STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

December 10, 2021

Janet Patterson
Advocates for Self Determination, LLC
28237 Orchard Lake Rd.
Suite 102
Farmington Hills, MI 48334

RE: License #: AS630337268
Investigation #: 2022A0991002
Rochester Home

Dear Ms. Patterson:

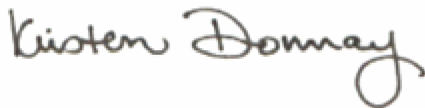
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 296-2783

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 #:	AS630337268
Investigation #:	2022A0991002
Complaint Receipt Date:	10/13/2021
Investigation Initiation Date:	10/13/2021
Report Due Date:	12/12/2021
Licensee Name:	Advocates for Self Determination, LLC
Licensee Address:	28237 Orchard Lake Rd., Suite 102 Farmington Hills, MI 48334
Licensee Telephone #:	(248) 723-7152
Licensee Designee:	Janet Patterson
Name of Facility:	Rochester Home
Facility Address:	4651 Rochester Road Troy, MI 48085
Facility Telephone #:	(248) 688-9032
Original Issuance Date:	12/11/2013
License Status:	REGULAR
Effective Date:	06/11/2020
Expiration Date:	06/10/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has been to the hospital at least twelve times in the past two months. Group home staff do not accompany Resident A to the hospital. The home manager has not been responsive to phone calls from the hospital to provide transportation back to the home.	Yes
On 10/19/21, Resident A walked away from the group home after direct care worker, Kiah Campbell, was rude and made degrading comments towards her.	Yes

III. METHODOLOGY

10/13/2021	Special Investigation Intake 2022A0991002
10/13/2021	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker- Katie Garcia
10/13/2021	Referral - Recipient Rights
10/15/2021	Contact - Telephone call made Left message for complainant
10/15/2021	Contact - Telephone call made To case manager- voicemail box full
10/15/2021	Contact - Telephone call received From case manager
10/15/2021	APS Referral Adult Protective Services (APS) referral - denied for investigation
10/20/2021	Inspection Completed On-site Unannounced onsite inspection- interviewed staff, Joslyn Flewellen
10/20/2021	Contact - Telephone call made To Shannon Williams, clinical director
10/22/2021	Inspection Completed On-site Unannounced onsite inspection- interviewed home manager

10/27/2021	Contact - Telephone call made Interviewed Resident A, Resident B, and staff Joslyn Flewellen via telephone
10/27/2021	Contact - Telephone call made Interviewed staff, Kiah Campbell via telephone
10/27/2021	Contact - Document Received Plan of service and incident reports
11/29/2021	Contact - Telephone call made To Katie Garcia, ORR
11/29/2021	Contact - Document Received Resident A's crisis plan
12/10/2021	Exit Conference Via telephone with licensee designee, Janet Patterson

ALLEGATION:

Resident A has been to the hospital at least twelve times in the past two months. Group home staff do not accompany Resident A to the hospital. The home manager has not been responsive to phone calls from the hospital to provide transportation back to the home.

INVESTIGATION:

On 10/13/21, I received a complaint alleging that Resident A has been to the hospital at least twelve times in the past two months. Group home staff do not accompany Resident A to the hospital. The complaint noted that at times the group home manager has provided transportation home from the hospital. On 10/08/21 and again on 10/12/21, multiple calls from the hospital to the home manager, Shawanna, and to the home went to voicemail. No return calls were received. There was no paperwork or staff accompanying Resident A to the hospital on these visits, which may have been the case on multiple previous visits. I left a message for the complainant on 10/15/21, but I did not receive a return phone call. On 10/20/21, I received additional allegations that Resident A walked away from the group home after direct care worker, Kiah Campbell, was rude and made degrading comments towards her.

I initiated my investigation on 10/13/21, by contacting the Office of Recipient Rights (ORR) worker, Katie Garcia. Ms. Garcia indicated that Resident A’s individual plan of service (IPOS) indicates that staff will provide 24-hour support services daily. Staff are to follow Resident A’s crisis plan to reduce hospitalizations.

