GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 23, 2022

Channe Hicks, Licensee Designee
HGA Non-Profit Homes Inc.
917 West Norton
Muskegon, MI 49441

RE: License #:	AS610091644
Investigation #:	2022A0356029
	Virginia's House

Dear Ms. Hicks:

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 #:	AS610091644
Investigation #:	2022A0356029
Complaint Receipt Date:	07/11/2022
Investigation Initiation Date:	07/11/2022
Report Due Date:	09/09/2022
Licensee Name:	HGA Non-Profit Homes Inc.
Licensee Address:	917 West Norton Muskegon, MI 49441
Licensee Telephone #:	(231) 728-3501
Administrator:	Channe Hicks
Licensee Designee:	Channe Hicks
Name of Facility:	Virginia's House
Facility Address:	391 Whispering Oaks Drive Muskegon, MI 49442-1853
Facility Telephone #:	(231) 788-5156
Original Issuance Date:	05/23/2000
License Status:	REGULAR
Effective Date:	11/23/2020
Expiration Date:	11/22/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's personal care needs were not attended to by staff at the facility.	Yes
Resident A's medications were not administered as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

07/11/2022	Special Investigation Intake 2022A0356029
07/11/2022	APS Referral Gene Gray, Muskegon Co. DHHS, APS Worker.
07/11/2022	Special Investigation Initiated - Telephone Gene Gray, APS.
07/12/2022	Contact - Telephone call made Relative #1.
07/15/2022	Contact - Document Sent Linda Wagner, ORR, HealthWest.
07/15/2022	Inspection Completed On-site
07/15/2022	Contact - Face to Face Trina Bankhead, DCW, Mari Harris, DCW and Resident A. Also saw resident's B, C and D.
07/18/2022	Contact - Document Sent Channe Hicks, LD and Darreco Scott, home manager, requested facility documentation.
07/19/2022	Contact - Telephone call made Myra Dutton, executive director.
07/19/2022	Contact-Documents received Facility documentation
07/20/2022	Contact - Telephone call received Linda Wagner, ORR.

08/01/2022	Contact - Telephone call made Gene Gray, APS and Linda Wagner, ORR.
08/09/2022	Contact-Face to Face Gene Gray, Linda Wagner, DCW Joanne Douglas, DCW Trina Bankhead, LD Channe Hicks, ED Myra Dutton, Home Manager Darreco Scott.
08/19/2022	Contact-Document Received Resident A's MAR (medication administration record) for July 2022.
08/23/2022	Exit Conference-Licensee Designee Channe Hicks

ALLEGATION: Resident A's personal care needs were not attended to by staff at the facility.

INVESTIGATION: On 07/11/2022, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported on Sunday, July 10, 2022, at 11:30a.m., Resident A was still in her room at the facility, she had refused to get out of bed and the house smelled of urine and feces. Resident A was completely saturated in urine and "poop" with her pajamas still on and no briefs. The complainant reported the urine was "going over the mattress and on to the floor," the staff did not offer to assist getting Resident A to the bathroom, the complainant took Resident A herself, bathed her and cleaned her up, dressed her and put a brief on her. The complainant stated Resident A's toenails were over ½ inch long and the staff did not initially know where to find any clippers. The complainant reported staff found a pair of clippers and the complainant clipped Resident A's nails. The complainant reported Resident A did not have a brief on and staff stated "well the night nurse must not have put any on her then" which means night staff did not check on Resident A all night. In addition, Resident A refuses to allow anyone to brush her teeth and staff stated Resident A only allows Relative #1 to brush her teeth, Resident A's teeth are brown. The complainant reported Relative #1 has asked repeatedly for staff to clean Resident A's teeth and it has not been done in the 2 years Resident A has lived in this facility.

