GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2022

Kristine Curtis
Impact Inc.
1001 Military St
Port Huron, MI 48060

RE: License #: AL740092230
Investigation #: 2022A0990017
River Bend #2

Dear Mrs. Curtis:

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.

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
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(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 #:	AL740092230
Investigation #:	2022A0990017
Complaint Receipt Date:	02/11/2022
Investigation Initiation Date:	02/11/2022
Report Due Date:	04/12/2022
Licensee Name:	Impact Inc.
Licensee Address:	1001 Military St Port Huron, MI 48060
Licensee Telephone #:	(810) 985-5437
Administrator:	Kristine Curtis
Licensee Designee:	Aaron Foote
Name of Facility:	River Bend #2
Facility Address:	1572 Meisner Rd East China, MI 48054
Facility Telephone #:	(810) 765-1002
Original Issuance Date:	11/16/2000
License Status:	REGULAR
Effective Date:	05/13/2021
Expiration Date:	05/12/2023
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct Care staff Taylor Workman assaulted Resident A.	No
Resident A is hard of hearing and Ms. Workman makes fun of this.	Yes
Ms. Workman discriminates against Resident A and other residents in the home.	Yes

III. METHODOLOGY

02/11/2022	Special Investigation Intake 2022A0990017
02/11/2022	APS Referral I made a complaint to Adult Protective Services (APS).
02/11/2022	Referral - Recipient Rights I made a complaint to the St. Clair County Office of Recipient Rights Director, Telly Delor via email. Ms. Delor replied via email.
02/11/2022	Special Investigation Initiated - Letter I emailed the administrator Aaron Foote a list of requested documents needed.
02/14/2022	Contact - Document Received I received the incident report regarding the allegations.
02/15/2022	Inspection Completed On-site I conducted an unannounced onsite investigation. I interviewed Resident A, Resident C, Resident D and Resident D. I interviewed home manager Heather King.
03/05/2022	Contact - Face to Face I conducted an interview with Aaron Foote, administrator.
04/05/2022	Contact - Telephone call made I left a detailed voice message with Taylore Workman, direct care staff.

04/05/2022	Contact - Document Sent I emailed Marrisa George St. Clair County Office of Recipient Rights (ORR) investigator.
04/05/2022	Contact - Document Sent I emailed Mr. Foote in attempt to arrange a phone interview with Resident B.
04/05/2022	Contact - Document Sent I emailed Adult Protective Services. I was informed that there was not an active investigation.
04/06/2022	Contact - Telephone call made I conducted a phone interview with Ms. George, ORR investigator.
04/07/2022	Contact - Telephone call made I conducted a phone interview with Ms. Workman, direct care staff.
04/08/2022	Contact - Telephone call made I made a phone call to Blue Water Workshop. I was informed that Resident B was not present.
04/11/2022	Contact - Telephone call made I conducted a phone interview with Resident B.
04/14/2022	Exit conference I left a detailed message regarding exit conference. Mr. Foote returned call and I conducted an exit conference.

ALLEGATIONS:

- **Direct Care staff Taylor Workman assaulted Resident A.**
- **Resident A is hard of hearing and Ms. Workman makes fun of this.**
- **Ms. Workman discriminates against Resident A and other residents in the home.**

INVESTIGATION:

On 02/11/2022, I received the complaint via email. In addition to the above allegations, it was reported that direct care staff Taylor Workman asked Resident A to turn down the television (TV) in the communal area of the home. Resident A is hard of hearing and had turned the volume up high. Resident A refused to turn down the TV and Ms. Workman unplugged the cable from the TV. It was also reported that later the same day Resident A was trying to reach for a pen and had to reach around Ms. Workman and Ms. Workman accused her of hitting her. Resident A did not hit her. Ms. Workman

calls Resident A stupid because of the earpiece she wears and told her that she looks so stupid when she wears it. The residents are “sick” of Ms. Workman being disrespectful and mean to them.

On 02/11/2022, I emailed the administrator Aaron Foote a list of requested documents needed. I observed that Resident A is diagnosed with Schizoaffective Disorder Bipolar Type; Borderline Personality Order and Post Traumatic Stress Disorder. Resident A had a treatment plan through St, Clair County Community Mental Health to address medication management, psychiatric treatment, and placement.

