continued physically aggressive actions toward others at the home."

The Letter stated that the discharge occurred on 11/27/2019 and it was their understanding that her support coordinator is working to secure other housing for her. "*The physical copy of the letter will be mailed in addition to this electronic copy. I also left a voice mail message for you regarding the emergency discharge."* The letter was sent by Lee Ann Shedleski-Holmden, Regional Director-Kent. Also copied on the letter was Tracey Hamlet, Executive Director of MOKA, Daudi Mbuta, Residential Coordinator, for MOKA, and me. I did not receive a copy of the 24-hour discharge letter. I checked the emails from Ms. Perdaris on 11/27/2019 and after that date and the 24-hour discharge letter was not received. I was made aware of the situation by Kent County Adult Protective Services, Kent County on 12/13/2019 when I received a "REQUEST FOR JOINT INVESTIGATION," from Katye Gee, LLMSW, Kent County Adult Protective Services.

On 02/05/2020 I conducted a telephone with Resident A's Case Manager, Kathy Johnson. She reported that when the Amanda home sent Resident A to the hospital and then refused her return to the home, it was difficult to find her a new placement because of the Thanksgiving holiday. Ms. Johnson reported there were no places open and no one she could reach for a possible placement. In addition, Resident A's guardian was out of town and she left no one in charge of her cases, so neither the Amanda home nor the case manager had any power to make new placement arrangements. Ms. Johnson said the only way she could secure a new placement for Resident A was for the guardian to sign for her admission. She had the crisis home ready to admit Resident A, but the guardian did not return until 12/04/2010 which was when Resident A was admitted to the crisis home. She stated that Resident A was in the Metro hospital from 11/27/2019 until 12/04/2019, with no medical necessity to be in the hospital. She stated that arrangements have now been made for Resident A to move to a new home on 02/11/2020.

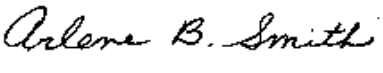
On 02/07/2020, I conducted a telephone exit conference with the Licensee Designee, Tracey Hamlet. Ms. Hamlet stated it was her understanding that the staff in the home who were working with Resident A were concerned that Resident A's behaviors were placing another resident at imminent risk of harm. We discussed the rule and I explained the department's rationale in substantiating a violation.

APPLICABLE RULE	
R 400.14302	**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.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: (a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home. (b) Substantial risk, or an occurrence, of self-destructive behavior. (c) Substantial risk, or an occurrence, of serious physical assault. (d) substantial risk, or an occurrence, of the destruction of property. (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 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. **(b) The licensee shall confer with the responsible agency, or if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply; (i)The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located. (ii) The resident shall have the right to file a complaint with the department. (iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to**

	return to the first available bed in the licensee's adult foster care home.
ANALYSIS:	Staff Catilin Koster, Carla Erickson and Brenda Peterson, the home manager all reported that on 11/27/2010 Resident A was displaying aggressive behaviors and staff were unable to calm her down. These behaviors were reportedly placing Resident A, the other home residents in danger, so Ms. Koster called the non-emergency police number and the officers came to help with Resident A. The police officer called for an ambulance and Resident A was transported to the hospital for assessment. While Resident A was at the hospital, her Supports Coordinator called the home staff to tell them that the nurse from the Metro Hospital had called her that they were sending Resident A back to the home. Resident A was subsequently brought back to the home by an EMT but was denied re-entry. As a result, the police were called to the home and Resident A was returned back to the hospital, where she remained for 6 days despite there being no medical justification for her stay. A 24-hour discharge notice was issued on 11/27/2019, which was the same day Resident A was not allowed to come back to the AFC home. Based upon the information obtained through this investigation, it does not appear that anyone was injured by Resident A or that any significant property destruction occurred, as staff were apparently able to successfully prevent this from happening. The licensee did not provide a 24-hour discharge notification to the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant as is required. It is therefore determined that a violation of the above cited rule has occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

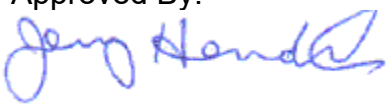
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



02/19/2020

Arlene B. Smith MSW — Date
Licensing Consultant

Approved By:



02/19/2020

Jerry Hendrick — Date
Area Manager