On 07/11/2022, I interviewed Adult Protective Services Worker, Gene Gray via telephone. Mr. Gray stated he went to the facility unannounced upon receiving this complaint and observed Resident A. She was clean, dressed appropriately and appeared as though her personal care needs were attended to. Mr. Gray stated he reviewed the complaint with the home manager, Darreco Scott. Mr. Scott informed Mr. Gray that he has recently stepped into the home manager role to fill-in for a vacancy they have. Mr. Gray stated Mr. Scott reported he was not present when the alleged incidents occurred, and he had not heard about the complaint until Mr.

Gray's contact. Mr. Gray stated Mr. Scott reported they have a lot of new staff at the facility.

On 07/12/2022, I interviewed Relative #1 via telephone. Relative #1 stated she went to visit Resident A on 07/10/22 at 11:30a.m. and as she approached the facility, she could see "a lot of scrambling" around inside and someone, a resident most likely, reached their hand out the door and locked the screen door so Relative #1 could not open the door. Relative #1 stated she was able to enter the facility after the screen door was unlocked and she asked where Resident A was. Relative #1 stated staff told her Resident A refused to get up and she was still in her room. Relative #1 stated no one called to inform her that Resident A would not get up, she (Relative #1) found Resident A in her room soaked in "pee and poop to her neck with no diaper on." Relative #1 stated Resident A is nonverbal and is not capable of "doing anything for herself" and that she relies on staff to take care of her. Relative #1 is not sure who the two staff were on this date but knows DCW (direct care worker) Joanne Douglas works the night shift and worked the night before her (Relative #1's) visit on 07/10/22. Relative #1 stated in a conversation she had with Ms. Douglas, she (Ms. Douglas) claimed that Resident A took her briefs off during the night, but Relative #1 stated Resident A is unable to dress or undress herself so more likely, Resident A never had briefs on when she went to bed on the evening of 07/09/2022. Relative #1 stated Resident A's toenails were ½ inch long on this date and she had to trim her nails and for the past two years, since Resident A moved into this facility, Relative #1 has been trying to get the staff at the facility to brush and clean Resident A's teeth. Relative #1 stated she is the only one who brushes Resident A's teeth. Relative #1 stated there is nothing in Resident A's plan that documents that she (Relative #1) would cut Resident A's nails or brush her teeth.

On 07/15/2022, I conducted an unannounced inspection at the facility. When I entered the facility, I observed Residents A & B, sitting at the dining room table. Resident A was appropriately dressed, and her hair was clean and styled. I inspected Resident A's room and it was clean and the bedding was dry and clean. The staff working on this date were Catrina Bankhead and Mari Harris. Ms. Harris stated she is a new DCW and was not working on 07/10/22. Ms. Bankhead stated she was working on 07/10/2022 when Relative #1 came to the facility to visit Resident A. I interviewed Ms. Bankhead privately in the office at the facility. Ms. Bankhead stated she went into Resident A's room and administered her 8:00a.m. medications but Resident A refused to get up that morning. Ms. Bankhead stated she always starts the morning with Resident A because she is the easiest to get up and ready if she is willing. On this day, Ms. Bankhead stated she attempted 2-3 times to get Resident A up, but she refused and pushed Ms. Bankhead so Ms. Bankhead stated she moved on to care for other residents. Ms. Bankhead stated she was caring for Resident C in Resident C's room and DCW, Nakenga Carter was sitting at the table when Resident D let Relative #1 in the facility on the morning of 07/10/2022. Ms. Bankhead stated Resident A also refused to get up for Relative #1 when she arrived. Ms. Bankhead stated Relative #1 informed her (Ms. Bankhead) that Resident A did not have a brief on and was wet. Ms. Bankhead stated Resident