On 10/15/21, I interviewed Resident A's case manager, Devon Cage, from Community Network Services (CNS) via telephone. Ms. Cage indicated that Resident A has a high utilization of the emergency room (ER) and goes to the hospital frequently. Staff typically drop Resident A off at the hospital or call Emergency Medical Services (EMS) to transport her to the hospital. Staff do not stay with Resident A at the hospital. Ms. Cage indicated that the home is short staffed, and they usually have one staff person on shift. There are five other residents in the home. Ms. Cage indicated that ideally staff should stay with Resident A until she is admitted to the hospital, but they are not able to do that due to being short staffed. There have been times when Resident A is transported back to the home via ambulance, or a ride share service due to staff not being available to transport her home. Ms. Cage indicated that she does not have concerns about Resident A eloping from the hospital, as Resident A feels safe at the hospital and enjoys being there. Ms. Cage indicated that she felt staff were following Resident A's plan of service. She stated that Resident A has very high acuity needs, and everyone is at a loss as to what to do next. Resident A receives case management and therapy services weekly, and she has a peer support specialist. Resident A does not have 1:1 staffing at this time. Resident A was released from Caro Center in June 2021. She has been hospitalized at least 10-15 times. Ms. Cage indicated that the home issued an emergency discharge notice for Resident A in August 2021. They have been unable to locate a new placement for Resident A. Ms. Cage is in the process of completing an application for state hospitalization for Resident A.

On 10/20/21, I conducted an unannounced onsite inspection at Rochester Home. I interviewed direct care worker, Joslyn Flewellen. Ms. Flewellen indicated that Resident A was still in the hospital and should be discharged later that day. Resident A has hospital seeking behaviors and has been to the hospital about 30 times since the end of June. Resident A often states that she does not feel well or that she does not want to be at the home. Staff try to redirect Resident A by talking with her or suggesting other activities, but it does not usually work. Staff contact the police or EMS and they transport Resident A to the hospital. When Resident A is transported to the hospital by EMS, staff usually provide Resident A's medication and guardianship information. When the police transport Resident A to the hospital, they typically only ask for Resident A's guardianship information. Ms. Flewellen indicated that Resident A usually goes to Troy Beaumont. They know Resident A at that hospital, so they do not need all of her information. The hospital has contact information for the home, as well as the home manager's cell phone number. The home manager is the only staff in the home who can provide transportation. If she is not available, then Resident A is usually transported back to the home by cab or Lyft. Sometimes the home manager will go pick up Resident A the next day. Ms. Flewellen indicated that Resident A's plan does not indicate that she needs a 1:1 staffing ratio, but Resident A gets upset when she does not get all of the attention from staff. She becomes violent and disrespectful or will elope from the home if she is not getting attention. Staff are not able to give Resident A their undivided attention, as there are six residents in the home. Ms. Flewellen indicated that Resident A is not allowed to go out into the community unsupervised.

On 10/20/21, I interviewed the clinical director, Shannon Williams, via telephone. Ms. Williams indicated that Resident A moved into the home on 06/08/21 and has had numerous hospitalizations since that time. They have submitted two emergency discharge notices for Resident A, but a new placement has not been located yet and it has been months. Resident A is frequently transported to the hospital by the police or an ambulance. The hospital has the home manager's contact information. Ms. Williams indicated that nobody in the home requires one to one staffing. There are times when there is only one staff person on shift when Resident A goes to the hospital, so staff cannot stay with her. Ms. Williams also stated that a lot of hospitals are not allowing staff to remain with the residents due to COVID restrictions.

