GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 24, 2023

Jzsa-Jaza Gibson
Pharaoh's Rest Haven, LLC
1102 S. West Avenue
Jackson, MI 49203

RE: License #: AS380412065
Investigation #: 2023A0007012
Pharaoh's Rest Haven I

Dear Ms. Gibson:

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.
- Be signed and dated.

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380412065
Investigation #:	2023A0007012
Complaint Receipt Date:	02/28/2023
Investigation Initiation Date:	02/28/2023
Report Due Date:	04/29/2023
Licensee Name:	Pharaoh's Rest Haven, LLC
Licensee Address:	1044 S. MLK Jr. Drive Jackson, MI 49203
Licensee Telephone #:	(517) 513-3381
Administrator:	Jzsa-Jaza Gibson
Licensee Designee:	Jzsa-Jaza Gibson
Name of Facility:	Pharaoh's Rest Haven I
Facility Address:	114 W. Biddle Street Jackson, MI 49203
Facility Telephone #:	(517) 962-4683
Original Issuance Date:	11/17/2022
License Status:	TEMPORARY
Effective Date:	11/17/2022
Expiration Date:	05/16/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 02/28/2023, Resident A was put outside for a 45-minute time out. The temperature was 36 degrees when Resident A was found outside alone. Resident A smacked a stick against a postal truck. The police were contacted, and when they arrived, they talked to the owner of the AFC home by phone. It was stated that they did not have to let Resident A into the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/28/2023	Special Investigation Intake - 2023A0007012
02/28/2023	Special Investigation Initiated - On Site - Face to face contact with Ms. Gibson, Licensee Designee, Employee #1, and the residents.
02/28/2023	Contact - Telephone call received from APS Worker #1, Discussion.
03/02/2023	Contact - Face to Face with APS Worker #1. Discussion.
03/23/2023	Contact - Face to Face with APS Worker #1. Discussion.
04/07/2023	Contact - Telephone call made Ms. Gibson. Documents requested and contact information for Mr. Jones.
04/10/2023	Contact - Telephone call made to Mr. Jones, no answer.
04/10/2023	Contact - Telephone call made to Ms. Gibson, Discussion. She will have Mr. Jones contact me.
04/10/2023	Contact - Telephone call received from Mr. Jones, APS Worker #1 and I interviewed Mr. Jones.
04/10/2023	Contact - Face to Face with APS Worker #1. He will be substantiating the case.
04/11/2023	Contact - Telephone call made to Guardian A. Interview.
04/13/2023	Contact - Telephone call made to Ms. Gibson, Discussion.

04/18/2023	Contact - Face to Face with APS Worker #1. A referral to ORR has been made.
04/18/2023	Contact - Telephone call received from Case Manager #1. APS Worker #1 and I spoke with Case Manager #1.
04/18/2023	Contact - Document Received - Copy of AFC Assessment Form from Case Manager #1.
04/19/2023	Contact - Telephone call made to APS Worker #1 and I spoke with ORR Officer #1.
04/19/2023	Contact - Telephone call made to Ms. Gibson, Licensee Designee.
04/19/2023	Exit Conference conducted with Ms. Gibson, Licensee Designee.

ALLEGATIONS:

On 02/28/2023, Resident A was put outside for a 45-minute time out. The temperature was 36 degrees when Resident A was found outside alone. Resident A smacked a stick against a postal truck. The police were contacted, and when they arrived, they talked to the owner of the AFC home by phone. It was stated that they did not have to let Resident A into the home.

INVESTIGATION:

As a part of this investigation, I reviewed the Incident Report 497-4981-23, authored by Officer #1 from the Jackson City Police Department, and the following was noted:

On February 28, 2023, Officer #1 was dispatched regarding a disorderly subject; that a white male had hit a mail truck and thrown a stick at the mailman. Officer #1 spoke to the mailman and was informed that there was no damage caused and that he was not hit with the stick.