On 02/14/2022, I received an incident report regarding the allegations. The incident report (IR) documented that on 02/10/2022 at 8:15PM, Resident A while in the living room screamed “Shut the fuck up you fucking bitch” at other residents who were in the dining room area. Resident A stood up from the couch and then turned the volume on the TV up to 100 while screaming and swearing at the other residents and sat back down. Direct Care staff Ms. Workman turned down the volume of the TV in attempt to de-escalate the incident and calm Resident A. Resident A stood up from the couch and followed Ms. Workman to the medication area and threw a juice container at Ms. Workman, hitting her on the arm. Resident A continued to follow Ms. Workman screaming “I’m going to beat your ass.” The police were called. The corrective measures were to follow Resident A’s Individual Plan of Service (IPOS) and safety policies.

On 02/15/2022, I conducted an unannounced onsite investigation. I interviewed Resident A, Resident C, Resident D and Resident E. I interviewed the home manager Heather King.

Resident A said that on 02/10/2022 she had an incident with direct care staff Ms. Workman, who does not respect that she and Resident E are hard of hearing. Resident A said that on the night of the incident, she was watching TV around 8PM and had to turn the volume up because she was not able to hear the TV. Ms. Workman yelled at her to turn the volume down. Resident A told Ms. Workman that she could not hear the TV if she turned it down. Ms. Workman came and unplugged the TV cable. Resident A became upset and exploded. Resident A said that she exploded because it was a build-up because Ms. Workman has teased and called her names in the past.

Resident A said that she walked over to Ms. Workman as she was in the dining room area at the medication cart. Resident A began yelling at Ms. Workman to plug the cable back to the TV. Resident A said that Ms. Workman was not listening to her therefore, she grabbed the med scanner from the med cart and Ms. Workman slammed her hand down to take it back. Resident A pushed Ms. Workman and told her that she needed to plug the cable back up to the TV. Ms. Workman accused her of assaulting her. Resident A said that she only pushed Ms. Workman because she slammer her right hand down onto the med cart. Resident A admitted to yelling at Ms. Workman and following her. Resident A said that Ms. Workman called the manager Heather King. Resident A said that no one saw Ms. Workman slam her hand down because their

backs were towards the living room area where the other residents were sitting. The police arrived shortly after the incident and took her statement. Resident A was not arrested because she had an injury to her hand. Resident A displayed her right hand and there was a slight discoloration. Resident A further said that she talked to someone at the prosecutor's office and was informed that there is not enough evidence to file charges. Resident A said that she spoke to Aaron Foote, administrator and he did nothing because he is only concerned about keeping staff. Resident A said that she has lived at the home for three years and this was her first physical incident. Resident A stated that she was in a domestic violence marriage and does not believe in physically attacking others. Resident A admitted to having verbal aggression incidents in the past but has worked on this. Resident A said that she is being discharged from the home due to this incident. Resident A has talked to Channel 2 news and other authorities regarding the discrimination she is experiencing.

Resident A said that at one point she had a good relationship with Ms. Workman. Resident A described personal conversations with Ms. Workman about her boyfriend, dating relationship and her new baby. Resident A said that the relationship began to deteriorate because Ms. Workman started teasing her about her wearing the head piece with headphones to hear on her cell phone. Ms. Workman told her "You look pathetic and stupid with that on." Resident A explained to Ms. Workman why she needed the headpiece and Ms. Workman said, "You look retarded." Resident A further described that she had heard Ms. Workman tell her suitemate Resident B (she and Resident B share a bathroom with conjoining rooms) that she stinks and heard her call Resident B "disgusting." Resident A said that Resident B is about 400 pounds, and she does have a body odor, but she should not be talked to disrespectfully by Ms. Workman. Resident A also described that Ms. Workman has told residents "Why do I need to see your ugly face." Resident A has heard Ms. Workman tell Resident B and Resident E that they need to go take a bath in front of several residents. Resident A said that she once heard Ms. Workman tell Resident E "You stink go brush your teeth you make me want to vomit."

I interviewed Resident C. Resident C said that she witnessed the altercation between Resident A and Ms. Workman. Resident A told her to be quiet because she cannot hear the TV. Resident C said that Ms. Workman was passing meds in the dining room area. Ms. Workman told Resident A to turn down the TV. Resident C said that Ms. Workman walked over to the TV and unplugged it. Resident A went after Ms. Workman and pushed her. Resident C that Resident A began chasing Ms. Workman because she was on the phone crying. Resident C observed Resident A push Ms. Workman twice. Shortly thereafter, Ms. King arrived as well as the police.

