GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 3, 2021

Kimberly Pemberton and Bert Pemberton
5640 Meadowview
Sterling Heights, MI 48310

RE: License #: AF500262745
Investigation #: 2022A0990006
Pemberton House

Dear Kimberly and Bert Pemberton:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A previous recommendation for a provisional license was made in special investigation #2021A0990022, which remains in effect.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AF500262745
Investigation #:	2022A0990006
Complaint Receipt Date:	09/07/2021
Investigation Initiation Date:	09/07/2021
Report Due Date:	11/06/2021
Licensee Name:	Kimberly Pemberton and Bert Pemberton
Licensee Address:	5640 Meadowview Sterling Heights, MI 48310
Licensee Telephone #:	(586) 668-1192
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Pemberton House
Facility Address:	5640 Meadowview Sterling Heights, MI 48310
Facility Telephone #:	(586) 264-8524
Original Issuance Date:	01/08/2004
License Status:	REGULAR
Effective Date:	09/13/2020
Expiration Date:	09/12/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Mrs. Pemberton is very rude to Resident B. On multiple occasions she could be heard cursing at him.	Yes
Mrs. Pemberton withholds snacks from Resident B as a form of punishment when he refuses to take his medications.	Yes
Mrs. Pemberton is upset when Resident B asks to go to the hospital when having suicidal ideations.	Yes
Resident A was dropped off at Liberties Day Center and was not given his 12PM medication. Mrs. Pemberton gave him the medication at 2:30PM**.**	Yes
Resident A was sleeping in a room with four beds lined-up. The residents do not have privacy.	Yes
The home smells awful. The home is poorly kept. There is an uncleaned standing fan with layers of built-up dust. There is a bay window that is very dusty.	Yes
The residents were dropped off at Liberties Day Program before they were open and left outside unsupervised.	No
Additional Findings	Yes

III. METHODOLOGY

09/07/2021	Special Investigation Intake #2022A0990006 NOTE: This special investigation was originally combined with special investigation #2021A0990022 therefore, some contacts were prior to the complaint date.
08/27/2021	APS Referral Adult Protective Services (APS) referral initiated at intake.
09/01/2021	Contact - Telephone call received I conducted a phone interview with Ms. Krystal Shaw, APS investigator.

09/07/2021	Special Investigation Initiated - Letter I emailed Relative A to request a phone interview.
09/08/2021	Contact - Telephone call made I conducted a virtual interview with Relative A.
09/08/2021	Contact - Telephone call made I conducted a phone interview with the Public Guardian.
09/16/2021	Contact - Telephone call received I received a phone call from Ms. Shaw, APS. Ms. Shaw provided updated information regarding the investigation. APS is not substantiating for abuse or neglect and closing their investigation.
09/17/2021	Contact - Document Received I received and responded to an email from Relative A.
09/24/2021	Contact - Document Sent I responded to an email from Relative A.
10/15/2021	Inspection Completed On-site I conducted an unannounced onsite investigation. I interviewed Burt Reynolds- co-licensee and Resident B.
10/18/2021	Contact - Telephone call made I conducted a phone interview with Resident A.
10/29/2021	Contact - Document Sent I replied to an email from Mrs. Pemberton. I scheduled a phone interview with Mrs. Pemberton.
11/01/2021	Contact - Telephone call made I conducted a phone interview with Relative B and Relative B1.
11/04/2021	Contact - Telephone call made I conducted a phone interview with Mrs. Pemberton.
11/04/2021	Contact - Telephone call made I conducted a phone interview with Diane Buchanan from Liberties Drop-in day center.
11/19/2021	Exit conference I conducted an exit conference with Mrs. Pemberton.

