GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2022

Paula Barnes
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS500404109
Investigation #: 2023A0612008
Brandenburg

Dear Ms. Barnes:

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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500404109
Investigation #:	2023A0612008
Complaint Receipt Date:	11/29/2022
Investigation Initiation Date:	12/01/2022
Report Due Date:	01/28/2023
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 - 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Paula Barnes
Licensee Designee:	Paula Barnes
Name of Facility:	Brandenburg
Facility Address:	50351 Jefferson Chesterfield, MI 48047
Facility Telephone #:	(586) 273-7015
Original Issuance Date:	01/19/2021
License Status:	REGULAR
Effective Date:	07/19/2021
Expiration Date:	07/18/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/23/22 Resident A had a bruise on the inside of his left thigh approximately 6" in diameter and a cut on his knee. Staff stated that Resident A had a tantrum and was thrashing on the floor causing the injury. This behavior is not typical of Resident A. On 11/21/22 Resident A injured his head and leg. Staff said he tripped and bumped his head. Direct care staff, Jaquan Boyd has been on shift when these incidents occurred.	Yes

III. METHODOLOGY

11/29/2022	Special Investigation Intake 2023A0612008
12/01/2022	APS Referral This referral was made by Adult Protective Services (APS) worker Debra Johns
12/01/2022	Special Investigation Initiated – Letter I emailed assigned APS worker Debra Johns regarding the allegation
12/06/2022	Contact - Telephone call made I completed a telephone interview with Resident A’s guardian
12/06/2022	Contact - Telephone call made Telephone call to Resident A's Supports Coordinator, Jessica Konkolesky
12/06/2022	Contact - Document Received I received five photos of Resident A's injuries sent via text message
12/07/2022	Inspection Completed On-site I interviewed Resident A, Resident B, Life Skills program manager, Nicole Walton, Life Skills staff Michelle Young, program coordinator Eva Hemphill, home manager Jessica Davis, direct care staff JaQuan Boyd, and direct care staff Margaret Anderson

12/08/2022	Contact - Telephone call made I completed a telephone interview with direct care staff, Gayle Green
12/08/2022	Contact - Document Received I received a copy of Resident A's Beaumont outpatient discharge summary, Residential Progress Notes dated 12/01/22 - 12/06/22, and three Incident Reports
12/09/2022	Contact - Telephone call made I completed a telephone interview with direct care staff, Jimmy Williams
12/19/2022	Exit Conference I called licensee designee, Paula Barnes to conduct an exit conference.

ALLEGATION:

On 11/23/22, Resident A had a bruise on the inside of his left thigh approximately 6" in diameter and a cut on his knee. Staff stated that Resident A had a tantrum and was thrashing on the floor causing the injury. This behavior is not typical of Resident A. On 11/21/22, Resident A injured his head and leg. Staff said he tripped and bumped his head. Direct care staff, Jaquan Boyd has been on shift when these incidents occurred.

INVESTIGATION:

On 12/01/22, I received a complaint from Adult Protective Services (APS) that indicated Resident A is nonverbal and resides at the Brandenburg home. On 11/23/22, Resident A had a huge bruise on the inside of his left thigh, approximately 6 inches in diameter and a cut on his knee. Staff stated Resident A had a tantrum and was thrashing on the floor causing the injury. This type of behavior is not typical for Resident A. On 11/15/22, Resident A refused to walk and could not get off the floor. Resident A was taken to the doctor who stated nothing was physically wrong with him, it was due to weight gain. Then on 11/21/22, Resident A had an injury to his head and leg. Staff stated Resident A tripped and bumped his head on a wall. The injuries have since healed. Direct care staff, Jaquan Boyd is usually the night staff attending to Resident A when the incidents occur.

On 12/01/22, I initiated my investigating by emailing the assigned APS worker, Debra Johns regarding the allegation. Ms. Johns stated a referral has been made to law kenforcement. Detective Lee with the Chesterfield Police Department is conducting an investigation. On 12/07/22, I coordinated with Ms. Johns who stated Detective Lee is

moving forwarding with charging direct care staff, JaQuan Boyd with third degree physical abuse. The case is being taken to the prosecutor. On 12/19/22, Ms. Johns informed me that she is substantiating her investigation.