The police contacted and interviewed Resident A, who resides at the facility. Resident A stated to the police that he was upset and tired. Resident A said that he got upset and threw an item in the residence. Resident A was transported back to the facility by law enforcement. Once they arrived, Resident A informed that he wanted to stay in the patrol car as it was cold outside.

Officer #1 documented that contact was made with Mr. Jones, who reported to be the husband of Ms. Gibson, owner of the facility. Officer #1 advised that Resident A had been picked up and brought back to the facility. Mr. Jones advised that Resident A had thrown multiple items in the residence, which almost

hit other clients. Mr. Jones advised that Resident A could not come in the residence because it was “state law” that Resident A have a 45-minute time-out, outside of the residence. When Officer #1 told Mr. Jones that they did not believe that was “state law” and that it was too cold for Resident A to be outside walking around, Mr. Jones stated that Officer #1 was not the state and that was the law. According to Officer #, Mr. Jones refused to allow Resident A into the home.

Mr. Jones was able to get Ms. Gibson on the phone, who was out of town. Ms. Gibson told Officer #1 that Resident A could not go into the residence and that he should be taken to jail or the hospital. Ms. Gibson was advised that Resident A did not qualify for jail or hospitalization per JPD standards. According to the report, Ms. Gibson was still unwilling to allow Resident A into the residence. Mr. Jones would only allow Resident A in the home if he took the “PR pill,” which is a medication that calmed him down. Resident A reported that he had already taken a pill that morning. Resident A stated that they are always trying to give him extra meds. Officer #1 asked Resident A how often he was made to take 45-minute time outs and not allowing him back into the home and he informed that it happened all the time. It was noted that the temperature outside that day was 35 degrees Fahrenheit and “very cold.” Mr. Jones eventually allowed Resident A back into the residence after Resident A took the “PR pill.”

Resident A’s guardian, Guardian A, was contacted and informed of the situation. Other investigating agencies were also contacted regarding this matter.

It was also noted that the police left the home around 11:20 a.m. and by 12:50 p.m., Ms. Gibson contacted the police advising that Resident A was actively assaulting staff and residents. When the police arrived, Resident A was gone, and Ms. Gibson began speaking of the prior incident from earlier that day. Ms. Gibson also had other residents outside and told the residents to tell Officer #1 what Resident A had done. One resident (name unknown) said that Resident A threw something at him. It sounded to Officer #1 that it was a lamp thrown; however, Ms. Gibson quickly corrected him, stating it was a laptop. Officer #1 documented that it appeared that Ms. Gibson was coaching the resident.

On February 28, 2023, APS Worker #1 and I conducted an unannounced on-site investigation and made face to face contact with Ms. Gibson, Licensee Designee, Employee #1, and the residents. Resident A was not home at the time of the on-site visit.

Ms. Gibson informed us that Resident A and Resident B have not been getting along. Resident A was taken to the store to get coffee and cereal. Then she took Resident B to get his medication injection. Ms. Gibson stated that it’s as if Resident A wants her to pick between either him or Resident B.

Ms. Gibson stated that Resident A took the medication laptop and barricaded himself in a room. In addition, that Resident A almost hit Resident C in the head with an object, he broke a lamp, and a picture frame.

According to Ms. Gibson, Resident A is prescribed the PRN, Ativan, to help him calm down. In addition, that per his BTP, he can go for a twenty-minute walk; he can go over to the other house on Francis Street. While Resident A was out on the walk, he came in contact with the police. Resident A was brought home. The police were at the home for 45-minutes. Resident A would not get out of the police car. Staff told Resident A that he needed to calm down. It took him 30-minutes to take his PRN medication.

Ms. Gibson also recalled that after the police left, Resident A broke a glass and tried to attack Mr. Jones. Resident A then left the home. Law enforcement went to find him. Ms. Gibson plans to issue a discharge notice. According to Ms. Gibson, while having his behaviors, Resident A damaged a laptop, lamp and picture frame.

Ms. Gibson informed us that Resident A was never refused access to the home. While at the facility, we briefly spoke to Employee #1. She denied not allowing Resident A back into the home.

