GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 8, 2025

Sherman Taylor
Taylor's Special Care Services, Inc.
Ste 210
Southfield, MI 48034

RE: License #: AS630405301
Investigation #: 2025A0991004
Winchester Home

Dear Sherman Taylor:

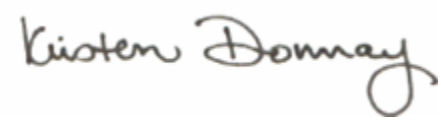
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
3026 W. Grand Blvd. 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

I. IDENTIFYING INFORMATION

License #:	AS630405301
Investigation #:	2025A0991004
Complaint Receipt Date:	11/12/2024
Investigation Initiation Date:	11/12/2024
Report Due Date:	01/11/2025
Licensee Name:	Taylor's Special Care Services, Inc.
Licensee Address:	23800 West Ten Mile Rd Ste 210 Southfield, MI 48034
Licensee Telephone #:	(248) 350-0357
Licensee Designee:	Sherman Taylor
Name of Facility:	Winchester Home
Facility Address:	21001 Winchester Street Southfield, MI 48076
Facility Telephone #:	(248) 350-0357
Original Issuance Date:	01/26/2021
License Status:	REGULAR
Effective Date:	07/26/2023
Expiration Date:	07/25/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/05/2024, Resident A signed out and went into the community without staff supervision. She was returned to the home by law enforcement. Later that day, Resident A physically assaulted Resident B. Resident A was taken to the hospital for psychiatric care and Resident B was treated at the Emergency Department for injuries sustained from the assault. Resident A requires 1:1 staffing within eyesight at all times.	Yes
Resident B missed five doses of Clonazepam (Klonopin) in October 2024.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/12/2024	Special Investigation Intake 2025A0991004
11/12/2024	Special Investigation Initiated – Telephone Contacted assigned Office of Recipient Rights (ORR) worker, Natalie Hall
11/12/2024	Referral - Recipient Rights Received from Office of Recipient Rights
11/13/2024	APS Referral Received additional information from Adult Protective Services (APS) assigned to Taneisha Sims
11/13/2024	Contact - Telephone call made To assigned ORR worker, Natalie Hall
11/13/2024	Contact - Telephone call made To assigned APS worker, Taneisha Sims, left message
11/14/2024	Contact - Telephone call received Return call from APS worker, Taneisha Sims
11/16/2024	Contact - Document Received

	Resident A's individual plan of service, behavior plan, and incident reports
11/19/2024	Inspection Completed On-site Unannounced onsite inspection- interviewed Resident B, home manager, area manager, and staff
11/19/2024	Contact - Document Received Medication records, physician contacts
11/20/2024	Contact - Telephone call made To Easter Seals Behaviorist, Mark Lakier
11/22/2024	Contact - Telephone call made To Easter Seals Case Manager, Sherry VanHulle
11/27/2024	Contact - Document Sent Request for additional documentation sent
12/03/2024	Contact - Document Received Resident A's behavior logs, incident reports, plan of service, daily logs
12/18/2024	Contact - Telephone call received From Natalie Hall- additional allegations re: Resident B
01/08/2025	Exit Conference Left message for licensee designee, Sherman Taylor

ALLEGATION:

On 11/05/2024, Resident A signed out and went into the community without staff supervision. She was returned to the home by law enforcement. Later that day, Resident A physically assaulted Resident B. Resident A was taken to the hospital for psychiatric care and Resident B was treated at the Emergency Department for injuries sustained from the assault. Resident A requires 1:1 staffing within eyesight at all times.

INVESTIGATION:

On 11/12/24, I received a complaint from the Office of Recipient Rights (ORR), alleging that staff did not provide appropriate supervision to Resident A. On 11/05/24, Resident A signed out and went into the community without staff supervision. She was returned to the home by law enforcement. Later that day, Resident A physically assaulted Resident B. Resident A requires one on one staffing, and she is to always be within

eyesight. The complaint was referred to Adult Protective Services (APS), and it was assigned to Taneisha Sims for investigation.

I initiated my investigation on 11/13/24 by contacting the assigned Office of Recipient Rights (ORR) worker, Natalie Hall. Ms. Hall stated that she regularly receives phone calls from Resident B regarding issues at the home. Resident B was assaulted by Resident A in September 2024, and she had concerns when Resident A returned to the home, because she did not feel safe. Last week, Resident B was beaten up by Resident A again. Resident B went to the hospital following the attack, and she is still having headaches as a result. Ms. Hall stated that Resident A has a behavior plan, which states she needs one on one supervision and should be within eyesight of staff 24/7. She stated that prior to the attack on 11/05/24, Resident A went into the community by herself. She was returned to the home by the police after going to a Jewish Community Center. Resident A has a history of self-harming behavior and has been aggressive towards staff.