ALLEGATIONS:

- **Mrs. Pemberton is very rude to Resident B. On multiple occasions she could be heard cursing at him.**
- **Mrs. Pemberton withholds snacks and from Resident B as a form of punishment when he refuses to take his medications.**
- **Mrs. Pemberton is upset when Resident B asks to go to the hospital when having suicidal ideations.**

INVESTIGATION:

On 09/08/2021, I conducted a virtual interview with Relative A to discuss both complaints. Note: There is a concurrent special investigation involving Resident A. Resident A shares a room with Resident B. Relative A said that while on phone calls with Resident A she could hear Mrs. Pemberton yelling at Resident B. Mrs. Pemberton could be heard on multiple occasions cursing at Resident B, and telling Resident B to get out, and heard Ms. Pemberton making statements that she hates Resident B father's "guts." According to Relative A (no date provided), Resident B wanted to go to the hospital because he was hearing voices, Mrs. Pemberton told him that it was a waste of time and that she wanted Resident B out of her home. Relative A said that Resident A told her that he heard Mrs. Pemberton yell at Resident B telling him that if he moved out that day it would not be soon enough. Relative A said that Mrs. Pemberton, withholds Resident B's nighttime snacks when he refuses his medications. Relative A said that Resident A told her that one-time Resident B refused his medications and Mrs. Pemberton tossed the medications in the trash.

On 09/08/2021, I conducted a phone interview with Resident A and Resident B's Public Guardian (PG). PG said that she has been informed about the issues regarding Resident B and Mrs. Pemberton in the past. PG said that there have been terrible arguments between Resident B and Mrs. Pemberton. PG said that Resident B does have attention-seeking behaviors and Relative B feeds into these behaviors in which, causes issues with Mrs. Pemberton. PG admitted that Mrs. Pemberton and Relative B do not get along well. PG said that Mrs. Pemberton refuses to allow Relative B inside of the home for visits. Resident B does want to move however, he has lived at Pemberton House 3-4 years. PG said that she has nowhere else to place Resident B. PG said that Mrs. Pemberton and Resident B's relationship "is not the best" but she does not think that Resident B is being abused. PG said there was an incident where Resident B wanted to go to the hospital and there was an issue, but she does not recall all details. PG said that Resident B was taken to the hospital.

On 10/15/2021, I conducted an unannounced onsite investigation. I interviewed Burt Pemberton, co-licensee, and Resident B. Mr. Pemberton said that Mrs. Pemberton was in Las Vegas and would be returning tomorrow.

I interviewed Resident B. Resident B said that lately Mrs. Pemberton has been nice to him. Resident B said that she gets angry when he wants to go to the hospital.

Resident B said that back in January 2021, he was hearing voices to self-harm, and he asked Mrs. Pemberton to take him to the hospital. She told him that he was lying and called him “a fucking retard” and said he was “fucking stupid”. Resident B said he was taken to the hospital via ambulance and was admitted for five days. Resident B said that when he returned from the hospital, Mrs. Pemberton acted as if she did not like him anymore.

Resident B said that in June 2021, he was hearing voices again and needed to go the hospital and when he told Mrs. Pemberton this, she became upset and cursed at him. Resident B said that he contacted Relative B who intervened, and Mrs. Pemberton told him that Relative B is not allowed to visit the home anymore. Resident B said that Mrs. Pemberton does not like Relative B. Resident B said that at times he has refused his medication Celexa because it makes him “feel funny.” One time he did not take it and Mrs. Pemberton threw the pills in the garbage because she was upset. Resident B said that he refuses medications frequently. Mrs. Pemberton refused him an evening snack for five days when he came back from the hospital in June because she was upset with him for needing to go the hospital.

On 10/18/2021, I conducted a phone interview with Resident A. Resident A said that each morning Mrs. Pemberton argues with Resident B. Resident A said that it seemed like daily there was something new that Mrs. Pemberton had an issue with Resident B about. Mrs. Pemberton asked Resident B to help him out at Liberties Day Program because he was new going there. Mrs. Pemberton told Resident B that if he did not help Resident A, he would not receive a nighttime snack. Resident A also said that if Resident B refused to take his medication, she would not give him a snack. Resident A witnessed Resident B ask Mrs. Pemberton for a snack and she yelled “get out!” Resident A has witnessed Mrs. Pemberton tell Resident B, “I hate you and your father’s guts.” Resident A said one time Mrs. Pemberton made Resident B upset that he left the home alone. Mrs. Pemberton did nothing. Resident B eventually came back to the home. Resident A said that he did not witness Mrs. Pemberton yell at the other residents. Resident A said that Mrs. Pemberton was always uptight and riled-up quick about things.