A was wet but there was no BM (bowel movement) in the room as she would have smelled it and noticed it earlier when she attempted to get Resident A up. Ms. Bankhead stated Resident A did not have a brief on. Ms. Bankhead stated there was not a brief on the floor or anywhere around Resident A's room to indicate she had one on and somehow took it off. Ms. Bankhead stated she reviewed the staff notes from the previous shift and did not see anything documented that was out of the ordinary. The notes did not say Resident A refused to get ready for bed or to allow staff to put a brief on her. Ms. Bankhead stated Ms. Douglas worked the nightshift on 07/9/22-07/10/22 and would have gotten Resident A ready for bed. Ms. Bankhead called Ms. Douglas and asked about getting Resident A ready for bed and putting briefs on her and was reportedly told varying stories from Ms. Douglas about Resident A removing her own pajamas and taking the brief off herself. Ms. Bankhead stated Ms. Douglas told her Resident A dressed herself and forgot to put a brief on herself. In addition, Ms. Bankhead stated Resident A's pajamas are zip up onesie style and they are put on backwards, so she is unable to reach her brief. Ms. Bankhead stated Resident A is not able to dress and undress herself let alone put a brief on by herself. Ms. Bankhead stated Resident A refuses to do certain things when she is not used to staff or there is new staff that she does not know. Ms. Bankhead stated she noticed Resident A refusing to get up on Sundays when Ms. Carter worked and was the DCW initiating Resident A to get up. Ms. Bankhead stated they tried to have Ms. Bankhead get Resident A up, get her in to the bathroom and then Ms. Carter take over Resident A's care from there, but on 07/10/22 Resident A refused to get up for Ms. Bankhead.

Ms. Bankhead stated the staff that Resident A trusted to provide nail care and to brush her teeth, Annie Meyers left approximately 1 ½ months ago and for the past 1 ½ months, Ms. Bankhead stated she has attempted to brush Resident A's teeth and trim her toenails, but it "only happens if she (Resident A) allows it to happen" and therefore, there is not a consistent method of completing Resident A's nail clipping and teeth brushing.

During this inspection, I observed Resident A brushing her teeth while Ms. Harris was supervising, Ms. Harris was not aware this was part of the complaint allegation. Resident A's teeth did not appear brown in color. Ms. Bankhead stated Ms. Harris, while being a newer staff, has a way with Resident A and Resident A tends to do things for her. Ms. Bankhead and Ms. Harris do not know when the last time was that Resident A saw a dentist.

On 07/19/2022, I received and reviewed facility documentation for Resident A. I reviewed Resident A's assessment plan for AFC residents, signed by (former) home manager, Julie Pence and Relative #1. The assessment plan documents that Resident A requires assistance with toileting and describes Resident A's needs as, *'staff give reminders every 2 hours for bathroom.'* The assessment plan documents that Resident A requires assistance with grooming (hair care, teeth, nails) and describes Resident A's needs as, *'staff assist but she refuses her teeth brushing.'*

There is no further information describing what staff should do regarding Resident A's nail care or oral care if she refuses.

On 07/19/2022, I received and reviewed the HealthWest Skill and Behavior Support Plan written by Emily Ketelhut, LMSW, dated 05/04/2022. The behavior support plan documents, *'these are the least restrictive methods in order to keep (Resident A) safe and comfortable in her environment. Backwards pajamas, (Resident A) requires special PJs that zip in the back so that she cannot get to her feces, which she examines and smears. The PJs do not appear to bother (Resident A) due to the longevity of wearing the clothing.'*

On 07/19/2022, I received and reviewed the IPOS (Individual Plan of Service) for Resident A, facilitated by Caitlin Keglovitz, effective 05/04/2022-05/03/2023. The IPOS documents the following, *'Personal care services including eating/feeding, special dietary needs, bathing/showering, grooming, nail care and dressing will be provided to assist you in performing your own personal daily activities. Services are provided by HGA staff. Home staff will help (Resident A) by scheduling and providing transportation to all scheduled medical appointments in order for them to occur as needed and scheduled.'* The IPOS documents, '*OT (occupational therapy) Following staff assistance for set-up, (Resident A) will brush the front of her teeth 4 times then allow Virginia Home staff to complete oral care in the rest of her mouth for 60% of trials over the next 180 days.'* *Ms. Wagner stated medical appointments includes dental appointments.