I received and reviewed copies of Resident A's Individual Plan of Service (IPOS) Addendum completed by Easter Seals case manager, Sherry VanHulle, dated 10/16/2024, as well as her Behavioral Assessment Plan completed by Easter Seals behaviorist, Mark Lakier, dated 05/16/2024. I noted the following relevant information from the documents:

Resident A's IPOS Addendum dated 10/16/2024 states:

- If (Resident A) is facing a mental health crisis, Taylor Special Care Winchester Home will call 911 and have (Resident A) taken to the nearest emergency room for evaluation. Home will contact SRS (Supported Residential Services) Case Manager and SRS RN will be provided with outcome of hospital contact.
- Winchester Home staff will accompany (Resident A) at all times in the event of a personal safety emergency and will remain with (Resident A) until a determination is made by medical staff.

Resident A's IPOS Addendum includes the following goal for Resident A with an implementation date of 03/12/2024 and a target date of 03/11/2025:

- "I would like to go out for walks and out to the store. I will sign in and out of the home when I go out into the community. I will be home for times that are medication administration times. If I am lost or in a crisis, I will call Winchester home to provide my location."
- Intervention: (Resident A) has full community access.

Resident A's IPOS Addendum notes that the purpose of the addendum is to add a goal and objective for a behavior plan. It includes the following goal and objectives for a behavior plan with an implementation date of 10/16/2024 and target date of 03/11/2025:

- (Resident A) will be provided with the following interventions for behaviors:
  - Self-Injurious Behavior
  - Inappropriate Access of Emergency Services
  - Verbal Aggression
  - Physical Aggression
- Winchester Home will be trained on interventions for the above behaviors.
- SRS behavior specialist will review behavior plan quarterly or with more frequency when warranted.
- Intervention: Winchester Home will follow behavior plan interventions.

Resident A's Behavior Assessment Plan dated 05/16/2024 notes the following:

- (Resident A) was referred for a behavioral assessment due to concerns of verbal aggression, physical aggression, elopement, inappropriate contact of emergency services and safety for herself and others in the community.

The Behavior Assessment Plan notes the following as a reactive strategy to Resident A's behaviors:

- Responding to Physical Aggression
  - Safety is of primary concern during instances of physical aggression. It is imperative that (Resident A) and the individual that the aggression is directed toward are separated so that the process of de-escalation can continue. Whenever possible, two staff should be involved in the situation so that one staff can attend to each individual involved. Additionally, staff should quickly check the environment to ensure that any dangerous items that could be used as a weapon are secured safely.

The Behavior Assessment Plan notes the following proposed restrictions for Resident A:

- (Resident A) must remain within eyesight of staff when accessing the community.
- Rationale & Criteria for Removal:
  - (Resident A) has a history of self-injurious behavior and aggression that places her at risk of harm if not monitored by staff. For this reason, it is recommended that this restriction remains in place until the following criteria is met:
    - (Resident A) has had zero incidents of self-injury for six consecutive months.
    - Once meeting criteria for removal, it is recommended that community access is reintroduced gradually, beginning with short periods of time. This will be explored further by the Behaviorist when (Resident A) is nearing criteria for removal.

- (Resident A) will be provided with 1:1 staffing for 24 hours daily.
    - 1:1 staffing is to be in eyesight of her at all times (including her room). (Resident A) is allowed to use the bathroom with the door closed. Staff should remain outside the door with ability to listen for concerning behaviors. When (Resident A) is actively sleeping the door is allowed to be closed. While she is sleeping, staff should remain outside the door and be able to listen for when she awakes. Once (Resident A) awakes she should be in eyesight of staff. (Only as 1:1 authorizations are approved by OCHN)
- Rationale & Criteria for Removal:
    - (Resident A) has a significant history of self-harm, causing a significant safety concern. For these reasons, it is recommended that (Resident A) be provided with 1:1 staffing 24 hours daily. This restriction remains in place until the following criteria is met:
        1. (Resident A) has had 30 consecutive days of zero incidents self-harm.
        2. Once meeting these criteria, it is recommended that (Resident A)'s 1:1 staffing is faded to 16 hours per day.
        3. Once (Resident A) has had another 30 consecutive days of zero incidents of self-harm, 1:1 staffing will be faded to 8 hours per day.
        4. Once (Resident A) has had another 30 consecutive days of zero incidents of self-harm use 1:1 staffing will be discontinued.

On 11/19/24, I conducted an unannounced onsite inspection at Winchester Home with the assigned ORR worker, Natalie Hall. I interviewed Resident B. Resident B stated that she was physically attacked by Resident A. She was sitting in her room on her bed when she heard loud noises. Suddenly, she felt intense head pain. Resident A grabbed her hair, which was in a bun, and pulled her onto the ground, which hurt her knee. Resident A was punching her and pushing her face into the ground. Resident B was screaming for help. Resident B stated that Resident A then went downstairs and was pulling mirrors off the wall, trying to slit her wrists. Resident B stated that she could not get up following the attack. The other residents who live in the home had to help her up. She stated that nobody else was in the room when it happened. There was only one staff person, Katie, on shift when it happened. Katie was downstairs at the time of the attack. Resident B stated that she was not arguing with Resident A, and did not do anything to prompt the attack. She stated that Resident A is "psychotic." Resident A "plays Jesus music and laughs." Resident B stated that she had a concussion as a result of the attack. She has been having problems thinking.