As we drove back to the office, APS Worker #1 and I looked around the neighborhood to see if we could find Resident A, however, we did not see him.

On February 28, 2023, APS Worker #1 later informed me that he spoke with Officer #1 and Mr. Jones told them that Resident A could not come back to the home for 45-minutes. Therefore, the police dropped him off at the library. There is also a concern that Resident B is aggressive towards Resident A. Staff took Resident B out today and that upset Resident A.

On March 2, 2023, APS Worker #1 informed me that he interviewed Resident A, and he provided me with information regarding the interview. Resident A reported that the previous day was difficult. He reported to APS Worker #1 that he threw the computer and broke a lamp. Resident A was vague with the details regarding the incident. Resident A stated that he did not want to take the PRN medication, Ativan, because he felt he was already calm when they asked him to take the medication to come back into the home. APS Worker #1 asked if staff refused for him to come back into the home, but Resident A did not provide any details regarding the matter. Resident A reported that he goes for walks, but it’s difficult because of his spine. Resident A reported to walk for short distances, then sits down. Resident A questioned why he has to go for a walk, especially when his back hurts. In addition, that they moved Resident B upstairs, as he hit him (Resident A), knocking his glasses off. Resident A reported to be upset because the owner had mentioned a 30-day discharge notice.

APS Worker #1 also interviewed Employee #2, who denied any concerns regarding Resident A. In addition, that she has never had any incidents with Resident A while she has been working.

On March 23, 2023, I made face to face contact with APS Worker #1. He informed me that Resident A has been moved to a facility in another county. Resident A has had behaviors at his new placement, including starting a garbage fire in the middle of the night.

On April 7, 2023, I contacted Ms. Gibson and requested documents from Resident A's file and the contact information for Mr. Jones.

On April 10, 2023, APS Worker #1 and I interviewed Mr. Jones. He stated that he was at the house meeting with the electrician when Resident A started having his behaviors. He stated that once Resident A left, he was only gone about five minutes before returning with the police. When Resident A returned with the police, he was still upset. Mr. Jones informed that he encouraged Resident A to take a walk to calm down. I inquired if Resident A received his PRN medication and Mr. Jones informed that he did.

Mr. Jones stated that he has known Resident A for a while and usually, he will walk to the other house on MLK Drive and when he returns, he's usually calmed down. Mr. Jones stated that when Resident A is in a behavior, he tears things up, then later apologizes once calmed. This time, he didn't calm down. I inquired if Resident A was told he needed to take a 45-minute time-out and Mr. Jones denied the allegations. He stated he told the police that he encouraged Resident A to take a walk. He stated that Resident A came back into the house when the police brought him back home.

Mr. Jones denied that he refused to allow Resident A back into the home. Mr. Jones stated that he has never seen Resident A act like this. He recalled that when Employee #1 asked Resident A to get out of the police car, he was cursing at her, saying her mother was a "whore." The police asked Employee #1 to give the medications to them to give to Resident A.

Mr. Jones stated he didn't know anything about the allegations that Ms. Gibson said the police needed to take Resident A to jail or the hospital.

On April 11, 2023, I contacted Resident A's guardian, Guardian A. She informed me that Resident A resided in the home for approximately six months. Regarding the incident that occurred on February 28, 2023, she stated that there was a new resident admitted into the home, and that he had kept up most of the residents the night before. Once Resident A finally fell asleep, staff were calling him, telling him he needed to get up. Resident A stated that he wanted to sleep. Resident A got up and he bumped the wall, causing a picture frame to fall. The staff then screamed at him to get out and leave. Resident A put on his shoes. Resident A was told to leave for the 45-minute time out. According to Guardian A, it was 29 degrees Fahrenheit

