GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2021

Sonia McKeown
JARC
Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630085648
Investigation #: 2021A0605048
Greenberg Shiffman Stein

Dear Ms. McKeown:

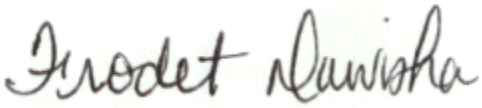
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630085648
Investigation #:	2021A0605048
Complaint Receipt Date:	08/26/2021
Investigation Initiation Date:	08/26/2021
Report Due Date:	10/25/2021
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Administrator/Licensee Designee:	Sonia McKeown
Name of Facility:	Greenberg Shiffman Stein
Facility Address:	28773 Village Lane Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-1762
Original Issuance Date:	07/02/1999
License Status:	REGULAR
Effective Date:	09/18/2020
Expiration Date:	09/17/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff (DCS) Donald “Darnell” Hudson put his arm around Resident A’s neck and choked him. Mr. Hudson also 'cussed at' Resident A.	Yes

III. METHODOLOGY

08/26/2021	Special Investigation Intake 2021A0605048
08/26/2021	Special Investigation Initiated - Telephone I contacted Office of Recipient Rights (ORR) worker Alanna Honkanen regarding the allegations. Ms. Honkanen stated that Adult Protective Services (APS) is also investigating these allegations.
08/31/2021	Contact - Document Sent I emailed Adult Protective Services (APS) Tiffany Pitts regarding the allegations. Ms. Pitts emailed back stating she is currently investigating these allegations.
09/07/2021	Inspection Completed On-site I conducted an unannounced on-site investigation in collaboration with ORR worker Alanna Honkanen. We interviewed the assistant home manager Donald Hudson, direct care staff (DCS) Mattie Gates and Resident B. We observed Residents C, D, and E who were non-verbal.
10/05/2021	Contact - Telephone call made I left a voice mail message for the Director of Vocational Services at Living and Learning Jen Carpen.
10/05/2021	Contact - Telephone call made I interviewed the home manager Portia Lindsay, direct care staff (DCS) Mehmet Ozbej, Leonard Simpson, Godfrey Ogholo and Floyd Blake regarding the allegations. I texted DCS Breshena Jenkins to contact me as her voice mail box was full.
10/05/2021	Contact - Document Received I received a telephone call from ORR Alanna Honkanen who stated she will be substantiating these allegations.

10/05/2021	Contact - Document Sent I emailed APS Tiffany Pitts requesting the outcome of her investigation.
10/05/2021	Contact - Telephone call received I received a return call from Living and Learning, Jen Carpen regarding the allegations.
10/12/2021	Contact - Telephone call made I interviewed Resident A's stepmother via telephone regarding the allegations.
10/12/2021	Contact – Telephone call received I received a telephone call from JARC CEO Shaindle Braunstein regarding additional information on DCS Donald Hudson. I received a telephone call from JARC Chief Administration Officer Brett Nicholson regarding the allegations.
10/12/2021	Contact – Telephone call made I contacted ORR Alanna Honkanen following up on her investigation and the additional information received from JARC.
10/12/2021	Exit Conference I conducted the exit conference with licensee designee Sonia McKeown via telephone with my findings.
10/14/2021	Exit Conference I conducted another exit conference with licensee designee Sonia McKeown via email with my findings.

ALLEGATION:

Direct care staff (DCS) Donald “Darnell” Hudson put his arm around Resident A’s neck and choked him. Mr. Hudson also 'cussed at' Resident A.

INVESTIGATION:

On 08/26/2021, intake #181659 was called in by Office of Recipient Rights (ORR) and Adult Protective Services (APS) alleging direct care staff (DCS) Donald “Darnell” Hudson choked Resident A and cussed at Resident A.

On 08/26/2021, I contacted ORR worker Alanna Honkanen via telephone who stated she and APS will be investigating these allegations.

On 09/07/2021, I along with ORR worker Alanna Honkanen conducted an unannounced on-site investigation at Greenberg Shiffman Stein (GSS) group home. Residents B, C, D, and E were present as were DCS Donald Hudson and Mattie Gates.

