GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 14, 2022

Robert and Laura Hopkins
P O Box 728
Evart, MI 496310728

RE: License #: AM670015943
Investigation #: 2022A0009036
Hopkins 80th Ave AFC

Dear Robert and Laura Hopkins:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame 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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM670015943
Investigation #:	2022A0009036
Complaint Receipt Date:	06/24/2022
Investigation Initiation Date:	06/24/2022
Report Due Date:	07/24/2022
Licensee Name:	Robert and Laura Hopkins
Licensee Address:	1375 Chaput Sears, MI 49679
Licensee Telephone #:	(231) 734-5936
Administrator:	Laura Hopkins
Name of Facility:	Hopkins 80th Ave AFC
Facility Address:	2366 80th Avenue Evart, MI 49631
Facility Telephone #:	(231) 734-6349
Original Issuance Date:	03/17/1995
License Status:	REGULAR
Effective Date:	12/20/2021
Expiration Date:	12/19/2023
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A staff person used physical force other than physical restraint with residents.	Yes

III. METHODOLOGY

06/23/2022	Contact – Document (email) received from licensee/administrator Ms. Laura Hopkins
06/23/2022	Contact – Telephone call made to licensee/administrator Ms. Laura Hopkins
06/23/2022	Contact – Telephone call made to Community Mental Health (CMH) recipient rights officer Ms. Jill McKay, left message
06/24/2022	Special Investigation Intake 2022A0009036
06/24/2022	APS Referral
06/24/2022	Special Investigation Initiated – Telephone call made to CMH recipient rights officer Ms. Jill McKay
06/27/2022	Contact – Telephone call received from adult protective services worker Mr. Adam Hawkins
06/28/2022	Inspection Completed On-site Interviews done with CMH recipient rights officer Ms. Jill McKay. Interviews with Resident A, Resident B, Resident C, Resident D, Resident E and Resident F
06/29/2022	Contact – Telephone call made to adult protective services worker Mr. Adam Hawkins, left message
06/30/2022	Contact – Telephone call received from adult protective services worker Mr. Adam Hawkins
06/30/2022	Contact – Telephone call received from CMH recipient rights officer Ms. Lisa Jones
07/07/2022	Contact – Telephone call made to licensee/administrator Ms. Laura Hopkins

07/12/2022	Contact – Telephone call made to CMH recipient rights officer Ms. Jill McKay
07/12/2022	Contact – Telephone call made to former direct care worker Mr. Joseph Higgens
07/12/2022	Contact – Telephone call made to former direct care worker Mr. Renardo Lemons
07/12/2022	Contact – Telephone call made to direct care worker Mr. Joshua Shephard
07/12/2022	Contact – Telephone call made to direct care worker Mr. Ryan Minaker
07/13/2022	Contact – Telephone call made to adult protective services worker Mr. Adam Hawkins
07/13/2022	Contact – Telephone call received from CMH recipient rights officer Ms. Jill McKay
07/14/2022	Exit conference with licensee/administrator Ms. Laura Hopkins

ALLEGATION: A staff person used physical force other than physical restraint with residents.

INVESTIGATION: I received an email from licensee/administrator Ms. Laura Hopkins on June 23, 2022. She said that she received a telephone call from Community Mental Health (CMH) recipient rights officer Jill McKay. Ms. McKay told her that she received serious allegations against direct care worker Joseph Higgens. She instructed Ms. Hopkins to remove Mr. Higgens from employment effective immediately. Ms. Hopkins stated that she did so but does not know what is alleged against Mr. Higgens. She provided me with Ms. McKay's contact information.

I attempted to contact Ms. McKay on June 23, 2022 and left a voicemail message for her. I did speak with Ms. McKay the next day. She told me that she had information that direct care worker Joseph Higgens had used physical force with Resident A and Resident B. She confirmed this during her own in-person interviews with residents from the Hopkins 80th Ave AFC home. Ms. McKay confirmed that Mr. Higgens was no longer working in the home pending the investigation. She said that she had also made an adult protective services (APS) referral. I told her that I would be conducting an investigation and would be doing my own on-site interviews of the residents. Ms. McKay requested that she be present during the interviews. I opened an investigation after learning the nature of the allegations.

I spoke with adult protective services worker Adam Hawkins by phone on June 27, 2022. He reported that he is also investigating the matter. I told him that I planned on making an on-site inspection the next day and was meeting with the recipient rights officer to conduct the interviews.