outside that morning. Resident A went outside and was walking down the street. He had a twig in his hand, and he scraped the side of the mail truck. The mailman said, “Hey bud, you can’t do that.” The homeowner called the police to report that Resident A was destroying property and the police responded to the situation. The police contacted Resident A. The police said they were going to call the home and Resident A said that he could not go into the home because he was in time out. Resident A reported that they do this all the time. The police called the home and spoke with the owner’s husband (Mr. Jones). According to Guardian A, the husband refused to allow Resident A back into the home. The police then spoke to Ms. Gibson, and she also said he was in a 45-minute time out. The police informed that she could not do that, and Ms. Gibson stated that she just did. The police took Resident A to a restaurant or someplace to get coffee. Resident A told the police that now, he would not get breakfast. He reported to not get breakfast if he misses the meal with everyone else. Guardian A stated that Resident A told the police that he's not allowed to eat if he gets into trouble. The police then took Resident A back to the home. He was calm.

I inquired if Resident A received his PRN medication during the incident and Guardian A stated that the staff brought it out to him. She also stated that the owners were not kind during this incident. Guardian A stated that the police had contacted her during the incident to make her aware of the situation. Regarding the timeout, Guardian A stated she told Ms. Gibson she did not know where she was getting the 45-minute time out because Resident A has a BTP and that’s not in his plan.

I inquired about Resident A moving about independently in the community and Guardian A stated that he could not be in the community without staff. I inquired about him going for a walk that day, and she stated that the staff said they could see him through the window. She recalled that Ms. Gibson had taken Resident A to the store, and Resident A was not ready to leave; so, she left him there for two ½ hours, until the staff from the store called her. Then she went and picked him up. Guardian A stated that Resident A has intellectual disabilities, and he can become confused. She informed that he’s a forty-year-old male, but sometimes he can act like he is seven or eleven-years-old. She stated that if left alone in the community, Resident A will try to find his way home; he must be supervised when in the community.

She also recalled that Resident A got into a physical altercation with two residents and Ms. Gibson said it was okay because they were protecting her.

As a part of this investigation, I contacted Ms. Gibson and requested the February medication logs, AFC Assessment Plan, the Individual Plan of Service and Behavior Treatment Plan for Resident A.

A review of the medication logs reflected that Resident A is diagnosed with Schizoaffective Disorder, Bipolar, Specified Neuro Development Disorder d/t Cerebral Palsy and Intermittent Explosive Disorder.

The medication log reflected that Resident A was prescribed Lorazepam 1MG PO Tab. The instructions included taking one tablet by mouth once per day only if feeling irritated or angry, may repeat after 4 hours if needed. The Lorazepam 1 MG Po Tab was also prescribed as a PRN, to be taken every 4 hours as needed. It was noted that Resident A received the medication (Lorazepam)at 8:00 a.m. and 8:00 p.m. each day for the entire month of February. It was noted that on the date of the incident (February 28, 2023), there was no documentation that Resident A had received the PRN medication, Lorazepam, as had been reported by law enforcement and individuals interviewed.

On April 10, 2023, I contacted Ms. Gibson, and she confirmed that Resident A was given the PRN medication, Lorazepam. She informed that Resident A would not enter the house, as he was sitting in the police car. She stated that the police were talking to him and talked him into taking the medication. I inquired about the administration of the PRN, as it was not documented on the medication log submitted. Ms. Gibson stated that I asked for the February MAR, but the incident occurred on March 3rd, 2023. Ms. Gibson agreed to provide me with a copy of the medication logs for March. She later forwarded me a copy of the February MAR for Resident A.

After I received the (second) February MAR for Resident A, I followed up with Ms. Gibson and inquired about the information provided. She reported that the laptop was broken; therefore, the information was not documented at that time. In addition, that she contacted Quick Mar about a missed PRN. It should be noted that the second time I received the February MAR, it had been updated. It documented the PRN had been given on February 28, 2023, at 11:55 a.m. by Employee #1. I asked Ms. Gibson if the computer was broken, how did staff document that the other medications had been administered, after the incident on February 28, 2023, and she stated that she brought over another laptop for staff to use.

I also asked about Resident A going for 45-minute walks to cool down. Ms. Gibson stated that she never said anything about 45-minute walks. She recalled that they did discuss in team meetings to give the Ativan (Lorazepam), as it takes twenty-minutes to kick in, and that Resident A could walk to the other house. They said that would be fine.