On 12/06/22, I completed a telephone interview with Resident A's guardian. Resident A has lived at the Brandenburg home since 11/13/20. Since living in the home, he has never had any injuries. Resident A's guardian stated on 11/21/22, at 4:00 am she received a call from direct care staff, Jaquan Boyd who stated Resident A tripped, fell and hit his head on the wall. Resident A allegedly tripped on the molding between the carpet and the floor. The following week, home manager Jessica Davis called and said Resident A was having a hard time walking. Resident A's guardian took him to the hospital where he received head to toe X-rays. There were no injuries found. The doctor said there was nothing physically wrong with Resident A and his issue walking was due to weight gain.

On 11/23/22, Resident A's guardian received another call. Staff said Resident A was having a tantrum and throwing himself on the floor. Resident A's guardian stated Resident A is a very safe and cautious person he does not have a history of throwing tantrums or injuring himself. Following this incident, while Resident A was at his family home, his guardian observed significant bruising on Resident A's inner thigh and his knee was swollen.

Resident A goes to Life Skills Center, he has not had any issues there that would result in these injuries. Resident A's guardian stated she has seen Resident A interact with staff in his home there have been no issue with the interactions. Resident A's guardian has not seen him interact with direct care staff Jaquan Boyd. Mr. Boyd is the newest staff in the home, he works on the midnight shift. Resident A's guardian stated Resident A is nonverbal. He is unable to identify staff by name or answer questions related to this investigation. At this time all Resident A's injuries are healed. Resident A's guardian provided five photos of Resident A's injuries sent via text message.

On 12/06/22, I reviewed five photos. I observed a cut on Resident A's forehead near his hairline, significant purple bruising on Resident A's inner left thigh, redness to his knee, and light red bruising to the top of his foot.

On 12/07/22, in collaboration with APS worker, Debra Johns and Recipient Rights Specialist, Johnna Kopah I completed an unscheduled onsite investigation at Life Skills Center and the Brandenburg home. At Life Skills Center I interviewed Resident A, Life skills program manager, Nicole Walton, and Life Skills staff Michelle Young. At the Brandenburg home I interviewed program coordinator Eva Hemphill, home manager Jessica Davis, direct care staff JaQuan Boyd, direct care staff Margaret Anderson and Resident B.

On 12/07/22, I interviewed Life Skills program manager Nicole Walton and Life Skills staff Michelle Young. Ms. Walton and Ms. Young consistently stated when Resident A was dropped off at Life Skills Center on 12/06/22, they were told from his home staff

that Resident A was jumping on the couch and the couch broke. Resident A sustained a scratch to his arm. That afternoon, when Ms. Young changed Resident A's brief, she observed a "horrific" bruise on Resident A's left arm it was blue, purple, yellow, and green. She took a photo of the injury and made a Recipient Rights complaint. While at Life Skills Resident A is compliant, he does not require reminders and he is not rambunctious. Ms. Walton and Ms. Young stated one week before thanksgiving, Resident A was limping, favoring his leg, and was unable to get up off the floor without assistance. A week later they observed bruising to Resident A's leg. Ms. Walton and Ms. Young stated they have noticed these past few weeks that Resident A appears hesitant to go home and he is also flinching when staff offer him things. These behaviors were not noticed until recently. Ms. Walton and Ms. Young stated prior to these recent incidents they have never seen any bruises on Resident A.

On 12/07/22, I interviewed Resident A at Life Skills Center. Resident A is nonverbal and therefore he unable to answer questions related to this investigation. Resident A's Life Skills staff, Ms. Young assisted Resident A with showing me a bruise on his left arm. The bruise was near his arm pit. It was dark purple in the center and yellow on the outside. I also observed slight bruising on the left side of his chest under his arm. When Resident A was asked how things are at home, he got up from the table he was seated at and walked away ending the interview.