On 09/07/2021, DCS Mr. Hudson was interviewed regarding the allegations. Mr. Hudson has been with JARC for one year but only two months as the assistant home manager. On 08/24/2021, all the residents including Resident A were having breakfast. Resident A finished eating first and wanted to go to workshop. Mr. Hudson advised him, not yet as it was still too early to go to workshop. Resident A became upset and began cussing at Mr. Hudson and at the other residents. Mr. Hudson tried to redirect Resident A to go outside to calm down, but Resident A refused and kicked the screen door. Mr. Hudson stated that he then went to the back bedroom to assist Resident C who had taken all his clothes off. Mr. Hudson returned and saw Resident A getting close to the other residents and then Resident A began walking towards the TV. Mr. Hudson stated that Resident A has broken several TV's; therefore, to prevent another TV from breaking, Mr. Hudson intervened. He stated, "I tried to apprehend him. I stopped Resident A by turning him around. My arm touched the back of his neck, but I did not put him in a choke hold." Mr. Hudson demonstrated how he stopped Resident A. Mr. Hudson's left arm was stretched out and his right hand was on Resident A's back. He tried to turn Resident A around, but that's when Resident A pulled away and ran outside. Mr. Hudson stated that Resident A is taller than him, so it is impossible to put Resident A in a choke hold. Ms. Honkanen showed Mr. Hudson pictures of Resident A's neck that were taken by Living and Learning workshop on the morning of 08/24/2021. The pictures showed red marks on both the left and right side of Resident A's neck. Mr. Hudson then stated, Resident A "snatched away from me as my shoulder was on the back of his neck," inferring that may be how Resident A sustained the marks on his neck. Mr. Hudson stated after he assisted with getting the other residents situated, he dropped Resident A early to workshop.

Mr. Hudson stated that DCS Mattie Gates was in the kitchen and did not witness the incident. He stated the other residents were either outside or in their bedrooms and did not witness the incident. Mr. Hudson denied cursing at Resident A. He stated he only told Resident A to calm down and that Resident A was cussing at Mr. Hudson and Resident A threatened Resident D saying, "I'm going to kill you." Resident D told Mr. Hudson, "Resident A hit me." Mr. Hudson did not witness Resident A hitting Resident D.

Mr. Hudson stated that according to Resident A's crisis plan, Resident A should be redirected; ask to go outside and if redirection does not work, then to call Resident A's stepmother. Mr. Hudson stated, "In my opinion, I followed the crisis plan and I tried to the best of my ability to calm him down." However, Mr. Hudson stated he only tried to redirect Resident A and did not reach out to Resident A's stepmother the morning of 08/24/2021 when redirecting Resident A did not work. Mr. Hudson stated that he did text Resident A's stepmother after the stepmother sent Mr. Hudson a text message on 08/24/2021 after learning about the incident from workshop.

On 09/07/2021, DCS Mattie Gates was interviewed regarding the allegations. Ms. Gates has been with JARC for about five and a half years and has only been at GSS group home for about two and a half years. On 08/24/2021, Ms. Gates was in the kitchen finishing breakfast. Resident A finished breakfast first and wanted to leave for workshop around 7:30AM instead of 9AM when Resident A usually goes to workshop. Resident A does not know time; therefore, Mr. Hudson told Resident A to wait 15 minutes. Resident A stated “I’m not waiting. I want to go now.” Mr. Hudson then tried to tell Resident A he had to wait, but Resident A continued to refuse. Now Resident A and Mr. Hudson were in the living room while Ms. Gates remained in the kitchen. Ms. Gates stated she could hear Mr. Hudson and Resident A “going back and forth,” and then she heard Resident A say to Resident D, “Next time I’m going to kill you.” Ms. Gates then heard Mr. Hudson telling Resident A, “That’s not nice to say. Why are you saying that?” Ms. Gates then heard Resident A cussing and that is when Mr. Hudson said, “I’ll just take him and sit there.” Ms. Gates stated she did not witness anything between Mr. Hudson and Resident A. She stated that staff from Living and Learning workshop called saying that Resident A reported to the staff at workshop that “Mr. Hudson choked Resident A.” Ms. Gates stated she asked Mr. Hudson who denied choking Resident A. Resident A was picked up from workshop at 3:15PM and Ms. Gates did not observe any marks on Resident A’s neck. Ms. Gates stated that the workshop called Resident A’s stepmother who then called Ms. Gates. Ms. Gates reported she did not witness anything. Ms. Gates stated that Resident A is “very vocal,” and that Resident A “would tell you if he did not like something you did to him.” Ms. Gates stated Resident A never came into the kitchen to tell her that Mr. Hudson choked him.