On April 13, 2023, I called and spoke to Ms. Gibson to gain clarification regarding the BTP and the AFC Assessment Plan. I inquired about Resident A's supervision level when in the community, as the AFC Assessment Plan documents that he can move about independently in the community. It was also documented that Resident A could take walks when upset or agitated to calm down. However, the BTP documents a "Restrictive Behavior Plan (Subject to BMC Review)." The BTP defines the behavior definition as "Elopement is leaving his place of residence alone, especially when escalated and walking along the road near traffic, anytime of the day or night." Staff are to follow Resident A during elopement to monitor for health

and safety and to offer alternatives to elopement. It also documented that Resident A would remain in line of sight of staff in the community for three consecutive months with no elopement. The Individual Plan of Service documented that staff would follow Resident A if he leaves the home when escalated for safety and encourage the use of coping skills, using neutral tones.

Ms. Gibson stated that Resident A already had a BTP in place when he was admitted into the home. That they follow Resident A and keep an eye on him. She stated that Mental Health Professional #1 wrote the treatment plan, and it includes positive supports and walks.

As a part of this investigation, I reviewed the notes charted by staff for Resident A. At 12:00 a.m. on February 28, 2023, Resident A was observed sitting at the dining room table eating cereal and playing his video game. Resident A was asleep in bed during the 2:00 a.m. and 3:00 a.m. notations. At 4:00 a.m., Resident A's sleep was interrupted as Resident B was being loud. The residents had a disagreement, which was defused by staff. At 5:00 a.m. Resident A's sleep was interrupted again, as Resident B was having a hard time sleeping. At 6:00 a.m., Resident A was trying to go back to sleep after being awaken, due to Resident B. At the 7:00 a.m. shift change, Resident A was asleep. At 8:00 a.m., staff documented that Resident A ate his breakfast and took his morning medications. At 9:00 a.m., Resident A was out with the administrator, as he was having a rough morning. At 10:00 a.m. Employee #1 documented that Resident A locked himself in his room with the laptop. The staff member opened the door with a key. Resident A threw the laptop, a lamp, and broke a picture frame. Resident A almost hit Resident C with the laptop. At 11:00 a.m., staff documented that Resident A was in the police car, refusing to come inside the home. Staff noted that Resident A was upset. It was also documented that "Staff offered PRN med. After 45-minutes took med for police." At 1:00 p.m. Employee #1 documented that Resident A was outside having behavioral issues. There was no charted information for the 2:00 p.m. hour. At 3:00 p.m., Employee #2 documents that Resident A was outside on a walk upon her arrival to the home. She also noted that Resident A has been upset and been in behaviors for a while that day. At 4:00 p.m. Employee #2 documented that Resident A was returned to the facility by the authorities; he was calmed down.

As a part of this investigation, I reviewed three incident reports authored by staff. On February 28, 2023, at 7:30 a.m., Employee #1 documented that Resident A was fussing because Resident B was stomping and kept him up all night, causing him to not get enough sleep. Resident B picked up a lamp and tried to hit Resident A and staff intervened. Ms. Gibson was contacted, and she picked Resident A up and took him to Walmart to get his favorite snacks. Resident B went for a walk and was also taken to Walmart. Ms. Gibson spoke to both residents. It was also noted that Resident B's bedroom would be moved upstairs so they would not have rooms next to each other.

At 10:12 a.m., Employee #1 documented that Resident A grabbed the staff laptop from the medication cart and locked himself in his bedroom. Staff asked for it back, she knocked on the door, but he would not let her into the room. Staff used her key to enter the room. Resident A threw the laptop at a client's head and broke the laptop. Resident A also broke the lamp and a picture frame. Staff documented that Resident A ran out of the house and was brought back by the police. The officers stated that the resident was physically destroying the Post Man's vehicle with a stick. Staff asked Resident A to take a walk to calm down, as he was still very upset and agitated. Staff documented that they were following his behavior treatment plan. The corrective measures included that Resident A sat in the police car for 45-minutes, and the police assisted Resident A with taking his PRN medication, Ativan, for agitation and aggression. Resident A then went to his room. It was noted that the administrator would be issuing a 24-Hour discharge notice.