On 10/22/21, I conducted another unannounced onsite inspection at Rochester Home. I interviewed the home manager, Shawanna Walker. Ms. Walker indicated that Resident A was back in the hospital, as she was complaining about not feeling well and stated that her throat hurt last night. She stated that Resident A has hospital seeking behaviors and goes to the hospital all the time. Staff try to talk to Resident A and redirect her, but nothing seems to work to convince her to stay. Resident A does not stay in the home for a long enough time to settle in and become stable. Resident A is not able to be in the community without supervision. Ms. Walker stated that she transports Resident A to the hospital or Resident A is transported by EMS. The hospital is not allowing staff to remain with Resident A due to COVID precautions. Ms. Walker stated that when Resident A first moved into the home, they would provide Resident A's medication records, insurance information, and guardianship information. She stated that the hospital and EMS know Resident A now and they do not want the paperwork when they come to pick her up. Ms. Walker indicated that Resident A typically goes to Troy Beaumont. They have her cell phone number and contact her when she is ready to be discharged. Ms. Walker stated that she was not aware of a time when the hospital was unable to reach her. Ms. Walker stated that on 10/08/21, she picked up Resident A from Troy Beaumont Hospital. She was not sure what happened on 10/12/21. She stated that it must have been late if they called on 10/12/21.

On 10/27/21, I interviewed Resident A via telephone. Resident A stated that she goes to the hospital a lot. She usually goes by herself. Resident A stated that she normally goes to Troy Beaumont and the hospital staff know her there. She is able to get ahold of staff at the home if she needs to while she is at the hospital. Resident A stated that she is not allowed to go out in the community by herself. She needs supervision when she is in the community.

On 10/27/21, I interviewed direct care worker, Kiah Campbell, via telephone. Ms. Campbell indicated that Resident A goes to the hospital all the time, at least every other day. Staff try to redirect Resident A, but it does not work. She stated that staff do not stay with Resident A when she goes to the hospital. The hospital staff call the house or contact the home manager on her cell phone when Resident A is ready to be discharged. Ms. Campbell indicated that Resident A is a regular, so they do not provide her information to EMS anymore.

I reviewed copies of incident reports dated: 08/28/21, 08/31/21, 09/01/21, 09/11/21, 09/15/21, 09/16/21, 10/06/21, 10/11/21, 10/19/21, 10/21/21, and 10/26/21, which all indicate that Resident A was hospitalized.

I reviewed a copy of an incident report dated 09/11/21. The incident report indicates that Resident A was transported to Crittenton Hospital in Rochester instead of Troy Beaumont. She was later discharged alone. Eventually, Resident A was picked up in downtown Rochester and was transported to Ascension Providence Hospital. An additional incident report dated 09/13/21 indicates that staff asked Resident A where she was during missing hours. Resident A stated that she walked to downtown Rochester after being discharged from the hospital. She stayed out by the gas station until the Troy police picked her up.

I reviewed an incident report dated 10/25/21, which indicates that Resident A was dropped off to the home by ambulance without the home or home manager being notified by Troy Beaumont Hospital.

I reviewed a copy of Resident A's individual plan of service (IPOS) dated 08/05/21 and an amended IPOS dated 09/16/21. The IPOS indicates that Resident A needs 24-hour specialized residential support and services to provide daily guidance and assistance to appropriately care for self and the living environment, for medication management, meal planning and preparation, making and keeping health care appointments, engaging in leisure pursuits, safely accessing the community, building trust and getting along with others, problem-solving concerns, and understanding and adhering to physician/health care recommendations. The IPOS indicates that one of Resident A's goals is as follows, "I want to stay in the group home and not leave, spend less time in the hospital." The IPOS notes that home staff will monitor Resident A daily for increased symptoms of psychosis, including rapid speech, isolation, agitation, and verbalized distress. Home staff will intervene in times of crisis, using the crisis plan and following each step. They will assist Resident A in expressing her concerns rather than seeking hospitalization. Home staff will encourage Resident A to follow her crisis plan in attempts to reduce the need for hospitalization or ER contact. The home staff will alert the case manager if there is any need or concern and write incident reports as appropriate.

The "supports for well-being and safety" portion of Resident A's IPOS was not completed. It indicates that a supports plan is not applicable. There is no documentation regarding the individual monitoring needs for Resident A while in the community or during awake or sleep hours. There is no documentation of personal safety risks for Resident A.