Ms. Gates stated that Mr. Hudson never left the living room to assist any resident getting dressed. She does not recall which resident was sitting in the living room or was in their bedroom. Ms. Gates stated she has no reason to believe that Mr. Hudson choked Resident A. Ms. Gates stated she again asked Mr. Hudson, “Why are they saying you choked Resident A?” Mr. Hudson stated, “I tried to stop him from going to the TV, so I put my arm out and he pulled away from me.”

Ms. Gates stated according to Resident A’s crisis plan, staff must try to redirect Resident A, then if cannot redirect to call Resident A’s stepmother and if that does not work, then to pass a PRN medication. Ms. Gates believes Mr. Hudson followed the crisis plan as Mr. Hudson tried to redirect Resident A and when that did not work, Mr. Hudson agreed to take Resident A to workshop early. Ms. Gates stated about a week ago, there was an incident with Resident A. Resident A tried to flip the table and then punched the glass window in the kitchen because he wanted his girlfriend to come over. Ms. Gates tried to redirect him, then called the stepmother who was not available, so Ms. Gates then called the police. Ms. Gates stated that Resident A told her, “I wanna be bad, I wanna be bad against the world.”

On 09/07/2021, Resident B was interviewed regarding the allegations. Resident B stated that Resident A is always getting into trouble. Resident B stated, “Resident A punched the kitchen glass window because he was mad. He wanted to go early to

work.” Resident B did not see Mr. Hudson put his arms around Resident A or pull Resident A down to the floor. Resident B stated, “Mr. Hudson is a nice guy. All the staff is nice.” Resident B has not heard Mr. Hudson curse or use any profanity towards Resident A or any other resident.

On 09/07/2021, I reviewed Resident A’s crisis plan completed by Macomb-Oakland Regional Center dated 02/18/2021. According to the crisis plan, when Resident A has a behavior, staff will attempt to redirect Resident A, call family/guardian, or support coordinator and if behaviors continue to escalate to aggressive behaviors, then to call 911. The crisis plan stated that physical contact beyond high fives and fist bumps is not recommended. There is no statement regarding any physical restraints to be utilized with Resident A.

On 10/05/2021, I received an email from APS worker Tiffany Pitts. Ms. Pitts stated she interviewed Mr. Hudson and Resident A on 08/27/2021, regarding the allegations. The following are the interviews:

> “Mr. Hudson stated that on Tuesday 08/24/2021, he and Ms. Gates were on shift together. He stated that at approximately 7:30am Resident A was agitated because he wanted to go to work early. Mr. Hudson stated that workshop does not start until 9:00am, which is what he stated he told Resident A. He stated Resident A was very agitated and kept demanding to go to workshop early. Mr. Hudson denied knowing why Resident A was anxious to get to workshop early. Resident A was agitated and began threatening the other residents and cursing because he could not get his way. He stated Resident A was stomping in and out of the house. He stated Resident A has a history of aggressive and destructive behavior. He stated Resident A has broken four tv's since being at the home. He stated when Resident A walked near the television, he put his arm out and around his neck to turn him away from the television, but Resident A pulled away. He stated Resident A had a chain around his neck. He denied that he choked Resident A. He stated that pictures were taken, and Resident A did not have any injuries.”
>
> “APS made an unannounced face to face visit with Resident A at his group home. Upon arriving to the home, the staff were loading the residents into the van to take them on an outing to a picnic. APS was able to me meet with Resident A. He was in good spirits. He appeared excited to be going to the picnic. APS met with Resident A privately in his bedroom. APS asked Resident A did something recently happen with a staff. He stated, "yes" and went on to say that his staff, "Darnell" choked him and cursed at him. APS asked him, “What did the staff say to him? and he said, "Fuck You". APS asked Resident A, “Why did the staff choke and swear at him? and he stated, “he did not know.” APS asked if he or the staff was upset about something. He stated the staff was upset but he does not know why. Resident A denied that he was upset about anything, he stated he just wanted to go to workshop. When asked when did this incident occur, he stated he doesn't know. When asked if he had any injuries, he stated no. APS did not observe any injuries on the Resident A. When asked if he

> received any medical attention, he stated no. When asked if he feels safe at the home, he stated yes. When asked if the staff, "Darnell" has been working at the home since the incident, he stated yes. When asked if he feels unsafe or scared of the staff "Darnell", he stated no. When asked if he told anyone about the incident, he stated, his "stepmom." He denied that he told anyone else about the incident."