Resident B stated that this was the second time she was attacked by Resident A. About three weeks earlier, Resident B was sitting down to eat cereal when Resident A grabbed the bowl and smashed it on her head. The bowl broke and cereal went all over the place. Resident A grabbed her bun and pushed her onto the ground. She was

ripping Resident B's hair out. Resident A ran to get a knife to stab her, but staff, Katie, stopped her. Resident A went to the hospital following this incident, but they brought her back to the home. Resident B stated that to go through this twice is unnecessary. Resident B stated that the owners know what a scary person Resident A is, and she cannot believe they brought her back to the home for it to happen a second time. Resident B stated that there is usually only one staff working at the home, but sometimes there are two staff during the day. She stated that both incidents happened at night when there was only one staff on shift.

On 11/19/24, I interviewed direct care worker, Katie Yancey. Ms. Yancey stated that she has worked at the Winchester Home for two years. She typically works from 4:00pm-12:00am. Before she came in for her shift on 11/05/24, she received a phone call from the Bloomfield Hills Police. They stated that they had Resident A, because she was at the Jewish Center in Bloomfield Hills. Ms. Yancey stated that she was not on shift yet, so she got the police in contact with the home manager. Ms. Yancey arrived for her shift at 4:00pm and Resident A was not yet back at the home. She stated that the police brought Resident A back to the house by 5:00pm. Resident A told her that she caught the bus and went downtown. Somebody then came and picked her up and took her to Bloomfield.

After being dropped off at the home, Resident A was sitting at the dining room table listening to music, which had the lyrics, "I got murder on my mind." Ms. Yancey then heard a phone ringing, as Resident A was calling somebody on speaker phone. Resident A called the police and asked them to send someone to the house, because she wanted to kill herself. Resident A then went into the kitchen and threw everything off the stove. She ran into the bathroom, grabbed the air freshener, and sprayed Ms. Yancey in the face. Ms. Yancey tried telling Resident A that she could not do that. Ms. Yancey went to make sure the knives were locked up, and Resident A ran upstairs. Ms. Yancey heard screams coming from upstairs. She ran upstairs and Resident A was on Resident B's back. Resident B was on the floor with her head down. Resident A was pulling her hair and throwing punches. Ms. Yancey told Resident A to stop. Resident A then ran towards Resident C. Ms. Yancey was blocking Resident A to prevent her from getting to Resident C. Resident A then ran into the bathroom and started tearing up the bathroom. Ms. Yancey called 911 and told them to hurry up and get to the home. When the police and EMS arrived, they convinced Resident A to come out of the bathroom. Resident A had horizontal slits down her arms and was bleeding. Resident A and Resident B were both sent to the hospital. Ms. Yancey stated that she was the only staff on shift at the time, so she could not go to the hospital with them. They do not have any staff on-call. Ms. Yancey stated that when she came to work the next day, Resident B was back in the home. She was complaining that her head was hurting and stayed in bed for most the day during her shift. Resident B told Ms. Yancey that she did not have her discharge papers from the hospital, but they told her she had a concussion.

Ms. Yancey stated that she was not aware of Resident A requiring 1:1 staffing. She stated that they typically have two staff on first shift from 8:00am-4:00pm and one staff

on second and third shifts from 4:00pm-12:00am and 12:00am-8:00am. She stated that she felt they needed two staff on shift when they have residents who may harm themselves or others, such as Resident A, in the home. Ms. Yancey stated that after the initial incident when Resident A physically assaulted Resident B in September, they were told that they needed to have two staff on shift. They had two staff on first and second shifts for a couple of weeks and then it stopped. Ms. Yancey stated that Resident A has a behavior plan, and staff check off her behaviors on a tracking sheet. She stated that she never saw Resident A's behavior plan. She stated that nobody came to the home and trained staff specifically regarding Resident A's behavior plan. Ms. Yancey stated that Resident A is allowed to sign herself out to go to the store or to go for a walk. She was not aware of Resident A's plan stating that she needed 24 hours supervision or supervision in the community.