On 12/07/22, I interviewed program coordinator, Eva Hemphill. Ms. Hemphill stated Resident A's parents alleged that direct care staff, JaQuan Boyd was physically abusive to Resident A resulting in the bruising on his leg. Ms. Hemphill stated she did not see the bruise or photos of the bruise however, she and her supervisor, program manager Jamilla Cheetam conducted an internal investigation. Ms. Hemphill stated she interviewed Brandenburg staff and there were no reports of abuse. Ms. Hemphill stated Resident A's guardian took him to the hospital on 11/21/22. He was also seen by his primary care physician. There were no reports of abuse, and no recommendations were provided regarding his physical health.

On 12/07/22, I interviewed direct care staff, Margaret Anderson. Ms. Anderson started her employment on March 4, 2022. She typically works the day shift from 7:00 am – 7:00 pm. She usually works on shift with home manager, Jessica Davis. Ms. Anderson stated she was informed by Ms. Davis that Resident A had a bruise on his arm that he obtained from having a tantrum on the floor. Ms. Anderson does not know how Resident A got a cut on his head. Ms. Anderson stated Resident A requires constant redirection, he runs through the house and slams doors however, having tantrums is a new behavior that started a few weeks ago. Ms. Anderson stated when Resident A comes home from visits with his family he sits on the couch, looks out the window, and cries. Ms. Anderson has worked with direct care staff, JaQuan Boyd in the past. She has no concerns with the care he provides to the residents. Mr. Boyd works well with Resident A. Ms. Anderson denied that she was physically abusive towards Resident A and further denied that she caused the bruising to Resident A's body. Ms. Anderson stated that she does not believe that any Brandenburg did anything to Resident A that resulted in the bruises on his body.

On 12/07/22, I interviewed Resident B. Resident B stated he enjoys living in this home and gets along well with all the staff. Resident B stated Resident A runs around the house and keeps him up at night. Resident B stated he saw Resident A rolling from the couch onto the floor. Direct care staff, Mr. Boyd stood in front of the couch to try and keep Resident A from rolling off the couch and onto the floor. Mr. Boyd was not hurting Resident A, he was just trying to keep him on the couch. Resident B stated Mr. Boyd has never hurt him or any other resident in the home.

On 12/07/22, I interviewed home manager, Jessica Davis. Ms. Davis has been employed with the company for one year. She works the morning shift from 7:00 am – 7:00 pm, Monday – Saturday. Ms. Davis stated in October 2022, Mr. Boyd told her that Resident A injured his head by falling. This occurred while Mr. Boyd and Mr. Green were working on shift together. Mr. Green and Resident B were gone on a car ride and Mr. Boyd was in the bathroom. Around 8:00 pm Resident A fell injuring his head. His parents were notified, and the cut was treated with antibiotic ointment.

Ms. Davis further stated, on 11/19/22, Resident A was acting strange. He required more redirection than usual. He was running around the house, going into other resident's bedrooms, screaming, and rolling on floor. While rolling on the floor Resident A scrapped his leg. Over the weekend his leg began to bruise. The bruise became "massive." On 11/21/22, Ms. Davis received a call from Life Skills Center. They were concerned about Resident A's mobility; he did not want to walk. Upon receiving the call from Life Skills Center, she took Resident A to the emergency room for evaluation. Ms. Davis was told that Resident A had a contusion to his leg. The bruising would get bigger and look worse before it got better. Ms. Davis stated while at the emergency room Resident A had X- rays taken. There were no findings.

Ms. Davis stated there are times that Resident A does not want to walk. They have had to use a wheelchair to leave Life Skills Center as he refused to walk to walk to the van. She assumed it was because Resident A has scoliosis. Resident A has been needing more assistance with daily tasks such as showering. His parents were informed of these changes and on 11/15/22, Resident A's guardian took him to the emergency room for evaluation and he had an appointment with his primary care physician. Then on 11/17/22, Resident A had X- rays completed. There were no findings.