On 07/19/2022, I received and reviewed the daily progress notes for 07/09/2022-07/11/2022. DCW Joanne Douglas documented on 07/09/2022, 2nd shift, *'Changed into pj's, voided in toilet.'* On 07/09/2022, Resident A's oral care is not documented as done on all three shifts. Ms. Douglas documented on 07/10/2022, 3rd shift, *'(Resident A) slept all night.'* Ms. Bankhead documented on 07/10/2022 progress notes that Resident A's nails were clipped, *'(Relative #1) clipped'* and Relative #1 completed *'oral cares'* during 1st shift.

On 08/09/2022, Mr. Gray, Linda Wagner, Office of Recipient Rights, Muskegon HealthWest, and I interviewed Ms. Douglas. Attending this interview were Licensee Designee, Channe Hicks, Home Manager, Darreco Scott and Executive Director, Myra Dutton. Ms. Douglas confirmed that Resident A wears a brief during the day and at night. Staff are to check Resident A every 2 hours even during nighttime hours however, staff try not to wake Resident A up. Ms. Douglas stated if they wake Resident A up during the night, she often will not go back to sleep and will be up all night and up all day long. Ms. Douglas stated the only way Resident A is wet during nighttime hours is if staff do not assist Resident A with toileting before she goes to bed.

Ms. Douglas stated when she arrived to work on 07/9/22, Resident A's bed was made but underneath the bedding were wet sheets and a wet bed pad, so she stripped the bed and washed everything and made up a clean bed for Resident A.

Ms. Douglas stated Resident A wears long pajamas with legs in them that zip up, because if Resident A has button up pajamas, she will rip them off. Ms. Douglas stated Relative #1 wanted her (Ms. Douglas) to put Resident A's pajamas on, not backwards as Resident A's plan directs but frontwards and so that is what she (Ms. Douglas) has been doing. Ms. Douglas stated if Resident A gets up in the morning at 6:30a.m., she takes care of Resident A's morning personal care, if Resident A will not get up until after 7:00a.m., she ends her shift at 7:00a.m. so Resident A's personal care will be left for the incoming shift. Ms. Douglas stated she thinks on 07/9/22-07/10/22, Resident A "ripped her brief off" or "she didn't have a brief on, and I didn't realize it." Ms. Douglas stated Resident A has to have a rapport with staff or she will refuse to participate in or allow staff to complete personal care.

Ms. Douglas stated she brushes Resident A's teeth when she works 2nd shift (3:00p.m.-11:00p.m.) because Resident A will allow Ms. Douglas to assist her with this. Ms. Douglas stated staff document brushing Resident A's teeth on the staff notes/progress notes and staff have attempted to take Resident A to dentist appointments, but Resident A refused to get out of the van once they arrived. Ms. Douglas was unable to tell us when this occurred was or when Resident A's last dental appointment was.

Ms. Douglas stated staff try to clip Resident A's nails however, she kicks and refuses. Ms. Douglas stated she has taken Resident A to the podiatrist in the past and promised Resident A McDonalds if she would allow the podiatrist to clip her nails and Resident A let them work on her feet.

Mr. Scott and Ms. Hicks stated typically, the home manager of the facility schedule dental appointments but Relative #1 does also. Mr. Scott and Ms. Hicks stated it is easier if the home manager schedules the appointments because it is easier to keep track of everyone's appointments if they do it. Mr. Scott and Ms. Hicks stated this facility has been without a steady home manager for a long time and only recently did Mr. Scott step in to assist until a full-time home manager can be put in place. Mr. Scott stated he will check to find out when Resident A's last dental visit occurred. Mr. Scott and Ms. Hicks stated Resident A's care plan in-service with staff is completed every 90 days, so staff should be up to date and knowledgeable about the care Resident A requires.