On 10/05/2021, I interviewed the home manager Portia Lindsay via telephone regarding the allegations. Ms. Lindsay has been with JARC for seven years and has been the home manager at GSS group home for three years. Ms. Lindsay was on maternity leave from 06/18/2021-09/18/2021; therefore, she was not present during the incident on 08/24/2021. Ms. Lindsay heard from Resident A's stepmother what happened. The stepmother told Ms. Lindsay that Resident A said that Mr. Hudson choked him. Resident A also told the workshop that Mr. Hudson choked him and then the workshop reported the incident to ORR. Ms. Lindsay stated she has never witnessed Mr. Hudson put any residents in a choke hold prior to her leaving on maternity leave. Ms. Lindsay stated that Resident A's crisis plan is to redirect Resident A or to call the stepmother. She stated sometimes this works and sometimes it does not. When the redirection and calling the stepmother do not work, the stepmother comes to GSS group home and assists in calming Resident A down. Ms. Lindsay stated although staff reach out to the stepmother, she has never had to do that because "I do not have any issues with Resident A. Resident A listens to me." Ms. Lindsay has not had issues with staff mistreating residents; however, she has witnessed Mr. Hudson become agitated with Resident A and when that happens, Mr. Hudson takes a moment and goes outside. Ms. Lindsay stated Resident A is the only resident with behaviors and that all staff are fully trained and competent in addressing Resident A's behaviors including Mr. Hudson. Ms. Lindsay stated Resident A's crisis plan states that staff will attempt to redirect, call the stepmom and sometimes staff call Ms. Lindsay as Resident A listens to her. Ms. Lindsay stated she had the stepmom attend one of their staff meetings regarding Resident A. The staff were able to ask the stepmom questions regarding what to do when Resident A has a specific behavior. Ms. Lindsay stated this meeting was beneficial for Resident A and all staff.

On 10/05/2021, I interviewed DCS Mehmet Ozbej via telephone regarding the allegations. Mr. Ozbej has been with JARC for three years. On 08/24/2021, he was not present during the incident but heard what happened. Mr. Ozbej stated he talked to Mr. Hudson about hearing that Mr. Hudson choked Resident A. Mr. Hudson told Mr. Ozbej that he (Mr. Hudson) did not have Resident A in a choke hold. Mr. Hudson told Mr. Ozbej that he did not want Resident A to go towards the TV because he did not want Resident A to break the TV again. Mr. Ozbej stated that Mr. Hudson did not go into any further details regarding the incident other than stating he never put Resident A in a choke hold. Mr. Ozbej stated he has never witnessed Mr. Hudson, or any other staff use a choke hold on Resident A. Mr. Ozbej stated that Resident A's crisis plan does not indicate any physical restrains so "we don't touch him." Mr. Ozbej stated that he follows the crisis plan by redirecting Resident A which Mr. Ozbej stated sometimes that does not work so he calls the stepmom to speak with Resident A and that seems to always

for Mr. Ozbej. Mr. Ozbej has not observed any red marks on Resident A's neck. Mr. Ozbej stated he has never heard Mr. Hudson, or any other staff use foul language with Resident A.

On 10/05/2021, I interviewed DCS Godfrey Ogholo via telephone regarding the allegations. Mr. Ogholo has been working for JARC for 10 years. On 08/24/2021, he was not present but heard that Resident A reported that Mr. Hudson had Resident A in a choke hold. Mr. Ogholo stated, "I would say that cannot be because being how tall Resident A is and how short Mr. Hudson is, it would require force by Mr. Hudson which I cannot see that happening." Mr. Ogholo has never witnessed Mr. Hudson put Resident A in a choke hold. He has not observed any red marks on Resident A's neck. Mr. Ogholo stated Resident A is belligerent towards staff and sometimes there is destruction of property; however, Mr. Ogholo follows Resident A's crisis plan. He stated, he does not reinforce Resident A's negative behavior and allows Resident A to finish with his temper tantrum which typically works as Resident A then apologizes to Mr. Ogholo for his behavior. Mr. Ogholo stated that he recalls receiving training a couple of years ago by Resident A's psychiatrist who advised staff not to engage or use any physical restraints, but to be firm with Resident A when he is having a behavior.