On 11/19/24, I interviewed the area manager, DeJana (DJ) Hernandez. Ms. Hernandez stated that she has worked for the company for 13 years and has been an area manager for the last two years. Ms. Hernandez stated that on 11/05/24, she was at the home with the residents while the home manager, Roxanne, was out on an appointment. Ms. Hernandez stated that Resident A wanted to go to the gas station on Lahser. She asked Resident A to wait until Roxanne came back, as Resident A's gait can be a little wobbly sometimes. Resident A did not want to wait. She signed out and left to go to the gas station around 1:00pm. Around 4:00pm, Resident A had not returned to the home yet. Ms. Hernandez told the home manager to contact Resident A's case manager, call the police non-emergency number, and let the next staff on shift know. Ms. Hernandez stated that after she left the home, she received a call from Roxanne letting her know that she heard from the police, who had picked Resident A up from a church and were bringing her back to the home. Ms. Hernandez stated that she was not at the home when Resident A came back. Ms. Hernandez stated that Resident A is allowed to sign out and go into the community per her individual plan of service (IPOS). She stated that she was aware that Resident A had a behavioral treatment plan, and there is a contradiction between the IPOS and behavioral treatment plan. The behavior plan recommends one on one staffing for Resident A. She stated that they had a copy of Resident A's behavior plan in the home. Ms. Hernandez stated that she informed the program manager, Stuart Grant, of this staffing recommendation. She stated that she did not recall when they received the behavior plan or when she spoke to Mr. Grant, but it was a couple weeks before the incident on 11/05/24. Mr. Grant stated that he would speak to Resident A's case manager about the plan. Resident A's IPOS was amended to state that they were to follow the behavior plan. Ms. Hernandez stated that they had a corporate management meeting on or around 10/21/24. During this meeting, they discussed the need for one-on-one staffing for Resident A. The administrators stated that they did not have staff for that. Ms. Hernandez stated that they typically have two staff on the morning shift, one staff on the afternoon shift, and one staff on the midnight shift. She stated that this is not enough staff with Resident A in the home. Ms. Hernandez stated that she allowed Resident A to go into the community, even though the behavior plan stated she needed one-on-one staffing and could not

access the community without supervision. She stated that Resident A was going to go regardless. She asked her to wait for Roxanne, as Roxanne would have taken her, but Resident A wanted to go right away. Ms. Hernandez stated that they did not put any extra measures in place to protect Resident B, after Resident A assaulted her in September. She stated that they had extra staff “for a minute,” but then things were quiet for a while, until the next incident happened in November.

On 11/19/24, I interviewed the home manager, Roxanne Turner. Ms. Turner stated that she was not at the home on 11/05/24, when Resident A signed herself out, as she was on an appointment. She stated that the police called her and told her that Resident A was at the Jewish Center. They asked her to come get her, but she was the only staff on shift, so she could not leave to get her. The police ended up bringing Resident A back to the home. Ms. Turner stated that someone at the Jewish Center called the police, because Resident A just walked in there. After she returned to the home, Resident A seemed fine. She was laughing and playing on her tablet. She did not appear to be agitated when Ms. Turner left the home. Ms. Turner stated that she was aware that Resident A had a behavior treatment plan, but she was not sure when they received it. She stated that they received a hard copy of the plan from the office. Staff have to read it over and acknowledge what it says. She stated that she was aware of the recommendation for one-on-one staffing, but this was never done. She did not know why the staffing was never put in place. Ms. Turner stated that nobody ever came to the home to train them on the behavior plan. She stated that they just received the behavior sheets and read over what they have in place. The behaviorist came to the home to conduct an assessment but did not have a conversation regarding the recommendations. Ms. Turner stated that the area manager, DJ, brought up the staffing issue to administration in the office, but she personally never had a conversation with anyone about it. Ms. Turner stated that she felt they needed a second staff person on the afternoon shift, as that is the shift when a lot goes on at the home. She stated that at times they did have a second staff on the afternoon shift, but it was not on a day-to-day basis. Ms. Turner stated that Resident A is allowed to go into the community per her IPOS. She was not aware that the behavior plan stated she needed supervision in the community. Ms. Turner stated that she always said Resident A should not be going out alone anyway, because she is not steady on her feet. She did not bring this up with anybody. Ms. Turner stated that she did not see Resident A’s behavior plan until September. She stated that they did not put any extra safety measures in place after Resident A assaulted Resident B in September. They were just closely monitoring her. No additional staff were put on shift.

On 11/20/24, the assigned ORR worker, Natalie Hall, and I interviewed Mark Lakier, the behaviorist from Easter Seals, via telephone. Mr. Lakier stated that he completed a behavioral assessment for Resident A on 05/16/24. At that time, Resident A was residing in a different licensed adult foster care facility. Resident A was discharged from that home and moved to Winchester Home following a psychiatric hospitalization in August. Mr. Lakier stated that the staff at Winchester Home were trained on Resident A’s behavioral plan. He could not recall the date, nor could he locate any documentation