Resident C said that Resident A and Ms. Workman were friends. Resident C said that Ms. Workman has a 10-month old baby and has observe her showing Resident A baby pictures on her phone. Resident C said that she had never observe Resident A assault anyone in the past however, she has heard her yell at others. Resident C said that Resident A has a temper. Resident C said she and Resident A were friends but since the incident occurred, she has not spoken to her.

Resident C denied ever hearing Ms. Workman say abusive words or statements to other residents. Resident C said that she has heard Ms. Workman tell Resident B and Resident A to go shower. Resident C said that she does not share a room with Resident B or Resident E.

I interviewed Heather King the home manager. Ms. King was not present at the home when the incident occurred but arrived on the scene after receiving a phone call from Ms. Workman that Resident A pushed her. Ms. King said that the sheriff's department came right after as she was the one that called them. When Ms. King arrived at the home, she observed Resident C and Resident D really upset. Ms. King was told that Resident A had the volume of the TV up to 80. The officers advised Resident A to go to her bedroom. Ms. King has met and is still meeting with Resident A's clinical staff to address this behavior in which she contributes to her refusing her medications. Since December 2021, Ms. King said that Resident A has not been consistently taking her medications and her guardian and supports coordinators are aware of this. They are exploring a new placement for Resident A because she may need a smaller setting as she is very independent. Ms. King said that Resident A has threatened other residents in the past, but she has not physically assaulted anyone. Resident A picks and chooses when she wants to take her medications. Last night Resident A took all of her medications which was the first time she has done so since December 2021. Ms. King knew at some point that Resident A would spiral because she is not fully medicated. Ms. King said that normally, Resident A sleeps all day and stays up all night. Ms. King is normally up at night watching TV and there are no issues with her not being able to hear the TV. Ms. King said that the discoloration on Resident A's hand has been there for some time because she has a dry skin condition.

I interviewed Resident D. Resident D said that on 02/10/2022 she was sitting in the living room in the blue recliner and Resident A was sitting on the couch in front of the TV. Resident A turned around and told Resident C to be quite because she was talking. Resident D said that Resident A stood up and turned the TV volume up to 100. Ms. Workman came over and unplugged the cable from the TV. Resident D said that Ms. Workman walked away and then Resident A ran over to her pushed Ms. Workman twice. Resident D observed Resident A push Ms. Workman's hand. Resident D said that Ms. Workman walked away towards the hallway and Resident A followed behind her yelling at her calling her names. Ms. Workman was crying. Resident D described that Resident A is talks loudly and tells other residents to "shut up" often. Resident D said that Resident A "acts as if she owns the place." Resident D said that since the incident she is no longer speaking to Resident A.

Resident D said that she has not heard Ms. Workman call residents' names. Resident D said that Ms. Workman is nice to her and others. Resident D said that Resident A is telling the other residents to lie for her that Ms. Workman hit her first because she does not want to get kicked out.

I interviewed Resident E. Resident E said that she witnessed the altercation between Resident A and Ms. Workman. Resident E said that Resident A told her that pushed Ms. Workman because she slammed her hand on the med cart. Resident D said that she was not facing them when the push occurred. Resident D only heard Resident A and Ms. Workman yelling at each other. Ms. Workman said that since Resident A would not turn down the TV, she took the cord away. Resident E said that Resident A showed her the bruise on her hand, but she is unsure if it was a bruise because Resident A says she has carpal tunnel on that hand. Resident E said that Resident A "has verbal anger issues."

Resident E said that Ms. Workman has been very accusatory towards her. Resident E said that in the past she did have an issue with taking other resident's left over food. Resident E said that she no longer does this, but Ms. Workman accuses her of doing this a lot. Resident E said that Resident A told her that Ms. Workman tells her that she looks stupid, and that Ms. Workman tells Resident A that Resident B is a "bitch." Resident E said that she has not heard these things. Ms. Workman has told her and Resident B to go shower. Resident E said that she tells them this in the communal area of the home which makes her uncomfortable.

On 03/05/2022, I conducted an interview with Aaron Foote, administrator. Mr. Foote said that he was not present when the incident occurred between Resident A and Ms. Workman. Mr. Foote said that Resident B was at workshop today. Mr. Foote said that ORR has not completed their investigation. They had planned to discharge Resident A after the incident but decided not to. Mr. Foote said that when the incident occurred, Resident A had not taken any of her medications for two weeks. Mr. Foote believes that St. Clair County Community Mental Health (CMH) has made a referral for a smaller placement for Resident A and that she may be moved at some point. Mr. Foote said that prior to the alteration he asked CMH and Resident A's guardian to have her petitioned to the hospital because she was refusing her medications and they refused to do so. Mr. Foote said that Resident A cannot be petitioned unless she is homicidal and/or suicidal. Mr. Foote has not heard any complaints regarding Ms. Workman making derogatory statements to residents until the incident occurred. Mr. Foote does not have a copy of the police report.