On 10/05/2021, I interviewed DCS Floyd Blake via telephone regarding the allegations. Mr. Blake has been with JARC since April 2021. On 08/24/2021, Mr. Blake was not present but heard different versions of the incident. He heard that Mr. Hudson had to physically stop Resident A from breaking the TV and that DCS Mattie Gates was in the kitchen and heard an altercation from the living room. On 08/25/2021, Mr. Blake worked his shift. He did not observe any marks on Resident A's neck, but Resident A told Mr. Blake what happened. Mr. Blake stated that Resident A was very detailed in the description of the incident. Resident A told Mr. Blake he finished eating breakfast first and wanted to go to workshop. Resident A told Mr. Blake that Mr. Hudson stated he was not ready, so Resident A was upset. Resident A told Mr. Blake that he (Resident A) started walking towards the TV and that is when Mr. Hudson grabbed his (Resident A) neck and then Resident A showed Mr. Blake how Mr. Hudson grabbed his neck. Resident A demonstrated a "choke hold," to Mr. Blake. Mr. Blake stated Resident A does not lie nor does he fabricate stories. He stated that Mr. Hudson does not like Resident A and that Mr. Hudson has made that know to Mr. Blake and to other staff. Mr. Blake has never witnessed Mr. Hudson, or any other staff put Resident A in a choke hold. Mr. Hudson stated he has also heard Mr. Hudson curse at Resident A on occasion when Mr. Hudson "does not want to be bothered by Resident A." Mr. Blake stated he does not have any problems with Resident A as Mr. Blake follows Resident A's crisis plan, redirect, and then contact stepmom if that does not work.

On 10/05/2021, I interviewed Jen Carpen with Living and Learning Center via telephone regarding the allegations. On 08/24/2021, Resident A told Ms. Carpen, "Mr. Hudson put his arm around my neck and choked me. He is swearing at me and call me retarded." Resident A told Ms. Carpen he did not know why Mr. Hudson put him in a choke hold, but Ms. Carpen stated that she can see that Resident A was "visibly scared." Resident A showed Ms. Carpen what Mr. Hudson did to him by demonstrating it on Ms. Carpen.

Ms. Carpen stated that Resident A put his arm around Ms. Carpen's neck in a "choking fashion," and said, like this. She observed the red marks on Resident A's neck and took pictures. Ms. Carpen stated there are times when Resident A gets blotchy around his neck area when nervous, so she does not know if this was the time or if these marks were caused by Mr. Hudson putting Resident A in a choke hold. Ms. Carpen stated that Resident A sometimes tries to joke around and be silly for attention, but this situation Resident A was "very serious," and Resident A's story was consistent when he reported to Ms. Carpen, to the stepmom and to ORR.

On 10/12/2021, I interviewed Resident A's stepmom via telephone regarding the allegations. On 08/24/2021, the stepmom received a telephone call from Resident A's workshop, Living and Learning advising her that Resident A reported that Mr. Hudson put him in a choke hold and was cursing and calling Resident A names. The stepmom was told that Resident A wanted to go to workshop early, but Mr. Hudson was not ready, so Resident A was upset. The stepmom stated that she is someone that staff can call to help with Resident A when staff is unable to redirect him. The stepmom never received a call that morning to assist with Resident A nor did any staff call her regarding the incident. The stepmom stated she texted Mr. Hudson asking him what happened. Mr. Hudson texted her back saying he did not call the stepmom because "he was able to resolve the situation quickly." Mr. Hudson told the stepmom he ended up taking Resident A to workshop an hour early and waited outside, but the stepmom was told by Living and Learning Center that Mr. Hudson and Resident A only arrived 10 minutes early. The stepmom agreed to forward the text messages to me between her and Mr. Hudson. The stepmom stated that Resident A does sometimes scratch his neck when he is nervous, but the red marks she observed in the pictures on Resident A's neck were not scratches. The stepmom stated that Resident A has been consistent with his story of what happened and that she believes Resident A. The stepmom stated Mr. Hudson is the only staff that does not utilize her when he is unable to redirect Resident A. The stepmom stated she attended a meeting with all staff to assist in how to redirect Resident A when his behaviors are escalating. She stated that Mr. Hudson was the only staff that did not ask any questions nor seemed to want any feedback as to how to deescalate Resident A when he is having a behavior. The stepmom stated that staff are great in caring for Resident A and that Resident A is happy living at GSS and he is safe.