Mr. Scott stated Resident A's nail care is to be completed after she takes a shower, and it should be documented in staff notes/progress notes. Mr. Scott stated Resident A refuses to take her socks and shoes off for staff, so they try to provide nail care after a shower.

On 08/09/2022, Mr. Gray and Ms. Wagner interviewed Ms. Bankhead since they were not at the inspection at the facility. Ms. Bankhead reiterated much of the information she provided to me during the onsite inspection on 07/15/2022. Ms. Bankhead stated on 07/10/22, she requested that Relative #1 clip Resident A's toenails because Resident A refused. Ms. Bankhead stated Resident A was wet on

07/10/22 when Relative #1 came to the facility at 11:30a.m., Resident A did not have a brief on, but she knows for a fact that Resident A did not have BM on her pajamas, on her body or on her bedding because she washed Resident A's pajamas and sheets/bedding and there was no BM on them. Ms. Bankhead stated that she is not aware of anything in Resident A's plan that says Resident A must be woke up during nighttime hours for a brief change. Ms. Bankhead stated the plan documents that Resident A needs to be checked on but does not need to be changed every two hours. Ms. Bankhead stated Resident A could have been put to bed without a brief on and without a brief all night and morning long.

Ms. Dutton informed us Ms. Carter no longer works at the facility.

On 08/17/2022, I received an email from Ms. Wagner with forwarded information from Mr. Scott regarding Resident A's dental care. Mr. Scott reported, *'After searching for supporting documentation regarding (Resident A's) dental history I came up short. Unfortunately, there is no documentation for her dental appointments. I contacted her supports coordinator to see if they had any info. They did not. I was informed by staff that (Relative #1) usually handled those appointments, and she was working on getting her in a specific dentist. At this point in time, I am working on getting a referral for MCDC (Muskegon County Dental Care) and will get her in as soon as possible.'*

On 08/23/2022, I conducted an Exit Conference via telephone with Channe Hicks, Licensee Designee. Ms. Hicks stated she understands and agrees with the information, analysis, and conclusion of this applicable rule. Ms. Hicks will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Relative #1 reported Resident A did not have briefs on and was saturated with urine and feces on 07/10/2022. Resident A requires the use of briefs at all times, Resident A's toenails were ½ inch long on this date and Relative #1 stated she is the only one who brushes Resident A's teeth. Ms. Bankhead stated Resident A did not have a brief on and was wet on 07/10/2022. Ms. Bankhead stated to her knowledge, there is not anything in Resident A's plan that says Resident A must be woke up during nighttime hours for a brief change. Ms. Bankhead stated staff attempt to trim Resident A's toenails and brush her teeth but Resident refuses, so they only are able

	to complete those personal care duties when Resident A allows it. Ms. Bankhead and Ms. Harris acknowledged they do not know when Resident A saw a dentist last. Ms. Douglas confirmed that Resident A wears a brief at all times and staff are to check Resident A every two hours even during nighttime hours. Ms. Douglas stated she brushes Resident A's teeth and staff have attempted to take Resident A to dentist appointments, but Resident A refused. Ms. Douglas was unable to tell us when this appointment was or when Resident A's last dental appointment was. The assessment plan documents Resident A's need for staff assistance with toileting every 2 hours, teeth, and nail care. Daily progress notes document Resident A's nails clipped and oral care for Resident A completed on 07/10/22 by Relative #1. Daily progress notes document Resident A '*slept all night'* on 07/09/22-07/10/22. Resident A's IPOS documents that staff must assist Resident A with grooming, nail care, dressing, scheduling, and providing transportation to all medical appointments. Mr. Scott and Ms. Hicks stated the home manager of the facility schedule dental appointments but Relative #1 does also. Mr. Scott reported there is no documentation to show that Resident A's dental appointments. Mr. Scott stated Resident A's nail care is to be completed after Resident A takes a shower and documented in staff progress notes. Ms. Douglas stated staff try to clip Resident A's nails however, she often refuses. Based on investigative findings, Resident A's personal care needs such as reminders for toileting every two hours, which does not indicate daytime hours only, as well as dental and nail care are not being attended to per Resident A's assessment plan, IPOS and Behavior Treatment Plan. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's medications were not administered as prescribed.