On 11/01/2021, I conducted a phone interview with Relative B and Relative B1 (Relative B1 listened on speakerphone and did not participate). Relative B said that Mrs. Pemberton has been rude to Resident B in the past. Relative B said that in January 2021, Resident B was hearing voices and suicidal and Mrs. Pemberton thought he was bluffing. Relative B said that Resident B was admitted to Ascension Hospital Macomb for 3-4 days as a result of that incident. Relative B said that in June 2021, Resident B was having suicidal thought and Mrs. Pemberton thought he as bluffing again. Relative B said that he needed to go the hospital and Mrs. Pemberton got upset with him and told him that he can no longer visit inside of the home. Mrs. Pemberton was mad at him because Relative B came to drive Resident B to the hospital because she would not take him. Relative B said that Mrs. Pemberton issued Resident B a 30-day discharge notice because of that incident. Relative B said that the PG got involved and Resident B was allowed to stay. Relative B said that he has heard Mrs. Pemberton curse at

Resident B such as yelling o “Shut the fuck up.” Relative B said that this was heard over the phone. Relative B said he has heard Mrs. Pemberton call Resident B a “retard” and “stupid.” Relative B said that Resident B has told him that Mrs. Pemberton has refused him snacks as punishments if he “acts-out.” Relative B said that about 1½ months ago Resident B was placed on snack punishment because he brought something home from Liberties Day Program that he was not supposed to bring to the home. Relative B said that Resident B does refuse his medications often, but is unaware that Mrs. Pemberton trashes the medication if he does not take it. Relative B said that Resident B gets into trouble with Mrs. Pemberton over “petty things.” Resident B has a guardian because they have more access to placement and services. When Resident B lived at home, there was difficulty with Resident B refusing to take his medications.

On 11/04/2021, I conducted a phone interview with Mrs. Pemberton. Mrs. Pemberton denied directly calling Resident B names. Mrs. Pemberton said she would say “that was stupid.” If Mrs. Pemberton said “retard” or “stupid”, it was indirect to Resident B. Mrs. Pemberton said when Resident B was hearing voices, she did not think that he needed emergency medical treatment and she would actively watch him instead. Mrs. Pemberton said that she did have an argument with Relative B because he would show-up at dinnertime to ask her questions that interrupted her. Mrs. Pemberton used to be very fond of Relative B and used to bake him bread. Mrs. Pemberton admitted to withholding Resident B’s nighttime snack as form of discipline during the exit conference on 11/19/2021.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(2) A licensee, responsible person, or any person living in the home shall not use any of the following methods of handling a resident for discipline purposes: (e) Mental or emotional cruelty, including subjecting a resident to verbal abuse, making derogatory remarks about the resident or members of his or her family or making malicious threats.
ANALYSIS:	Relative A, Resident A, Resident B and Relative B all confirmed that they have witnessed or overheard Mrs. Pemberton call Resident A “retard” or “stupid.” The Public Guardian confirmed that there have been terrible arguments between Resident B and Mrs. Pemberton. In June 2021, Resident B was hearing voices again and needed to go the hospital and when he told Mrs. Pemberton this, she became upset and cursed at him. Resident A heard Mrs. Pemberton tell Resident B that she “hates his father’s guts.”

	There is substantial information to support that Resident B was called names and there were derogatory remarks towards Relative B.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(2) A licensee, responsible person, or any person living in the home shall not use any of the following methods of handling a resident for discipline purposes: (d) Withholding necessary food, rest, or toilet use.
ANALYSIS:	There is sufficient information to support that Resident B was withheld snacks as a form of discipline. Resident B said that Mrs. Pemberton refused him an evening snack for five days in the past. Resident A said that if Resident B refused to take his medications, Mrs. Pemberton would not give him a snack. Relative B said that Mrs. Pemberton has refused Resident B snacks as punishment if he “acts-out.” Mrs. Pemberton admitted to withholding nighttime snacks for Resident B during the exit conference on 11/19/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: (m) The right to refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal.
ANALYSIS:	Resident B admitted that he refuses to take his Celexa medication because it makes him feel funny. Relative B said that Resident B has a history of refusing to take medications. Resident A observed once when Resident B refused to take his medications, Mrs. Pemberton then threw the medication in the trash and refused his nighttime snack.

	There is sufficient information to support that when Resident B refuses medications he is disciplined or treated without courtesy and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Resident A was dropped off at Liberties Day Center and was not given his 12PM medication. Mrs. Pemberton gave him the medication at 2:30PM.