Ms. Davis stated on 11/23/22, Resident A went with his family for Thanksgiving. He returned on 11/29/22. There were no issues or injuries upon his return. On 12/5/22, she was on shift with direct care staff, Margaret Anderson, Resident A kicked the couch. He did not sustain any injuries however, the couch broke. Ms. Davis stated she does not believe that any staff including Mr. Boyd was physically abusive towards Resident A. Ms. Davis denied that she was physically abusive towards Resident A.

On 12/07/22, I interviewed direct care staff, JaQuan Boyd. Mr. Boyd is the assistant home manager. He started his employment in September 2022. He works on the midnight shift from 7:00 pm – 7:00 am. He typically works with direct care staff, Gayle

Green, or Jimmy Williams. Mr. Boyd stated while working on the midnight shift with Mr. Green Resident A began throwing a tantrum. Resident A was rolling himself from the couch onto the floor and rolling around on the floor. This behavior lasted for 10 -15 minutes. During this time, Resident A was crying and rolled himself onto the floor multiple times. While Resident A was falling off the couch and onto the floor, Mr. Boyd caught Resident A to prevent him from hitting his face. Then he and Mr. Green lifted Resident A up and placed him back on the couch. Mr. Boyd explained while lifting Resident A up off the floor and back onto the couch he was on Resident A's left side and Mr. Green was on his right side. Mr. Boyd stated while standing behind Resident A with his palms open, he placed his hands under both of Resident A's arms, near his armpits to lift him. Mr. Boyd stated the bruising on Resident A's arms could be a result of him lifting him off the floor. Mr. Boyd stated once Resident A was back on the couch, he stood in front of the couch to prevent Resident A from rolling back onto the floor. Mr. Boyd remarked, "I am not an abuser. I don't do things like that." Mr. Boyd denied using physical force against Resident A. Mr. Boyd further denied that Mr. Green used physical force against Resident A. Mr. Boyd stated he was informed by detective Lee that Mr. Green reported that he pinned Resident A down. Mr. Boyd stated, Mr. Green lied. He denied pinning Resident A down on the couch. Mr. Boyd stated Mr. Green lies about everything. He does not like to work and other staff do not like to work with him because he does not do his work.

Mr. Boyd stated the bruise on Resident A's leg was caused by Resident A having a tantrum on the floor and rolling between the recliner chair and the TV stand. He was flailing his body. Resident A also hit his head on the TV stand. Mr. Boyd stated while this was occurring, he kept his distance because Resident A was kicking is feet. He gave Resident A verbal prompts to get up off the floor. The bruise on Resident A's leg started out the size of a quarter. He was taken to the doctor for evaluation. Mr. Boyd stated he asked the home manager, Ms. Davis about the outcome of the appointment and was told that Resident A hit a blood vessel in his leg which caused the bruising. Ms. Davis told him that the injury would look worse before it got better. Mr. Boyd stated Resident A bruises easily. If he is to have an injury such as a cut or a bruise they treat it with ice, and antibacterial ointment. However, Resident A does not like ice, so he is unwilling to keep ice on for any significant length of time.

Mr. Boyd stated on another occasion, Resident A tripped over the molding on the kitchen floor and hit his head causing an injury to his head. This occurred while he was in the bathroom cleaning, he was working on shift with Mr. Green however, Mr. Green was on a van ride with Resident B. Mr. Boyd stated Resident A does not like him. Resident A likes Mr. Williams and Ms. Anderson. Mr. Boyd stated Resident A responds differently to him and Ms. Davis noting that Resident A tends to flinch in his presence.