INVESTIGATION: On 07/11/2022, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported Resident A's morning medications were not administered as prescribed because staff did not get her out of bed until after 11:30 in the morning.

On 07/12/2022, I interviewed Relative #1 via telephone. Relative #1 stated she went to visit Resident A on 07/10/22 at 11:30a.m. and does not think Resident A was given her 8:00a.m. medications because she was still in bed.

On 07/15/2022, I conducted an unannounced inspection at the facility. I interviewed Ms. Bankhead who stated she was working on 07/10/2022 when Relative #1 came to the facility to visit Resident A. Ms. Bankhead stated while Resident A refused to get up and ready for the day, she was awake during the 8:00a.m. medication pass and Resident A's medications were administered by Ms. Bankhead and taken by Resident A.

On 07/19/2022, I received and reviewed staff progress notes dated 07/10/2022, Ms. Bankhead documented, *'(Resident A) was asleep, she woke up and took her meds, then layed back down. She refused to get up 4x, (Relative #1) stopped by and she got her up and dressed, all meds and treatments were complete, no BM, (Relative #1) was upset, she didn't have a brief on, no other concerns.'*

On 8/19/2022, I received and reviewed Resident A's Medication Administration Record (MAR) for the month of July 2022. The MAR documents Resident A's 8:00a.m. medications on 07/10/2022 were administered and signed as administered by staff initials of CB1, Catrina Bankhead. The medications are as follows, *'Budesonide/Pulmicort, sus 0.5mg/2 inhale contents of 1 vial via nebulizer twice daily, Calcium 600, take one tablet by mouth once daily, Famotidine/Pepcid, 20 mg tab, take one tablet by mouth twice daily, Fluticasone/Flonase, 50 mcg, use two sprays in each nostril once daily, Lamotrigine/Lamictal 100 mg, take one tablet by mouth twice daily, Polyeth GLYC POW 3350 NF, Risperidone tab 1 mg, take one tablet by mouth three times daily in the morning, at 11a.m. and in the evening, Thera-M tabs, take one tablet by mouth once daily, Trazodone, tab 150 mg, take ½ tablet by mouth three times daily.'*

08/23/2022, I conducted an Exit Conference via telephone with Channe Hicks, Licensee Designee. Ms. Hicks stated she understands and agrees with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist.

	Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Relative #1 stated she went to visit Resident A on 07/10/22 at 11:30a.m., Resident A was still in bed, and she does not think Resident A was given her 8:00a.m. medications. Ms. Bankhead stated she passed Resident A's 8:00a.m. medications on 07/10/2022 and Resident A took the medications. Staff progress notes dated 07/10/2022, documented, *'(Resident A) was asleep, she woke up and took her meds'* and was signed by Ms. Bankhead. Resident A's MARs documents that Ms. Bankhead administered, and Resident A took all of her 8:00a.m. prescribed medications on 07/10/2022. Based on investigative findings, there is not a preponderance of evidence to show that staff failed to administer Resident A's 8:00a.m. medications on 07/10/2022. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS

Investigation: On 07/19/2022, I received and reviewed the assessment plan for AFC residents. The plan is dated 03/25/2020 and signed by Julie Pence, former home manager and Relative #1.

On 08/23/2022, I conducted an Exit Conference via telephone with Channe Hicks, Licensee Designee. Ms. Hicks stated she understands and agrees with the information, analysis, and conclusion of this applicable rule. Ms. Hicks will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on investigative findings, Resident A's assessment plan has not been updated since 2020. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Elizabeth Elliott

08/23/2022

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

Jerry Hendrick

08/23/2022

Jerry Hendrick
Area Manager