At 12:53 p.m. Employee #1 documented that Resident A ran out of his room extremely upset. He went outside and started to break mailboxes of the posts. Mr. Jones went outside to monitor and make sure that Resident A did not destroy property (staff vehicles). Resident A broke a glass bottle and attempted to stab Mr. Jones. The police were contacted and arrived at the scene. Resident A took off running. A police report was made. The police obtained statements from the other residents. It was also documented that a 24-hour notice to vacate the premises would be issued and that the officials were notified.

On April 18, 2023, APS Worker #1 and I spoke with Case Manager #1. We discussed the BTP and the AFC Assessment Plan for Resident A. I inquired about Resident A's supervision level when in the community, as the AFC Assessment Plan documents that he can move about independently in the community. It was also documented that Resident A could take walks when upset or agitated to calm down. However, the BTP documents a "Restrictive Behavior Plan (Subject to BMC Review)." We discussed the AFC Assessment Plan and the information contained within the plan. It was discovered that the copy provided to licensing by Ms. Gibson was different than the copy provided to Case Manager #1. Case Manager #1 informed us that her copy did not include the information regarding Resident A taking walks when upset or agitated to calm down. She recalled that Ms. Gibson wanted more money for Resident A's care and was told she could not be provided with the increase without additional documentation of care provided. At first, she was resistant but then changed her mind. Ms. Gibson met with Mental Health Professional #1 and positive supports were put into place. Case Manager #1 stated that she thought Resident A was going out in the community with staff. Case Manager #1 confirmed that when Resident A is in the community, he is supposed to be supervised by staff. She also forwarded us a copy of the AFC Assessment Plan that she had on file, and it did not have the information about Resident A going for walks when upset or agitated to calm down documented on page 4 of the plan.

On April 19, 2023, APS Worker #1 and I spoke with ORR Officer #1, who is also investigating the complaint. We discussed details of each case. She also confirmed that per his plan, Resident A is not to be in the community without staff supervision.

On April 19, 2023, I spoke with Ms. Gibson, Licensee Designee, as I had some follow-up questions. Ms. Gibson denied leaving Resident A at the store because he wasn't ready to leave. She stated that there were incidents in which he would run off at the store and she would try to find him. She would contact staff and security to help locate him. Ms. Gibson denied that residents were physically fighting, and her saying it was okay because they were protecting her. Ms. Gibson appeared to be surprised by these allegations.

I also inquired as to how Resident A received his prescribed medications (Divalproex Sodium Dr. and Trazodone Hydrochloride) at 2:00 p.m., as the documentation provided, along with APS Worker #1 and I being at the home during that time, documented that Resident A was not home. Ms. Gibson stated that the employee must have given the medication once he returned to the home. She also mentioned that prescriptions are written to provide flexibility, such as medication to be given at bedtime (instead of providing a specific time).

We also discussed the BTP, and the inconsistent information documented in the AFC Assessment Plan. We discussed the importance of her knowing the BTP and following that plan.

During this phone call, I also conducted the exit conference. Ms. Gibson stated that she would comply. Ms. Gibson agreed to submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(p) The right of access to his or her room at his or her own discretion.**