On 12/08/22, I interviewed direct care staff, Gayle Green via telephone. Mr. Green started his employment in August 2022. He works the midnight shift from 7:00 pm – 7:00 am. He typically works with direct care staff Jimmy Williams or JaQuan Boyd. Mr. Green stated one evening while on shift with Mr. Boyd he was having trouble with Resident A. Every 10 – 15 seconds Resident A was getting up from the couch and

walking around the house going in and out of his bedroom. Mr. Green stated he changed Resident A's brief and Mr. Boyd told Resident A that it was time to go to sleep. Then, Mr. Boyd crossed Resident A's arms across his chest and laid him down on the couch. Resident A was laying with his back to the couch. Using his hands Mr. Boyd held Resident A down on the couch. Resident A was screaming and wrestling with Mr. Boyd trying to get up. Mr. Boyd then used his foot as leverage to pin Resident A to the couch. Eventually, Resident A fell onto the floor and stood up. The two continued to "tussle" and Resident A was screaming. Mr. Boyd pushed Resident A and he fell to the floor. Mr. Green stated this encounter lasted 15 – 25 minutes until eventually, Resident A laid down on the couch and went to sleep. Mr. Green stated as a result of this incident, the couch broke. This is the only time Mr. Green has witnessed Mr. Boyd become physical with a resident.

Mr. Green stated the next day when he changed Resident A, he saw scratches on his neck. Mr. Green stated the following day, direct care staff, Jimmy Williams observed bruising on Resident A and he called direct care staff, Margaret Anderson to find out what happened. Mr. Green stated Mr. Boyd is the assistant home manager. As such, he did not report what he witnessed at the time of the incident because he was afraid. When interviewed, Mr. Green stated he witnessed the incident on a Sunday. He told direct care staff Mr. Williams about it the following Monday or Tuesday. Mr. Green stated when the incident occurred all the residents were in bed asleep except for Resident B who he believes saw the end of Resident A and Mr. Boyd's encounter.

On 12/09/22, I interviewed direct care staff, Jimmy Williams via telephone. Mr. Williams started his employment in May 2022. He works on the midnight shift from 7:00 pm – 7:00 am. He typically works with direct care staff, Gayle Green or JaQuan Boyd. Mr. Williams has a history of working with Resident A, he provided Resident A with in-home direct care for three years while Resident A was living in his family home. These services were provided while Mr. Williams was employed with a different company.

Mr. Williams stated he did not see any incidents occur which may have resulted in the bruises on Resident A's body. However, after talking with other staff he believes direct care staff, Mr. Boyd restrained Resident A on the couch which resulted in the bruises. Mr. Williams stated he has never witnessed Mr. Boyd being physically abusive with any of the residents in the home. Mr. Williams trained Mr. Boyd and he stated that he has had to remind him of the appropriate way to physically guide/ redirect residents. Mr. Williams explained, he has seen Mr. Boyd grab residents by the arm and tell them to come with him. When this happened, he immediately explained to Mr. Boyd that he cannot do that and showed him the appropriate way to physically guide/ redirect a resident.

Mr. Williams described direct care staff Gayle Green as an underachiever. He stated Mr. Green's first reaction is to lie. Mr. Green lies about miscellaneous things. However, he believes that if Mr. Green feels like something will not negatively impact him, he will be honest. Mr. Williams stated Mr. Green was on shift with Mr. Boyd when the alleged incident occurred. As such, he believes Mr. Green's account of what happened. Mr.

Williams stated Mr. Boyd and Mr. Green seems to get along well. He does not believe Mr. Green would have any reason to retaliate against Mr. Boyd.

Mr. Williams started he has never seen Resident A roll himself of the couch, thrash himself onto the floor, or run though the house. If Resident A wants to get up from the couch it is usually because he has to go to the bathroom. Mr. Williams stated when he worked with Resident A in his family home, Resident A would flinch if he had done something wrong. Since living at the Brandenburg home Resident, A stopped flinching. However, recently he has noticed this behavior starting again. Mr. Williams denied that he was physically abusive towards Resident A and further denied that he caused the bruising to Resident A's body.