On 10/12/2021, the stepmom texted me the text messages between her and Mr. Hudson from their conversation regarding the allegations on 08/24/2021. The following are the text messages:

> "Stepmom texted, "Good morning, Darnell. Resident A said there was an incident at the house this morning. Can you tell me about it?
> Mr. Hudson texted, "Sure, he was being impatient this morning. We was telling him that it wasn't time to go yet so he was being disrespectful to everyone; cussing and threatening out the other guys. He was also being disrespectful to me and Mattie. He was also spitting and hitting the new screen door. I tried to direct him to go outside so he can calm down so that he wouldn't try to irritate the guys even more. That's when he started banging and spitting.
> Stepmom texted, "Ugh…how did you resolve it?

Mr. Hudson texted, “He didn’t calm down until I took him to work. We had to wait a whole hour until he went in.
Stepmom texted, “Okay, thank you. He has marks on his neck. Any idea how those got there?
Mr. Hudson texted, “When I tried to guide him to go outside, he snatched away from me and ran out.
Stepmom texted, “Okay.”
Mr. Hudson texted, “I had my arm around him. I tried to calm him down and I talked to him because he didn’t want to listen. This was the end of the text messages.”

On 10/12/2021, I contacted licensee designee Sonia McKeown via telephone and conducted the exit conference. I advised Ms. McKeown of my findings. Ms. McKeown said OK to submitting a corrective action plan.

On 10/12/2021, I received a telephone call from JARC’s CEO Shaindle Braunstein who stated she does not understand why GSS is being cited when there is medical documentation to reflect that Mr. Hudson has a shoulder injury would prevent him from raising his arm above his shoulders. Ms. Braunstein stated to speak with their Chief Administration Officer Brett Nicholson who has been conducting his own investigation regarding these allegations. Ms. Shaindle stated based on the new information regarding Mr. Hudson, ORR has reopened the case and will be reinvestigating these allegations.

On 10/12/2021, I contacted ORR Alanna Honkanen who stated she was informed by Mr. Nicholson that it was impossible for Mr. Hudson to put Resident A in a choke hold because Mr. Hudson was unable to lift his arm or bend his arm above his shoulders. Ms. Honkanen and I both interviewed Mr. Hudson together and Mr. Hudson demonstrated how he was able to lift his arm and bend his arm without difficulty. Mr. Hudson never once reported to Ms. Honkanen or me that he had any medical condition with his arm preventing him from lifting it. Mr. Nicholson emailed Ms. Honkanen a document provided by Mr. Hudson dated 09/016/2021, (three weeks after the incident) from Mr. Hudson’s physician stating that Mr. Hudson is under the physician’s care and will be off work. Ms. Honkanen stated she is waiting for additional documents from Mr. Nicholson and then will submit this new information along with her report for review. Ms. Honkanen will not be reinvestigating the allegations.

On 10/12/2021, I received a telephone call from Brett Nicholson, the Chief Administration Officer with JARC. Mr. Nicholson stated he is conducting his own internal investigation regarding these allegations and does not understand why licensing is substantiating this case. Mr. Nicholson stated he interviewed Mr. Hudson and all staff who denied that Mr. Hudson put Resident A in a choke hold. Mr. Hudson told Mr. Nicholson that Resident A ran into Mr. Hudson’s stretched out arm, but that Mr. Hudson never choked Resident A. Mr. Nicholson stated this was impossible because Mr. Hudson has an injury to his arm that Mr. Hudson cannot raise his arm above the shoulders, which would make it difficult to put Resident A in a choke hold because

Resident A is taller than Mr. Hudson. Mr. Nicholson was advised that the documents he sent to ORR were dated three weeks after the incident. He stated that Mr. Hudson will be visiting with his physician today and will have documentation to provide reflecting the medical condition Mr. Hudson had prior to the incident with his arm.