showing what date staff were trained. He stated that he was with Resident A's case manager, Sherry VanHulle, when they conducted the training. Mr. Lakier stated that Resident A was previously living at the Winchester Home about a year to a year and a half ago. She was doing really well at the home, but then she had a dental issue, which led to her contracting a brain disease. Resident A had brain surgery and could not initially return to Winchester due to mobility issues. He stated that while Resident A was at the other AFC home, she was having significant behaviors. The behavioral plan was put in place, and Resident A was hospitalized due to her behaviors. When she was ready for discharge, there were no placements available. The Winchester Home agreed to take her back, but they were not able to provide one to one staffing, as they did not have enough staff. Mr. Lakier stated that the recommendation at the time of Resident A's placement was for her to have one to one staffing, and he felt she needed, and would benefit from, this staffing pattern. Mr. Lakier stated that he and Resident A's case manager knew that the home could not provide the appropriate staffing, but she was still placed in the home because she was being discharged from the hospital and needed a placement. He was not sure if the case manager ever submitted an authorization request to the county for the enhanced staffing. Mr. Lakier stated that Resident A was required to be within eyesight of staff in the community. This requirement was in place at the time she moved into the home. He stated that he did train staff regarding this supervision requirement. Mr. Lakier stated that Resident A was very compulsive and reactionary. She has a significant history of verbal and physical aggression in her placements, as well as self-harm and suicidal ideations. Her behavior is unpredictable and impulsive. It cannot be attributed to any antecedent and there are no known triggers. Mr. Lakier stated that "in a perfect world" he would never have wanted Resident A to share a room with another individual, especially without one-to-one staffing. He stated that no other homes would accept Resident A, so they had to go with the placement that agreed to take her, even if it was not a perfect fit.

On 11/20/24, the assigned ORR worker, Natalie Hall, and I interviewed Sherry VanHulle, Resident A's case manager from Easter Seals, via telephone. Ms. VanHulle stated that Resident A moved to a different AFC home after she had brain surgery because she was using a walker and wearing a helmet, so she required a barrier free placement. While she was at the other AFC home, a behavioral treatment plan was added to her care requiring one to one staffing and requiring staff supervision while in the community. Ms. VanHulle stated that Resident A was displaying aggressive and assaultive behaviors towards herself and others, as well as property destruction. Resident A was hospitalized for behavioral reasons in July 2024, and her home issued an emergency 24-hour discharge notice due to her assaultive and destructive behaviors. Resident A was ready to be discharged from the hospital in August 2024, but she did not have a placement. Prior to her brain surgery, Resident A was residing at the Winchester Home. Resident A could now ambulate, and she stated that she wanted to go back to the Winchester Home. Ms. VanHulle stated that the licensee, Taylor's Special Care, knew about Resident A's history of self-harm, aggression, and property destruction. Resident A was previously on a very high dose of Clozaril with a clinical

range of 600 when living at the Winchester Home prior to her brain surgery, and she was doing pretty well. Resident A was not on Clozaril while she was in the hospital, so the psychiatrist had to re-initiate a titration plan. Resident A's Clozaril was not at a therapeutic level, as it was in the 100 range. Ms. VanHulle stated that Taylor's Special Care was aware that Resident A had a behavioral plan with one-to-one staffing and that her Clozaril was not in the clinical range when they agreed to take her back into the home in August. Ms. VanHulle stated that there was conversation with the licensee designee, Sherman Taylor, and the area director, Stuart Grant of Taylor's Special Care about Resident A needing one to one staffing before she moved back into the home. They stated that they did not have enough staff to provide one to one staffing. She told them that she would request funding through Oakland Community Health Network (OCHN) for the enhanced staffing, but they again stated that they did not have enough staff to provide it. Ms. VanHulle stated that she needed to find a placement for Resident A immediately, as Resident A was about to go "sub-acute" meaning that Medicaid would no longer pay for her to be in the hospital. Ms. VanHulle stated that Resident A was placed at Winchester Home even though Taylor's Special Care stated they could not provide the required staffing. She did not submit the request to OCHN for enhanced staffing, because Taylor's Special Care stated that they could not provide one to one staffing. Ms. VanHulle stated that Resident A required a higher level of staffing, and this would have been in her plan if the home had been able to provide it.

Ms. VanHulle stated that she went to the home with the behaviorist, Mark Lakier, and they trained the home manager, Roxanne, on the behavior plan, including the requirement for eyes on supervision in the community and one on one staffing. There were no other staff in the home at the time. She did not have documentation indicating what date the training took place. She stated that the behaviorist typically completes the training log. She stated that she usually visited the home from 9:00am-4:00pm, and the home manager, Roxanne, was typically the only staff at the home. Ms. VanHulle stated that Resident A was "doing well" initially when she moved back into the home in August. Then there started to be concerns. Resident A did not like having a roommate. She threw food and dragged staff down the stairs by their hair. Ms. VanHulle stated that on 10/16/24, she completed an addendum to Resident A's IPOS and put in the request for enhanced staffing due to Resident A's behaviors. She stated that she verbally informed Stuart Grant that she completed the addendum and request for one-to-one staffing. Mr. Grant told her that they could not provide the staffing. With regards to access to the community, Ms. VanHulle stated that Resident A had independent access to the community until the behavior plan was re-implemented and the addendum to the IPOS was completed on 10/16/24. Ms. VanHulle stated that the goal of Resident A signing in and out when going into the community should have been discontinued in the addendum to the IPOS, as this contradicted the information in the behavior plan, but she made an error and did not discontinue the goal. She stated that nobody from Taylor's Special Care contacted her about the discrepancy in the plans.