On 12/08/22, I received and reviewed the following documentation:

- Resident A's Beaumont outpatient discharge summary dated 11/21/22
  Resident A was seen for a fall and diagnosed with a thigh contusion. There were no follow up recommendations made.
- Resident A's Residential Progress Notes dated 12/01/22 – 12/06/22
  The progress notes do not provide any documentation on how Resident A sustained any injuries, nor do they detail any behavioral issues. Progress note written on 12/04/22, by JaQuan Boyd in summary indicated during the 7:00 pm – 7:00 am shift Resident A was diving off the couch.
- Incident Report (IR) dated 10/28/22 written by direct care staff, JaQuan Body
  In summary the IR indicated, at 9:45 pm while staff was cleaning the bathroom Resident A tripped in the kitchen. He hit his head causing a bruise above his left eye.
- Incident Report (IR) dated 11/19/22, written by direct care staff, JaQuan Boyd
  In summary the IR indicated, between 3:00 am - 6:45 am Resident A ran through the home. Staff attempted to calm him down, but he continued to sit on the couch and scream. Resident A got on the floor and began crawling around while screaming. Resident A rolled around on the floor kicking and waving his arms. Resident A bumped his head on the furniture. Resident A has bruises on his neck due to his pajamas rubbing against it, the left side of his forehead, his stomach, and his inner right thigh.
- Incident Report (IR) dated 12/05/22, written by home manager, Jessica Davis
  In summary the IR indicated, at 5:00 pm Resident A was laying on the couch and leaned over towards the floor. In the process of trying to get onto the floor he kicked the back of the couch causing damage. The couch will need to be replaced.

On 12/19/22, I called licensee designee, Paula Barnes to conduct an exit conference. I was informed by the receptionist that Ms. Barnes was out of the office today and tomorrow. I left a detailed voice message regarding my findings. In the message I informed Ms. Barnes that a corrective action plan would be required.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to conclude that direct care staff JaQuan Boyd, and direct care staff, Gayle Green are not suitable to meet Resident A's physical and emotional needs. It was consistently reported that on 11/19/22, while Mr. Green and Mr. Boyd were on shift Resident A continuously rolled himself off the couch and onto the floor. Resident A was heard crying, screaming, while kicking his feet and flaying his arms. This behavior went on for 15- 25 minutes during which time Resident A injured himself hitting his head and other body parts on the furniture. Neither Mr. Boyd nor Mr. Green used pro active or reactive interventions to aid Resident A during this behavioral crisis and further failed to protect Resident A both emotionally and physically. Moreover,Mr. Green stated that he witnessed Mr. Boyd using physical force against Resident A for 15-25 minutes and did not intervene or call for assistance. Thus, Mr. Green is not competent in handling emergency situations.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.**
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to conclude that direct care staff, Gayle Green is not competent in reporting requirements. Mr. Green witnessed Mr. Boyd pin Resident A onto the couch to prevent him from rolling on to the floor. Mr. Green failed to

	report the incident stating he was afraid to do so. As such, Mr. Green is not competent in reporting requirements.
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 Resident A's personal needs, including protection and safety were not attended to. Since October 2022, Resident A sustained multiple bruises on various places of his body as a result of falls, behavioral issues and/or the use of physical force against him.
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 the information gathered through my investigation there is sufficient information to conclude direct care staff, JaQuan Boyd used physical force against Resident A. Resident A had bruises on his arm, neck, forehead, stomach, and inner thigh. Mr. Green stated he witnessed Mr. Boyd hold Resident A down on the couch. Resident A was screaming and wrestling with Mr. Boyd trying to get up. Then, Mr. Boyd used his foot as leverage to pin Resident A to the couch. The only other witness, Resident B, stated although Mr. Boyd was not hurting Resident A, he witnessed him standing in front of the couch to prevent Resident A from rolling onto the floor. Mr. Boyd denied the allegation. He stated Resident A was rolling himself from the

	couch onto the floor. Mr. Boyd picked Resident A up off the floor and he admitted that the bruising on Resident A's arms could be a result of him lifting him off the floor.
CONCLUSION:	**VIOLATION ESTABLISHED**

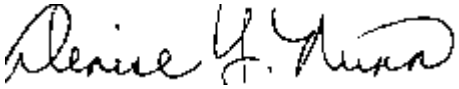
IV. RECOMMENDATION

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

12/19/2022

Johnna Cade — Date
Licensing Consultant

Approved By:



12/21/2022

Denise Y. Nunn — Date
Area Manager