I reviewed a copy of Resident A's crisis plan dated 07/14/2021. The plan indicates the mental/emotional health goal for Resident A is that she will not have suicidal thoughts anymore. The proactive plan is "trusting people" and the reactive plan notes that Resident A will listen to music, try to talk to home staff at the group home, and will call CNS. The crisis plan includes a section for hospital preferences, which notes that

hospitalization is the intervention of last resort. However, if hospitalization is necessary to ensure Resident A's health and safety then Havenwyck Hospital or Beaumont Hospital Troy are the preferred hospitals. The plan includes a section that indicates "What needs to happen?" if Resident A is hospitalized and notes, "Individual reports no needs if hospitalized." The crisis plan does not include any information about Resident A's hospital seeking behaviors. It does not include any steps for staff to follow to reduce hospital utilization. The crisis plan and IPOS do not specify whether or not staff need to supervise Resident A while she is at the hospital.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's protection and safety were not attended to at all times. Resident A requires 24-hour supervision and does not have community access. She has been transported to the hospital unaccompanied by staff on numerous occasions. Staff are not currently being permitted into the hospital due to COVID-19, but staff do not always provide medication and contact information when Resident A goes to the hospital, because Resident A goes to the hospital often and they assume hospital staff know her. Resident A was discharged from the hospital on 09/11/21 and 10/25/21 without staff's knowledge. Resident A's plan of service does not include any information about how staff should respond to Resident A's hospital seeking behaviors or what steps to take and the level of supervision required when Resident A is hospitalized.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique

	programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home does not have interventions in place to address Resident A's hospital seeking behaviors. Resident A's IPOS states that home staff will intervene in times of crisis, using the crisis plan and following each step; however, the crisis plan does not include any information about Resident A's hospital seeking behaviors. It does not include any steps for staff to follow to reduce hospital utilization. The crisis plan and IPOS do not specify whether or not staff need to supervise Resident A while she is at the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 10/19/21, Resident A walked away from the group home after direct care worker, Kiah Campbell, was rude and made degrading comments towards her.

INVESTIGATION:

On 10/20/21, I interviewed the clinical director, Shannon Williams, via telephone. Ms. Williams stated that Resident A eloped from the facility last night. She was located and transported to Beaumont Hospital in Royal Oak. Ms. Williams stated that staff, Kiah Campbell, was removed from the schedule, because it was reported that she was arguing back and forth with Resident A, which provoked Resident A and caused her to leave the facility.

On 10/22/21, I conducted an unannounced onsite inspection at Rochester Home. Resident A was in the hospital, but I interviewed the home manager, Shawanna Walker. Ms. Walker was not working when Resident A eloped from the facility on 10/19/21. Joslyn Flewellen and Kiah Campbell were on shift. Ms. Walker heard that Resident A and Ms. Campbell were yelling at one another and disrespecting each other. EMS had already been called to the home for Resident A, but Resident A told staff that they were going to have to find her and walked out of the home. Resident A was upset that Ms. Campbell had called her names. Ms. Walker stated that she never personally witnessed Ms. Campbell being verbally abusive towards Resident A. She stated that they typically get along well and she never had concerns about Ms. Campbell. Ms. Campbell was taken off the schedule pending an investigation.

On 10/27/21, I interviewed direct care worker, Joslyn Flewellen, via telephone. Ms. Flewellen stated that she was working with Kiah Campbell on 10/19/21. Around 6:30pm, Resident A came in and wanted to speak to Ms. Campbell. Ms. Campbell told Ms. Flewellen to go talk to Resident A instead. Ms. Flewellen stated that she did not go, because Resident A specifically asked to talk to Ms. Campbell. Ms. Campbell never went to talk to Resident A. A little while later, Resident A came out of her room again. She was pacing and stated that she did not feel well. She had a knot in her stomach and felt dizzy. Ms. Flewellen told Resident A to sit down and they would call for an ambulance. Ms. Flewellen told Resident A that EMS was on their way and that she should go get her stuff. Resident A came back and said that she did not want to be in the home. Ms. Campbell told Resident A that this was not a reason to go to the hospital. She stated that she did not want to be around Resident A either. Ms. Campbell told Resident A that she was a “retarded asshole” and a “white bitch.” Resident A said to Ms. Campbell, “You’re a whore.” Ms. Flewellen stated that Resident A was about to call Ms. Campbell the “N” word, but she stopped because she did not want to be disrespectful towards Ms. Flewellen. Resident A called Ms. Cambell a “ho.” Ms. Flewellen tried to intervene and told Ms. Campbell and Resident A that they were going too far. Resident A said, “fuck you” to Ms. Campbell and eloped from the home. Resident A left the home before EMS arrived.