I received and reviewed a copy of an immediate discharge notice issued by Taylor's Special Care Services on 11/05/24 for Resident A. The letter indicates that an

immediate discharge is being given due to Resident A's physical aggression towards the home staff and persons served.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Winchester Home did not have sufficient direct care staff on duty for the supervision and protection of the residents and to provide the services outlined in their assessment plans on 11/05/24 when Resident A went into the community without supervision and later assaulted Resident B. Resident A has a history of physical aggression towards staff and residents. She previously assaulted Resident B in September 2024. Resident A's IPOS addendum dated 10/16/24 notes that staff are to follow her behavior plan, which recommends a 1:1 staffing ratio for Resident A and states that there should be two staff to intervene if Resident A is being physically aggressive. Katie Yancey was the only direct care worker on shift on 11/05/24 when Resident A assaulted Resident B. The behavior plan also notes that Resident A must remain within eyesight of staff while accessing the community. On 11/05/24, Resident A signed herself out and went into the community without staff supervision. The area supervisor, DJ Hernandez, was covering a shift at the home and there was no staff available to accompany Resident A in the community. The staff at the home did not have a clear understanding of the level of supervision required while Resident A was in the community, as there were contradictions between the behavior plan and IPOS. Resident A's IPOS addendum also states that staff should accompany Resident A in the event of a personal safety emergency and remain with her until a determination is made by medical staff. Staff were unable to accompany Resident A or Resident B to the hospital on 11/05/24, as there was only one staff person on shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the licensee accepted Resident A into the home when they could not provide the appropriate level of supervision and protection. Resident A's behavior assessment plan was completed on 05/16/2024 and recommended 1:1 supervision due to self-injurious behavior, inappropriate access of emergency services, verbal aggression, and physical aggression. Resident A's case manager from Easter Seals, Sherry VanHulle, informed the licensee of Resident A's behavior plan at the time of placement, but Taylor's Special Care stated that they did not have the staff to provide one to one staffing for Resident A. They accepted Resident A into the home without the appropriate staffing or behavior plan in place due to their inability to provide an adequate number of staff. Furthermore, the layout of the home does not permit staff to closely monitor the residents, as it is a two-story home, and the resident bedrooms are located upstairs where there is very little room for staff to sit to monitor the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 staff did not ensure Resident B's safety and protection at all times. Resident B was physically assaulted by Resident A on 11/05/24, and she stated that she was still suffering from headaches. Resident B was previously assaulted by Resident A in September 2024. The area manager, DJ Hernandez, and home manager, Roxanne Turner, both stated that no additional safety measures were put in place following the assault on Resident B in September. There was only one staff on the afternoon shift when Resident B was attacked by Resident A on 11/05/24. The staff was also attacked by Resident A and was unable to intervene in a timely manner to prevent Resident B from getting injured.
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, Winchester Home did not implement the behavior interventions that were developed to address Resident A's unacceptable behavior. Resident A's IPOS addendum dated 10/16/24 notes that staff are to follow Resident A's behavior plan. The behavior plan recommends a 1:1 staffing ratio for Resident A and states that there should be two staff to intervene if Resident A is being physically aggressive. Winchester Home continued to operate with one staff on the afternoon and midnight shifts after the addendum to the IPOS was completed to implement the behavior plan. Staff also continued to allow Resident A to sign in and out of the home and access the community without staff supervision, despite the behavior plan stating that Resident A needed to be within eyesight of staff in the community. There

	were discrepancies between Resident A's behavior plan and IPOS, which were not corrected, causing confusion regarding the implementation of the plans. Staff were not sufficiently trained regarding the implementation of the behavior plan, as they did not know the supervision requirements.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B missed five doses of Clonazepam (Klonopin) in October 2024.