On 04/06/2022, I conducted a phone interview with Ms. Marissa George, ORR investigator. Ms. George said that she substantiated her investigation for violations against Ms. Workman for dignity/respect and services suited. Ms. George did not have enough evidence to support violations of abuse against Ms. Workman because all interviews concluded that Resident A was the aggressor. Ms. George said that the discoloration on Resident A's hand is due to a skin condition in which she has steroid cream. Ms. George said that Ms. Workman did not want to press charges against Resident A. Ms. George also said that Resident A does not want to get Ms. Workman in trouble.

Ms. George said that she interviewed Ms. Workman and she admitted to talking to Resident A about a domestic violence personal matter. Ms. Workman indicated that

she talked to Resident A about her about this because Resident A openly shares that she was in a domestic violent relationship. Ms. George said that therefore she substantiated Ms. Workman for Services Suited because it is not in Resident A's plan that staff can discus their personal relationship issues with her. Ms. George said that there is a "Personal Involvement Policy" in which, Ms. Workman crossed.

Ms. George said that she substantiated Ms. Workman for violation of dignity and respect because Ms. Workman admitted o unplugging the cable to the TV because it was too loud, and she was trying to pass meds. Ms. George said that it is confirmed by interviews that Resident A had the volume of the TV up to 100. Ma. George said that Ms. Workman said that she was going to plug the TV back up after she was done passing meds. Ms. George said that Ms. Workman admitted to teasing Resident A about her headpiece because they joked around a lot. Ms. George said that Ms. Workman told her that Ms. Workman admitted to telling Resident A that she looked silly wearing it.

On 04/07/2022, I conducted a phone interview with Ms. Workman, direct care staff. Ms. Workman said that on 02/10/2022she was in the dining room area preparing to pass medications. Ms. Workman could hear Resident A yelling at other residents telling them that she could not hear the TV. Ms. Workman told Resident A to calm down and to turn the volume up. Ms. Workman said that as more residents arrived in the dining room area because it was the nighttime medication pass, it got louder. Ms. Workman said that at that point Resident A turned the volume to 100. Ms. Workman asked Resident A several times to turn it down. Ms. Workman said that Resident A refused therefore, she went to the back of the TV and unplugged the cable line. Ms. Workman said thinking back now she understands that this may not have been the right way to handle the matter. Ms. Workman said that after she unplugged it, she went back to the med cart in the dining room area. Resident A approached her and was yelling at her. Ms. Workman said that Resident A then took her water bottle and threw it on the floor and pushed her. Ms. Workman backed away and was attempting to call Ms. King the manager and Resident A was following her yelling and screaming at her. Ms. Workman said that Resident A followed her to the courtyard. Ms. King arrived shortly thereafter along with the police who took a report.

Ms. Workman admitted to discussing personal relationship issues with Resident A because she talks about her experiences openly. Ms. Workman admitted to having a close relationship with Resident A at one point and now realizes that this was inappropriate.

Ms. Workman said that she never called Resident A names however, she did tell her that she looked silly wearing the headpiece. Ms. Workman was not intentionally trying to hurt and thought they were close at that point and was just teasing.

Ms. Workman denied ever openly talking to Resident B about her body odor. Ms. Workman said that she pulls her aside to tells her that she needs to take a shower. Ms. Workman said that it is Resident A who says inappropriate comments about Resident

B's body odor and lack of personal hygiene as they share a bathroom. Ms. Workman said that Resident E has a history of stealing other residents' food at mealtimes. Ms. Workman has not observed this behavior with Resident E lately. Ms. Workman said that Ms. King usually addresses this with Resident E.

Ms. Workman said that she has asked Resident B and Resident E to go shower but not in a mean way. Ms. Workman said that she may have said this while in the communal areas, but it was not her intentions to embarrass them.

On 04/11/2022, I conducted a phone interview with Resident B. Resident B said that she was present when the altercation occurred between Resident A and Ms. Workman. Resident B observed that after Ms. Workman unplugged the TV, Resident A and Ms. Workman were face to face and Resident A grabbed Ms. Workman's drink. Resident A grabbed the med scanner and threw it. Resident B said that Resident A showed her hand after the incident, and it looked swollen.