On 10/12/2021, I received an email from Brett Nicholson with a medical letter dated 10/12/2021 from Mr. Hudson's physician stating that Mr. Hudson was under the physician's care since 08/10/2021, due to a motor vehicle accident. It further stated that Mr. Hudson cannot extend his arms above his shoulders as his injury has severely impacted his range of motion.

On 10/14/2021, I conducted another exit conference with licensee Sonia McKeown via email advising her of my findings and that I will be moving forward with substantiating this case. Ms. McKeown requested to know how she can file an appeal. I advised Ms. McKeown that the appeal process is through the compliance conference which then I will need to change my recommendation to a provisional license.

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 my investigation and the information gathered, assistant home manager Donald Hudson did not address Resident A's unacceptable behavior according to Resident A's crisis plan completed by MORC on 02/18/2021. On 08/24/2021, Resident A was exhibiting an unacceptable behavior; threatening staff/residents and kicking the screen door. However, Mr. Hudson did not follow Resident A's crisis plan after attempting to redirect Resident A did not work. Instead of Mr. Hudson contacting the family/guardian as stated in the crisis plan, Mr. Hudson put his arm around Resident A who then pulled away from Mr. Hudson resulting in marks around Resident A's neck. Resident A was consistent in reporting how he sustained the marks. Resident A told his workshop, his stepmother, APS and

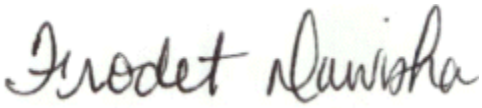
	ORR that Mr. Hudson put him in a choke hold, resulting in the marks on his neck. However, Mr. Hudson's story was inconsistent as it kept changing as to what transpired on 08/24/2021. Mr. Hudson reported to APS that he had his arm out and around Resident A's neck to turn Resident A around. Mr. Hudson told me and ORR that he never put his arm around Resident A's neck but that he only had his left arm out and his right hand on Resident A's back. In addition, Mr. Hudson texted Resident A's stepmother telling her that he (Mr. Hudson) had his arm around Resident A's neck after the stepmother asked Mr. Hudson about the marks on Resident A's neck. The crisis plan stated that physical contact beyond high fives and fist bumps is not recommended.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on my investigation and information gathered, DCS Donald Hudson used physical force other than physical restraint with Resident A. On 08/24/2021, Resident A was upset he was unable to go to workshop at 7:30AM when his workshop time is at 9AM. Mr. Hudson attempted to redirect Resident A, but the situation escalated when Resident A began kicking the screen door, cursing, and threatening staff and other residents. Resident A then began walking towards the TV and Mr. Hudson put Resident A in a choke hold. Resident A's story has consistently been the same when he reported that Mr. Hudson put him in a choke hold, to his workshop, his stepmom, and to APS. Mr. Hudson informed Resident A's stepmom via text message and to APS during their interview that he (Mr. Hudson) put his arm around Resident A, then Resident A pulled/snatched away from Mr. Hudson, when Mr. Hudson was asked about the marks around Resident A's neck. Mr. Hudson reported to me and ORR that he (Mr. Hudson) "tried to apprehend/stop" Resident A from breaking another TV

	by stretching out his left arm and putting his right hand on Resident A's back, then stated "my arm touched the back of his neck." I observed the pictures taken by the workshop of Resident A's neck on 08/24/2021 and there were red marks on both sides of his neck. According to Resident A's crisis plan dated 02/18/2021, there is no statement pertaining to any staff utilizing any physical restraints with Resident A. In fact, the crisis plan stated, "physical contact beyond high fives and fist bumps is not recommended."
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

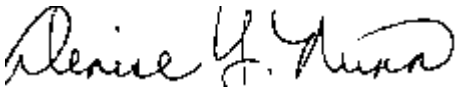
Contingent upon receiving an acceptable corrective action plan, I recommend this special investigation be closed and no change to the status of the license.



10/20/2021

Frodet Dawisha — Date
Licensing Consultant

Approved By:



10/21/2021

Denise Y. Nunn — Date
Area Manager