INVESTIGATION:

The complaint also alleged that Resident B missed five doses of her Clonazepam (Klonopin) in October 2024. On 11/19/2024, I conducted an unannounced onsite inspection at Winchester Home with the assigned ORR worker, Natalie Hall. I interviewed the home manager, Roxanne Turner. Ms. Turner stated that Resident B ran out of Klonopin (Clonazepam) at the beginning of October. She went two and a half days without the medication and missed five doses. She missed the am and pm doses on 10/05/24 and 10/06/24, as well as the pm dose on 10/07/24. Ms. Turner stated that the medication needs to be authorized by Resident B's psychiatrist, and she needs to have an appointment with the psychiatrist before they will refill the medication. She had a Zoom video call set up with the psychiatrist, but Resident B ran out of medication before the appointment. She did not know the date of the scheduled appointment. Ms. Turner stated that she was not the one passing medications, and she was not aware that Resident B was running low. Staff did not notify her that the medication was about to run out. The home does not have a medication coordinator, so Ms. Turner is responsible for making sure medications are in the home. She stated that she goes through medications each month to make sure they are in the home. Staff do not do pill counts. She did not have a method for keeping track of when medications would be running out. Ms. Turner stated that she spoke to Resident B's doctor about the medication running out, but she did not have any documentation regarding this conversation.

I reviewed a copy of Resident B's October 2024 Medication Administration Record (MAR). It notes that Resident B did not receive Clonazepam (Klonopin) Tab 1mg- Take 1 tablet by mouth twice daily at 8:00am on 10/05/24, 10/06/24, or 10/07/24. She did not receive the 8:00pm dose on 10/05/24 or 10/06/24. Staff made a note on the back of the MAR indicating that the medication was not in the home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident B did not receive Clonazepam (Klonopin) Tab 1mg- Take 1 tablet by mouth twice daily at 8:00am on 10/05/24, 10/06/24, or 10/07/24. She did not receive the 8:00pm dose on 10/05/24 or 10/06/24. The home manager stated that staff did not report to her that Resident B was running low on medication. Resident B needed to see the psychiatrist prior to the medication being refilled. This was not completed prior to Resident B running out of her medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Resident B did not receive her Clonazepam (Klonopin) Tab 1mg- Take 1 tablet by mouth twice daily at 8:00am on 10/05/24, 10/06/24, or 10/07/24. She did not receive the 8:00pm dose on 10/05/24 or 10/06/24. There was no documentation on file showing that a health care professional was contacted regarding the missed medication and what instructions were provided. The home manager stated that she contacted Resident B's physician, but she did not have any documentation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 11/19/24, Resident B stated that staff have not been following up regarding her medical appointments. She stated that she was supposed to go to the doctor four days ago, but the home manager, Roxanne, could not take her, so the appointment was rescheduled for one month from now. She stated that the home manager “had other things to do” and could not take her to the appointment. Resident B stated that staff usually tell her to schedule her own appointments, but then they cannot take her. This has been an ongoing concern.

On 11/19/24, I interviewed the home manager, Roxanne Turner. Ms. Turner stated that Resident B keeps trying to schedule her own appointments, and she does not check with staff to see if they can take her to the appointments. Staff took her to an appointment with the neurologist on 11/13/24, but the neurologist had an emergency and needed to leave before seeing Resident B. The appointment was rescheduled for 11/30/24, but it was for 3:30 or 4:00pm, so staff could not take Resident B, as they only have one staff on second shift. The appointment was then rescheduled for 12/10/24. Ms. Turner did not have copies of Resident B’s discharge paperwork from her hospital visit on 11/05/24, and she was not aware of what the recommendation was for follow-up after the hospital visit. She stated that Resident B was discharged from the hospital at 5:00am and took an Uber back to the home. Resident B did not provide any discharge paperwork to staff, and they have not been able to obtain it from the hospital or Resident B’s patient portal.

On 12/18/24, I received additional information from the assigned ORR worker, Natalie Hall, stating that on 12/03/2024, Resident B made a verbal complaint to ORR in which she reported the staff at the Winchester Home failed to follow the presurgical preparation provided by her surgeon’s office, resulting in her hernia surgery being cancelled. Resident B stated that she was scheduled to have three hernias removed on Thanksgiving Day, but the surgery was unable to be completed, because the home manager did not have her complete the bowel prep. As a result, the doctor could not complete the scheduled surgery. Resident B stated that the surgeon told her that he has “washed his hands of the situation” and indicated she should find a new surgeon. Resident B stated that the home manager was supposed to get the things she needed to complete the bowel prep and she had not.

The home manager, Roxanne Turner, stated that Resident B was scheduled for surgery on 11/26/2024, not Thanksgiving Day, and Resident B did not complete the necessary bowel prep. Ms. Turner was on vacation and was unaware of the need for a bowel prep. The area manager, DJ Hernandez, contacted the surgeon’s office the morning of the surgery, on 11/26/2024, and was only instructed which medications should be withheld that morning.

Ms. Turner stated that the procedure was originally scheduled for 11/21/2024. She spoke with someone from the surgeon's office who informed her that the home would receive a call and send the surgery time the day prior to the surgery, but nothing was received. Ms. Turner stated that she requested the information regarding the surgery be emailed to the office, but she was informed it was sent via mail. Ms. Turner stated that if the instructions were mailed and the envelope was addressed to Resident B, staff were not aware of it. Resident B did not tell any staff that the letter had arrived. Staff do not open the resident's mail.