Ms. Flewellen stated that she never witnessed Ms. Campbell calling Resident A names or speaking negatively towards her prior to this incident. She stated that Ms. Campbell sometimes ignores Resident A and does not want to deal with her. Resident A usually only comes out of her room to use the restroom or to eat meals if Ms. Campbell is on shift. Ms. Flewellen stated that Ms. Campbell instigated this incident. Resident A did not begin yelling until Ms. Campbell started yelling and calling her names. Ms. Flewellen told Ms. Campbell to complete an incident report since she was the one involved in the incident. Ms. Flewellen stated that when she came in the next day, the incident report said that Resident A got into it with Ms. Flewellen. Ms. Flewellen indicated that she was not a part of the verbal altercation, and she never had a negative interaction with Resident A. Ms. Flewellen stated that she contacted the home manager at the end of her shift and let her know what happened.

On 10/27/21, I interviewed Resident A via telephone. Resident A stated that she recalled getting into an an argument with staff, Kiah Campbell. Resident A stated that she asked staff if she could go to the hospital and Ms. Campbell was being snippy with her. Ms. Campbell told Resident A that she was not going to the hospital today. Ms. Campbell called Resident A “a dumb white bitch” and stated, “at least I don’t live in a group home.” Resident A stated that she went to her room, got her stuff, and walked out of the home. She was walking around until the cops found her and took her to Royal Oak Beaumont. Resident A stated that she did yell back at Ms. Campbell, but she did not call her any names. Ms. Campbell raised her voice, was yelling, and called Resident A out her name. Resident A stated that Ms. Flewellen was there and saw the incident happen. She was just listening and did not try to stop it. Resident A stated that this was the first time that Ms. Campbell was verbally aggressive towards her. She stated that they used to get along, but they don’t get along anymore. Resident A stated that this is

the only time she ever got into a verbal argument with staff. None of the other staff in the home have ever called her names, yelled at her, or made threats.

On 10/27/21, I interviewed Resident B via telephone. Resident B stated that Ms. Campbell has never called her any names. She never heard Ms. Campbell yell at other residents or call them names. She never heard Ms. Campbell yell at Resident A. Resident B stated that Ms. Campbell did raise her voice at her a few times, but otherwise she is a sweetheart. Resident B stated that she is not afraid of Ms. Campbell and that she is nice to everyone. She misses her and wants her to come back to work. Resident B stated that all of the staff in the home are very nice. They treat everyone well. Resident B stated that it is a wonderful group home and she loves it.

On 10/27/21, I interviewed direct care worker, Kiah Campbell, via telephone. Ms. Campbell indicated that on 10/19/21, Resident A came and said that she wanted to go to the hospital. Ms. Campbell asked Resident A why she wanted to go to the hospital and was trying to redirect Resident A. Resident A started yelling and they began going back and forth. Ms. Campbell stated that she never swore at Resident A and she never called her "a dumb white bitch." She stated that she told Resident A that she was getting on the office's nerves with her behavior. She told Resident A that she needed to stop, and she knew that she was not sick. Ms. Campbell stated that she has never been verbally aggressive towards Resident A. Resident A eloped from the home because she told her that she was faking it. Ms. Campbell stated that prior to Resident A leaving the home on 10/19/21, Ms. Flewellen asked Resident A why she kept running to the hospital. Resident A stated, "You know why I'm going to the hospital, because I'm afraid of you." Resident A then walked out the door. None of the other residents were present when this happened. Ms. Campbell stated that Resident A is afraid of Ms. Flewellen. She stated that Ms. Flewellen has gotten into it with Resident A a few times in the past. About a month ago, Ms. Flewellen got in Resident A's face and said that she was going to "beat her ass." Ms. Campbell indicated that she wrote an incident report and told the home manager about this incident, but nothing happened.