ANALYSIS:	The police report documented that Mr. Jones was able to get Ms. Gibson on the phone, who was out of town. Ms. Gibson told Officer #1 that Resident A could not go into the residence and that he should be taken to jail or the hospital. Ms. Gibson was advised that Resident A did not qualify for jail or hospitalization per JPD standards. According to the report, Ms. Gibson was still unwilling to allow Resident A into the residence. Mr. Jones would only allow Resident A in the home if he took the "PR pill," which is a medication that calmed him down. Resident A reported that he had already taken a pill that morning. Resident A stated that they are always trying to give him extra meds. Officer #1 asked Resident A how often he was made to take 45-minute time outs and not allowing him back into the home and he informed that it happened all the time. It was noted that the temperature outside that day was 35 degrees Fahrenheit and "very cold." Mr. Jones eventually allowed Resident A back into the residence after Resident A took the "PR pill." On February 28, 2023, Ms. Gibson informed us (APS Worker #1 and I) that Resident A was never refused access to the home. While at the facility, we briefly spoke to Employee #1. She denied not allowing Resident A back into the home. On February 28, 2023, APS Worker #1 later informed me that he spoke with Officer #1 and Mr. Jones told them that Resident A could not come back to the home for 45-minutes. Therefore, the police dropped him off at the library. Mr. Jones denied that he refused to allow Resident A back into the home. Mr. Jones stated that he has never seen Resident A act like this. He recalled that when Employee #1 asked Resident A to get out of the police car, he was cursing at her, saying her mother was a "whore." The police asked Employee #1 to give the medications to them to give to Resident A. During the interview with APS Worker #1, Resident A stated that he did not want to take the PRN medication, Ativan, because he felt he was already calm when they asked him to take the medication to come back into the home. APS Worker #1 asked if staff refused for him to come back into the home, but Resident A did not provide any details regarding the matter. Based on the information gathered during this investigation and provided above it's concluded that there is a preponderance of the evidence to support the allegations that Resident A did not have access to his room at his own discretion.

CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The police report documented that Mr. Jones would only allow Resident A in the home if he took the “PR pill,” which is a medication that calmed him down. Resident A reported that he had already taken a pill that morning. Resident A stated that they are always trying to give him extra meds. Mr. Jones eventually allowed Resident A back into the residence after Resident A took the “PR pill.”

According to Mr. Jones, the police asked Employee #1 to give the medications to them to give to Resident A.

According to Ms. Gibson, the police were at the home for 45-minutes. Resident A would not get out of the police car. Staff told Resident A that he needed to calm down. She stated that the police were talking to him and talked him into taking the medication. It took him 30-minutes to take his PRN medication.

On March 2, 2023, APS Worker #1informed me that he interviewed Resident A. Resident A reported to APS Worker #1 that he did not want to take the PRN medication, Ativan, because he felt he was already calm when they asked him to take the medication to come back into the home.

On the second incident report, Employee #1documented that at 10:12 a.m., Resident A grabbed the staff laptop from the medication cart and locked himself in his bedroom. Staff also documented that Resident A ran out of the house and was brought back by the police. The corrective measures included that Resident A sat in the police car for 45-minutes, and the police assisted Resident A with taking his PRN medication, Ativan, for agitation and aggression.

The police report documented that they left the facility around 11:20 a.m.

The medication log reflected that Resident A was prescribed Lorazepam 1MG PO Tab. The instructions included taking one tablet by mouth once per day only if feeling irritated or angry, may repeat after 4 hours if needed. The Lorazepam 1 MG Po Tab was also prescribed as a PRN, to be taken every 4 hours as needed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A reported to the police that he had already taken a pill that morning. Employee #1 documented that at 10:12 a.m., Resident A grabbed the staff laptop from the medication cart and locked himself in his bedroom. Staff also documented that Resident A ran out of the house and was brought back by the police. It was noted that Resident A sat in the police car for 45-minutes, and the police assisted Resident A with taking his PRN medication, Ativan, for agitation and aggression. The police report documented that they left the facility around 11:20 a.m. Resident A reported to APS Worker #1 that he did not want to take the PRN medication, Ativan, because he felt he was already calm when they asked him to take the medication to come back into the home. The medication log reflected that Resident A was prescribed Lorazepam 1MG PO Tab. The instructions included taking one tablet by mouth once per day only if feeling irritated or angry, may repeat after 4 hours if needed. The Lorazepam 1 MG Po Tab was also prescribed as a PRN, to be taken every 4 hours as needed. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not given his medication as prescribed, as he was given his PRN medication, Lorazepam too early.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

The police report documented that they contacted and interviewed Resident A, who resides at the facility. Resident A stated to the police that he was upset and tired. Resident A said that he got upset and threw an item in the residence. Resident A was transported back to the facility by law enforcement. Once they arrived, Resident A informed that he wanted to stay in the patrol car as it was cold outside.