INVESTIGATION:

On 09/08/2021, I conducted a virtual interview with Relative A. Relative A said that Mr. Pemberton transports the residents to Liberties Day Program on Thursdays because they go shopping for the home on Thursday's. Relative A said that Resident A was dropped off without being given his 12PM medication on 08/12/2021. Relative A said the first time on Thursday 08/05/2021, Resident A was dropped off; Mrs. Pemberton was questioned about how Resident A would be given his medication on time when he is at Liberties. Mrs. Pemberton told her that she would go to Liberties at 12PM to give him his medication, which she did. Relative A said that the second time, Resident A was at Liberties, Mrs. Pemberton did not go and give Resident A's medication at 12 PM. Relative A said that Mrs. Pemberton texts Resident A and told him that she would give him his medication when she picks him up at 2:30PM. Relative A is concerned that Resident A was given his medication 2.5 hours later than prescribed. Relative A emailed me text messages regarding the medication missed.

I reviewed the text messages: On 08/12/2021 at 10:53AM, Resident A texted Mrs. Pemberton asking her if she was going to give him his 12PM medication. Mrs. Pemberton replied at 11:21AM "I'll call you right back." Mrs. Pemberton texted Resident A at 11:30 AM: I cannot call you right now my phone is almost dead. I will give you your pills today when I get there at 2:30. And I will come in and talk to the staff there and see what their policy is for keeping medication for you.

I reviewed a text from Relative A to Mrs. Pemberton informing her that Resident A is having a tough time at Liberties and cannot handle wearing a mask. Relative A asked if Mrs. Pemberton could give Resident A's PRN medication which is to help him relax. Mrs. Pemberton replied the following: The mask rule is upsetting but he can sit outside. I will be giving him his afternoon medication when he gets back at 2:30PM.

On 09/08/2021, I conducted a phone interview with Resident A's Public Guardian (PG). PG was not aware of the medication incident at Liberties.

On 09/07/2021, I received documents from Mrs. Pemberton. I observed that Resident B's medication record indicates that he is prescribed Haloperidol, and it is to be taken four times per day at 8AM (two pills per day), 12PM, 5PM and 8PM.

On 10/18/2021, I conducted a phone interview with Resident A. Resident A said that he is supposed to receive a medication at 12PM. Resident A said that he went to Liberties Day program twice from 10AM to 2:30PM. The first day Resident A attended, Mrs. Pemberton came to the program and gave him his medication at 12PM. The second time he attended the program, Resident A said that Mrs. Pemberton did not give him his 12PM medication. Resident A called and texted Mrs. Pemberton about his 12PM medication. Resident A said that he needs his medication on time, or they do not work well.

On 11/04/2021, I conducted a phone interview with Mrs. Pemberton. Mrs. Pemberton admitted that one time she did give Resident A's 12PM medication at 2PM. Mrs. Pemberton said that the day program does not administer medications. They attend on Thursday from 10:30AM to 2:30PM. Mrs. Pemberton said that it does not specify a time, but the medication Haloperidol is to be taken four times per day. Mrs. Pemberton reviewed the medication bottle during the interview and realized that that the Haloperidol directions does specify that the medication is to be given at noon. Mrs. Pemberton said that this was an oversight, and she did not know that the medication was to be given exactly at noon. Mrs. Pemberton agreed to send a photo of the medication bottle.

I received photo of medication bottle on 11/19/2021. Resident A is prescribed Haloperidol tab 5mg and the administration instructions are as follows: take two tablets by mouth in the morning, one at noon, one at 4PM and one at night.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: (b) Not adjust or modify a resident's prescription medication without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any adjustments or modifications of a resident's prescription medication.
ANALYSIS:	Resident A is prescribed Haloperidol to be taken four times per day. Resident A did not receive the Haloperidol at 12noon because he was at day program. Resident A sent text messages to Mrs. Pemberton on 08/12/2021 asking for his medications. Mrs. Pemberton texted Resident A telling him that she would give him the medication at 2PM. Mrs. Pemberton admitted to not giving Resident A's Haloperidol at 12noon as prescribed.

CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

- **Resident A was sleeping in a room with four beds lined-up. The residents do not have privacy.**
- **The home smells awful. The home is poorly kept. There is an uncleaned standing fan with layers of built-up dust. There is a bay window that is very dusty.**

INVESTIGATION:

On 09/08/2021, I conducted a virtual interview with Relative A. Relative A said that Resident A frequently complained about the odor in the home. Relative A said that she purchased Resident A air freshener. Relative A observed that the home is dusty. Resident A is allergic to dust mites and that the dust bothered him. Relative A said that the bedroom that Resident A slept in was for four residents, there is no door to the room and there is no privacy. Relative A said that when she purchased snacks for Resident A there was no space to store them.

On 09/08/2021, I conducted a phone interview with Resident A's Public Guardian (PG). The PG said that she visits the residents every three months. PG did not express any concerns regarding the cleanliness, odor or bedroom spacing.

On 10/15/2021, I conducted an onsite unannounced investigation. I did not observe an odor in the home however, I was wearing a N-95 face mask. I did not observe excessive dust and there was no fan observable. In the past and prior inspections, I have addressed odor issues such as the smell of urine and a musty odor. I observed the bedroom where four residents sleep which was a garage that was converted to a large bedroom. The room was very cluttered and there were two residents laying in their beds. I observed a large pile of items in the middle of the bedroom. I observed that the four residents' dressers, storages boxes and items cluttered the room. Mr. Pemberton said that some of the items were Resident A's that needed to be picked up once they find him a new placement. Mr. Pemberton said that Resident A is still in the hospital, and they are still holding his belongings until a placement is found for him. There appeared to be multiple dressers, boxes, and belongings for the residents. I observed a door to the bedroom that was propped open with several jackets and clothing draped on top of it.

On 10/18/2021, I conducted a phone interview with Resident A. Resident A said that the home "smelled bad." Resident A said that the home is very dusty and that he is allergic to dust. Resident A said that his eyes itched and were red when he lived there. Resident A said there was a fan caked with dust in the home. Resident A said that there was not good ventilation, and it was hot inside the home in the summertime.

Resident A said that the only window that Mrs. Pemberton opened were in the bathrooms.

Resident A said that he did not like sharing a room with three other men. Resident A said that there was no privacy and there was no door. Resident A said that the room where he slept was inside a garage that got converted to a bedroom. Resident A said that the door was always open leading to the exit.

APPLICABLE RULE	
R 400.1431	**Bedrooms generally.**
	(8) A resident shall be provided with reasonable storage space for storage of his or her personal belongings.
ANALYSIS:	On 10/15/20221, I observed the bedroom that sleeps four to be cluttered with resident's items and no space for privacy. I observed multiple dressers, boxes, and personal items in the room for four residents. There was no room for usable space.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

The residents were dropped off at Liberties Day Program before they were open and left outside unsupervised.

INVESTIGATION:

On 09/08/2021, I conducted a virtual interview with Relative A. Relative A said that Resident A attended Liberties Day Program twice. Relative A had an issue with the program because Resident A does not like to wear a face mask. Relative A said that the program was going to ask him not to return if he refused to wear a face mask.

On 09/08/2021, I conducted a phone interview with Resident A's Public Guardian (PG). PG said that she would not have contested that Resident A attended program although, she was not aware that he attended twice.

On 11/01/2021, I conducted a phone interview with Relative B and Relative B1 (Relative B1 listened on speakerphone and did not participate). Relative B said that he had no knowledge of the incident.

On 10/18/2021, I conducted a phone interview with Resident A. Resident A said that Mr. Pemberton dropped him and the other residents (names not provided) at Liberties. Resident A said that Liberties opens at 10AM and Mr. Pemberton arrived there early. Mr. Pemberton told them to stand at the door until they opened. Resident A said that they were left unsupervised for 10 minutes until Liberties opened their doors.

On 10/15/2021, I conducted an unannounced onsite investigation. I interviewed Burt Pemberton-co-licensee and Resident B. Mr. Pemberton denied ever dropping off residents and leaving them in front of Liberties. Resident B said that he does not remember a time being left outside of Liberties before they opened.

On 11/04/2021, I conducted a phone interview with Mrs. Pemberton. Mrs. Pemberton said that she does not know anything about this incident. Mrs. Pemberton said that they open at 10AM and closes at 2PM.