I reviewed a copy of an incident report completed by direct care worker, Joslyn Flewellen. It notes that on 10/19/21, Resident A asked staff, Kiah Campbell to talk to her. Ms. Campbell never went to talk to Resident A. Resident A came into the living room. Ms. Flewellen asked what was wrong, and Resident A stated that she did not feel good. Ms. Flewellen called 911 to transport Resident A to the hospital. Ms. Campbell and Resident A began being disrespectful towards one another. Resident A told Ms. Campbell that she does not like her. Ms. Campbell told Resident A that she is "a retarded white bitch." Resident A responded by saying, "you a fat ho that does nothing but be on your phone." Ms. Campbell responded by stating. "That's why you're in a group home, not me." Ms. Flewellen told them that was enough and they were going too far. Resident A told Ms. Campbell not to call her retarded. Ms. Campbell responded, "You are retarded." Resident A stated, "Fuck you, bitch. You can call and have them find me." She then walked out the door.

I reviewed a statement written by Resident A. It indicates that on 10/18/21, Resident A wanted to go to the hospital because she was not feeling good. Kiah Campbell said in a snippy voice, "You're not going to the hospital today." Resident said something about you people. Then Ms. Campbell told Resident A that she was "a dumb white bitch." Resident A told Ms. Campbell that she was a "ho". Ms. Campbell said, "At least I don't live in a group home." That is when Resident A took off and left the group home. Resident A wrote in her statement that staff Joslyn Flewellen never got in her face or got physically or verbally abusive towards her.

I reviewed a copy of an incident report written by Kiah Campbell. It indicates that on 10/19/21, Resident A first stated that she wasn't feeling good and wanted to go to the hospital. Then Resident A stated that she was scared of one of the staff and didn't want to be there. Ms. Campbell told Resident A that was not a reason to go to the hospital and Resident A stated that she would call them herself to come get her. Resident A started "going off" on Ms. Campbell and walked off as the ambulance was on its way.

I reviewed a copy of an incident report completed by the home manager, Shawanna Walker. The incident report notes that on 10/19/21 at 7:40pm, the home manager received a phone call from staff on shift stating that Resident A and Kiah Campbell were arguing when Resident A left the home. The Troy Police, guardian, and case manager were notified. The home manager called around to locate Resident A. She was eventually located and transported to Royal Oak Beaumont.

On 12/10/21, I conducted an exit conference via telephone with the licensee designee, Janet Patterson. Ms. Patterson indicated the issue is that the hospital is not contacting the home manager or home before discharging Resident A. She stated all of the hospital staff know that Resident A lives in a group home and they should be responsible for Resident A's safe discharge from the hospital. Staff do not remain at the hospital with any residents after they are admitted to the hospital, and they are not being permitted into the hospital at this time due to COVID-19. I provided technical assistance and informed Ms. Patterson that this information should be included in Resident A's IPOS and crisis plan. Resident A's plan should include detailed information about the steps staff should take to prevent Resident A from overutilizing the hospital and what steps should be taken if she is hospitalized, including the level of supervision required, providing contact and medication information, and maintaining and documenting regular contact with the hospital. Ms. Patterson indicated that they have issued a discharge notice for Resident A, but the agency has not been making efforts to locate a new placement for Resident A. Ms. Patterson stated that Resident A's behaviors are a lot for staff to handle, but it is never appropriate or therapeutic for staff to speak to Resident A in a demeaning manner. She indicated that she would submit a corrective action plan to address these issues.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff were verbally abusive and made derogatory remarks towards Resident A. Resident A reported that staff, Kiah Campbell called her "a dumb white bitch" and said, "at least I don't live in a group home." Resident A engaged in a verbal altercation with Ms. Campbell, which resulted in Resident A eloping from the home. Staff, Joslyn Flewellen witnessed this incident and reported it to the home manager. Ms. Campbell denied the allegations, but indicated that she has witnessed Ms. Flewellen getting into verbal altercations with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

12/10/2021

Kristen Donnay — Date
Licensing Consultant

Approved By:

12/10/2021

Denise Y. Nunn — Date
Area Manager