According to Ms. Gibson, Resident A is prescribed the PRN, Ativan, to help him calm down. In addition, that per his BTP, he can go for a twenty-minute walk; he can go over to the other house on Francis Street (MLK Street). While Resident A was out on the walk, he came in contact with the police. Resident A was brought home.

According to charting notes, at 3:00 p.m., Employee #2 documented that Resident A was outside on a walk upon her arrival to the home. She also noted that Resident A had been upset and been in behaviors for a while that day. At 4:00 p.m. Employee #2 documented that Resident A was returned to the facility by the authorities; he was calmed down.

I reviewed the AFC Assessment Plan and BTP for Resident A. The AFC Assessment Plan documents that Resident A can move about independently in the community. It was also documented that Resident A could take walks when upset or agitated to calm down. However, the BTP documents a “Restrictive Behavior Plan (Subject to BMC Review).” The BTP defines the behavior definition as “Elopement is leaving his place of residence alone, especially when escalated and walking along the road near traffic, anytime of the day or night.” Staff are to follow Resident A during elopement to monitor for health and safety and to offer alternatives to elopement. It also documented that Resident A would remain in line of sight of staff in the community for three consecutive months with no elopement. The Individual Plan of Service documented that staff would follow Resident A if he leaves the home when escalated for safety and encourage the use of coping skills, using neutral tones.

Ms. Gibson stated that Resident A already had a BTP in place when he was admitted into the home. That they follow Resident A and keep an eye on him. She stated that Mental Health Professional #1 wrote the treatment plan, and it includes positive supports and walks.

I inquired about Resident A moving about independently in the community and Guardian A stated that he could not be in the community without staff.

Case Manager #1 confirmed that when Resident A is in the community, he is supposed to be supervised by staff.

ORR Officer #1 also confirmed that per his plan, Resident A is not to be in the community without staff supervision.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Resident A was transported back to the facility after being located in the community by law enforcement. According to Ms. Gibson, per his BTP, Resident A can go for a twenty-minute walk; he can go over to the other house on Francis Street (MLK Street). The BTP reflects that Resident A requires staff supervision while in the community. Guardian A stated that he could not be in the community without staff. Case Manager #1 and ORR Officer #1 both confirmed that Resident A requires staff supervision while in the community. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of evidence to support the allegations that the amount of supervision that Resident A required was not provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

A review of the first medication logs submitted reflected that on the date of the incident (February 28, 2023), there was no documentation that Resident A had received the PRN medication, Lorazepam.

I followed up with Ms. Gibson regarding this matter.

After I received the (second) February MAR for Resident A, I followed up with Ms. Gibson and inquired about the information provided. She reported that the laptop was broken; therefore, the information was not documented at that time. In addition, that she contacted Quick Mar about a missed PRN. It should be noted that the second time I received the February MAR, it had been updated. It documented the PRN had been given on February 28, 2023, at 11:55 a.m. by Employee #1. I asked Ms. Gibson if the computer was broken, how did staff document that the other medications had been administered, after the incident on February 28, 2023, and she stated that she brought over another laptop for staff to use.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	The first medication logs that were submitted reflected that on the date of the incident (February 28, 2023), there was no documentation that Resident A had received the PRN medication, Lorazepam. It should be noted that the second time I received the February MAR, it had been updated. It documented the PRN had been given on February 28, 2023, at 11:55 a.m. by Employee #1. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that the initials of the person who administered the medication was not entered at the time the medication was given.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of very detailed written corrective action plan, I recommend the status of the license remains unchanged.

Mahtina Rubritius 04/19/2023

Mahtina Rubritius Date
Licensing Consultant

Approved By:

A. Hunter 04/24/2023

Ardra Hunter Date
Area Manager