Resident B said that in the past Ms. Workman said inappropriate things to her but does not any longer. Resident B said that Ms. Workman would embarrass her by telling her to go take a shower in front of her housemates. Resident B said that she would say this aloud. Resident B heard Ms. Workman tell Resident E, "You smell" repeatedly. Resident B said that Ms. Workman was referring to Resident E's body odor. Resident B has observed many other incidents where Ms. Workman said inappropriate things, but she does not want to get anyone in trouble.

On 04/14/2022, I left a detailed message regarding exit conference. Mr. Foote returned my call and I conducted an exit conference. Mr. Foote said that he was made aware of the violations which are similar to the ORR allegations/investigation. Mr. Foote said that because of those violations Ms. Workman completed the full class for CMH Recipient Rights (not a refresher course), she received a job performance memo and reviewed policies on dignity and respect and appropriate conduct. I informed Mr. Foote that when he submits the correction action plan, he should send verification of these items as well as address how he plans to maintain compliance. Mr. Foote agreed.

APPLICABLE RULE	
R 400.15308	**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: (a) Use any form of punishment.
ANALYSIS:	On 02/10/2022, Resident A got into an altercation with Taylor Workman direct care staff. Resident A admitted to yelling and pushing Ms. Workman. Resident A said that Ms. Workman slammed her hand down but there were no witnesses to

	corroborate that Ms. Workman slammed her hand down. Ms. Workman said that after she unplugged the cable to the TV, Resident A pushed her and followed her throughout the building yelling and screaming at her. Resident C observed Resident A push Ms. Workman twice and chase her. Resident D observed Resident A push Ms. Workman twice. Resident D observed Resident A pushed Ms. Workman after she unplugged the TV. Resident E heard Resident A and Ms. Workman yelling at each other. Ms. King, the home manager said that Resident A is not medication compliant and contributes this incident to this. Mr. Foote said that Resident A had not taken her medications for two weeks when the incident occurred and asked her treatment team to have her petitioned and this was denied. According to Mr. Foote, CMH has made a referral for a smaller placement for Resident A because it would suit her better.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15307	**Resident behavior interventions generally.**
	(1) A licensee shall ensure that methods of behavior intervention are positive and relevant to the needs of the resident.
ANALYSIS:	On 02/10/2022, an altercation occurred between Resident A and direct care staff Ms. Workman. There is sufficient evidence to support that the behavior intervention was not positive and relevant to the Resident A's needs due to Ms. Workman unplugging the cable to the TV. Resident A turned the volume to the TV up to 100 and refused to turn it down because she is hard of hearing. Ms. Workman admitted to unplugging the cable to the TV because Resident A refused to turn it down. Ms. Workman realizes that she could handle the matter differently. Resident C observed Ms. Workman unplug the TV after Resident A refused to turn down the volume. Resident D and Resident E witnessed Ms. Workman unplug the TV which triggered Resident A. Ms. George from ORR substantiated Ms. Workman for a violation against for dignity/respect. According to Ms. George, Ms. Workman unplugging the TV is not treating the Resident A

	with dignity and respect because it was interfering with her passing medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15308	**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: (f) Subject a resident to any of the following: (iii) Derogatory remarks about the resident or members of his or her family.
ANALYSIS:	Direct care staff Ms. Workman made derogatory statements to Resident A, Resident B and Resident E. Ms. Workman teased Resident A about her headpiece that she uses because she is hard of hearing. Resident C had heard Ms. Workman tell Resident B and Resident C to go shower. Resident E said that Ms. Workman has told her to go shower in front of other residents. Resident E said that Ms. Workman accuses her of stealing food because she had an issue with it in the past but no longer. Resident B said that Ms. Workman embarrassed her in the past by telling her to go shower in front of her housemates. Resident B heard Ms. Workman tell Resident E that she smells. Ms. George said that Ms. Workman admitted to telling Resident A she looked silly wearing her headpiece. Ms. Workman admitted to teasing Resident A about her headpiece but not with the intentions of demeaning her. Ms. Workman admitted to telling Resident B and Resident E to go shower in front of others.
CONCLUSION:	**VIOLATION ESTABLISHED**

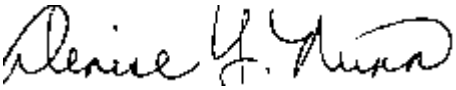
IV. RECOMMENDATION

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

04/14/2022

LaShonda Reed — Date
Licensing Consultant

Approved By:



04/19/2022

Denise Y. Nunn — Date
Area Manager