The area manager, DJ Hernandez, stated that she contacted the surgeon's office the morning of 11/26/2024, because nobody from the surgeon's office had contacted staff to inform them of what was required the morning of surgery. She was only told which medication to withhold from Resident B that morning and nothing else. She was not aware of the required bowel prep.

The medical assistant from the surgeon's office stated that Resident B's surgery was cancelled and rescheduled several times for various reasons. The surgery was originally scheduled for 10/10/2024, but it had to be cancelled. Resident B signed the consent forms and then the surgeon's office was made aware that Resident B had a guardian. Resident B's guardian was contacted, and the surgery was rescheduled for 10/31/2024.

The surgery date of 10/31/2024 was cancelled because there was no staff available to sit at the hospital during the surgery, and Resident B's guardian was unavailable as well. A third surgery date was scheduled for 11/21/2024, but it was cancelled for an unknown reason. The last surgery date of 11/26/2024 was cancelled due to a lack of pre-surgery prep.

The medical assistant spoke with the home manager, Roxanne Turner, in October 2024, when the initial surgery date was scheduled. She gave her a brief overview of the prep and informed her that more detailed instructions would be mailed to the home. The medical assistant informed Ms. Turner that Resident B would need to start antibiotics the day prior to the surgery and the prescription was called into the pharmacy. The surgeon informed Resident B that due to all of the cancellations, he felt Resident B should go elsewhere for the surgery. The surgeon stated that Resident B was not having any specific symptoms or pain related to the hernia, and she was not at risk of harm at this time; however, the surgery needed to be completed sooner rather than later.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or

	other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not follow the recommendations of Resident B's physician. Staff did not obtain Resident B's discharge paperwork following her hospitalization on 11/05/24, and were unaware of what follow-up instructions were given. Resident B's appointment with the neurologist on 11/30/24 had to be rescheduled due to staff not being available to take her to the appointment. Resident B's hernia surgery was rescheduled several times due to poor communication between staff, Resident B, and the surgeon's office. On 11/26/24, the date of the most recently scheduled surgery, staff were unaware of the required pre-surgery preparation, and did not contact the surgeon's office for instructions until the morning of the surgery, causing the surgery to be cancelled.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection I observed and noted the following regarding the home's maintenance:

- The railing on the stairway leading upstairs was loose and broken.
- The window in Resident B's bedroom was cracked.
- The carpet throughout the home was stained and dirty.
- The plumbing in the bathroom located in Resident B's bedroom was not working properly. Resident B stated that the shower could not be used as there were issues with sewage coming up into the shower. The home manager stated that maintenance was working on repairing the plumbing issue, but it was not yet fixed. I did not observe any sewage in the shower during my onsite inspection; however, they stated that the bathroom is not currently in use.
- Resident B stated that she can hear squirrels in the walls. The home manager stated that there was a hole in the roof, and there have been issues with squirrels and other critters getting into the attic. This has not yet been fixed by maintenance.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the onsite inspection, I observed and noted that the home had several maintenance issues, including a loose/broken railing on the stairs, a cracked window in Resident B's bedroom, stained carpeting, plumbing issues in the bathroom located in Resident B's bedroom. The home manager also reported that there is a hole in the roof and critters have been coming into the attic.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection, Resident B stated that her bedroom is always freezing cold. She stated that she has to wear gloves and a hat when she sleeps at night, as it gets even colder at night. I observed the thermostat in the downstairs area of the home to be set at 71°F. The thermostat showed that the current temperature in the home was 71°F. I went into Resident B's bedroom, which is on the upstairs level of the home. The second level of the home and Resident B's bedroom were noticeably colder than the downstairs area of the home. My thermometer provided a reading of 66°F in Resident B's bedroom. There was no thermostat located on the second level of the home.

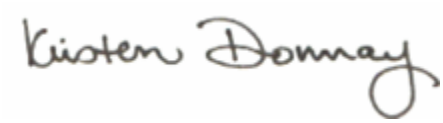
On 01/08/2025, I contacted the licensee designee, Sherman Taylor, to conduct an exit conference. Mr. Taylor was not available, so I left a message requesting a return phone call.

APPLICABLE RULE	
R 400.14406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.

ANALYSIS:	During the onsite inspection, I observed that Resident B's bedroom and the upstairs area of the home was noticeably colder than the lower level of the home. My thermometer provided a reading of 66°F in Resident B's bedroom. There was no thermostat located on the second level of the home.
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.



01/08/2025

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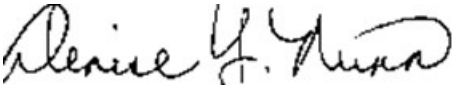
Kristen Donnay Date
Licensing Consultant

Approved By:



01/08/2025

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Denise Y. Nunn Date
Area Manager