On 11/04/2021, I conducted a phone interview with Diane Buchanan from Liberties Drop-in day center. Ms. Buchanan said that she has never observed Mr. or Mrs. Pemberton leave the residents in front of the building unsupervised. Ms. Buchanan said that Mr. Pemberton is usually the one that drops them off and he waits outside until each resident goes inside.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: (a) The amount of personal care, supervision, and protection required by the resident is available in the home.
ANALYSIS:	There is insufficient information to support that the residents were left outside of Liberties Day Program unsupervised. According to Resident B and Ms. Buchanan-Liberties Day Program staff, they do not recall the incident occurring. Mr. Pemberton denied leaving the residents in front of Liberties unsupervised.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/15/2021, I conducted an unannounced onsite investigation. I interviewed Burt Reynolds-co-licensee and Resident B. Resident B repeatedly asked during interviews if he was going to get in trouble when Mrs. Pemberton returns for speaking to licensing.

On 11/01/2021, I conducted a phone interview with Relative B and Relative B1. Relative B said that he is not allowed inside of the home because he had an argument with Mrs. Pemberton about Resident B wanting to go to the ER. Relative B said that he stays outside and picks up Resident B for visits.

On 11/04/2021, I conducted a phone interview with Mrs. Pemberton. Mrs. Pemberton said that she did have an argument with Relative B because he would show-up at dinnertime to ask her questions that interrupted her. Mrs. Pemberton spoke to Relative B last week and he was concerned about the investigation and did not want Resident B to become agitated. Mrs. Pemberton said that since Resident B was interviewed, he constantly asks if he is going to be interviewed again or if he is in trouble. Mrs. Pemberton said that the reason she stops allowing Relative B inside of the home is because one time he lost his cell phone in the Resident B's room (sleeps four residents) and he walked all around the room looking for it. Mrs. Pemberton said that one of the residents thought that Relative B was "spooky" because he was standing near his bed looking and asking about his cell phone.

On 11/19/2021, I conducted an exit conference with Mrs. Pemberton. Mrs. Pemberton understands the rule violation regarding the medication error. Mrs. Pemberton went into detail regarding each allegation and feels that they are untrue. I informed Mrs. Pemberton that based on my investigation at this time there was sufficient information to support rule violations. Mrs. Pemberton admits withholding Resident B's snacks at nighttime. Mrs. Pemberton read the licensing rule R 400.1419 (1) in regard to the time frame between dinner and breakfast to oppose my findings. Mrs. Pemberton and I looked at the number of hours that is between dinner and daytime which was 14.5 hours. Mrs. Pemberton said that Resident B has his own snacks at times. Mrs. Pemberton admitted that the bedroom was extremely cluttered and is now clean. Mrs. Pemberton and I discussed in detail concerns about the spacing of that bedroom. Mrs. Pemberton said that it is her right to refuse Relative B entry into the home because he hoovered over a resident looking for his phone. Mrs. Pemberton expressed that she did not like Relative B interrupting her while she is preparing dinner for the residents asking questions or concerns related to Resident B. Mrs. Pemberton said that there is no court order or visitation restrictions placed by the PG against Relative B. Mrs. Pemberton was informed of the violations and once the report is approved, a corrective action plan is required.

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibility.**
	(1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: (k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time.
ANALYSIS:	There is sufficient information to support that Mrs. Pemberton does not allow Relative B inside of her home. Resident B said that he needed to go the hospital and Relative B took him to the hospital and because of this, Relative B can no longer visit inside of the home. According to the public guardian, Mrs. Pemberton refuses to allow Relative B inside of the home for visits. Mrs. Pemberton described incidents that warranted her to stop visits however, those incidences do not rise to the level of restricting contact with relatives inside the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

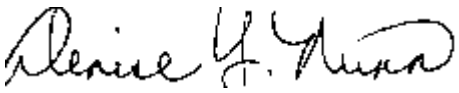
IV. RECOMMENDATION

A previous recommendation for a provisional license was made in special investigation #2021A0990022, which remains in effect.

11/19/2021

LaShonda Reed — Date
Licensing Consultant

Approved By:



12/03/2021

Denise Y. Nunn — Date
Area Manager