I met CMH recipient rights officer Jill McKay on June 28, 2022. I asked her about her interviews with the residents. She said that some of the residents told her that they had been hit or seen other residents get hit by direct care worker Mr. Higgens. Other residents denied that it had happened to them or that they had seen anything like that happen. We proceeded to the Hopkins 80th Ave AFC home. We initially spoke with Resident A. After some preliminary discussion, we asked him if there was anything that has happened at the home that he wanted to tell us. Resident A said that Mr. Higgens has "put him down on the floor". He said that he made Mr. Higgens upset and he knocked him off his feet. We asked Resident A how Mr. Higgens knocked him to his feet. He replied that Mr. Higgens has "smacked" him and then he falls. He demonstrated with an open hand across the side of his face. Mr. Higgens has said to him, "If you do that again, I'll smack you again." Resident A said it was always with an open hand. He said that he falls to the ground because being smacked takes him "off balance". Resident A said that his face has been red afterwards but that was all. He also shared that he has observed Resident B and Resident E being smacked in the same fashion by Mr. Higgens. He said that it is always when they "do something wrong" and Mr. Higgens gets angry at them. Resident A stated that this had been happening for some time and as recently as a few days before Mr. Higgens "quit".

We then interviewed Resident B. We asked him if anything had happened recently at the home. He replied that Mr. Higgens had left. He said, "Somebody told on him." We asked him what he might know about this. Resident B said that one time Mr. Higgens punched him in the nose and that blood started dripping out. He said that it happened because, "I made Joe (Higgens) mad that day." Resident B said that he likes Mr. Higgens a lot but did not like when that happened to him. He said that he could not remember exactly when that happened. We asked why that happened. Resident B replied it happened because, "I was not listening to him and not being good. He wants us to listen to him." We asked him what he did about the blood. Resident B said that Mr. Higgens got some paper towels and wiped the blood off the floor. He then threw the paper towels in the garbage. We asked him if anyone had seen that happen. He said that Resident C was sitting at the table behind him when it happened. He also said that "Renardo (Lemons) usually works at the same time as Joe (Higgens)." He said that he had also seen Mr. Higgens hit Resident D. He said that it was because Resident D, "won't keep his nose on his own business". Resident B denied that he has seen anything like that happen to anyone else there because "everyone else listens to him".

We then interviewed Resident C. After some preliminary discussion. We asked how things were going at the home. Resident C said that he really missed Mr. Higgens and wished that he could come back to work there. Resident C referred to Mr.

Higgens as “Papa” which I had noted on previous visits to the home. We asked him why he thought Mr. Higgens was not working there any longer. Resident C said that it was because Mr. Higgens “took somebody down to the ground and started kicking him”. He stated he saw Mr. Higgens kicking him. We asked who this happened to and he replied that it happened to Resident D. Resident C went on to say that he remembered that it happened on a Thursday because it was after one of their outings to town which always happens on Thursdays. He said that it happened to Resident D because Mr. Higgens was mad about something Resident D did over the weekend. Resident C denied that Mr. Higgens has done anything like that to himself. We asked if anything else had happened to the other residents. He said that he saw Resident B get hit and punched in the face by Mr. Higgens. Resident C said that he was in the same room and saw it happen. Mr. Higgens was mad at Resident B about something. We asked if he had ever seen anything else happen to anyone. Resident C said that the only other thing he had seen was Mr. Higgens slap Resident A “a couple of times”. He said that Resident A got up from the couch without permission and went to his room. Mr. Higgens yelled at Resident A and then another resident said that Resident A was getting hit by Mr. Higgens. The other resident who saw this was Resident F.

We then spoke with Resident D. After some preliminary discussion, we asked him if he ever gets in trouble there. He said that he does and that sometimes Mr. Higgens “yells and screams” at him. Resident D denied that Mr. Higgens ever did anything else but stated that he “does get mad real easy”. He said that Mr. Higgens “does like to yell at people”. He said that Mr. Higgens “only yells, nothing else”.

We then spoke with Resident E. After some preliminary discussion, we asked him if he ever gets in trouble there. Resident E said that he did sometimes. He said that Mr. Higgens has yelled at him and that he “would yell at us”. We asked Resident E if anything else has happened. He said that he has “been hit by him, by Joe (Higgens).” He said that it has happened when they have gotten into an argument. He said that Mr. Higgens has hit him in the face. Resident E demonstrated this by pointing to the side of his face. He indicated that Mr. Higgens used an open hand when he hit him in the face. We asked him why this happened. Resident E replied that “he just gets really mad”. He denied that he had seen it happen to anyone else. Resident E said that Mr. Higgens “was a nice guy once to him”.

We then spoke to Resident F. After some preliminary discussion, we asked him if there had been any recent changes in the home. He said that Mr. Higgens had left. We asked him what he thought about Mr. Higgens. He said that “He is a nice guy and takes us shopping.” We asked Resident F what happens to them if they get in trouble. He said that Resident A has gotten in trouble for taking his (Resident F’s) stuff. Resident F said that he told Mr. Higgens not to hit Resident A. He denied that Mr. Higgens hit Resident A. He “just yelled at him”. He said that there was a time when Mr. Higgens accidently hit him (Resident F) and caused him to get stitches several years ago. He indicated that the place that he received stitches was above

his eye, on his eyebrow. Resident F said that he wanted us to know that it was just an accident.

I spoke with APS worker Mr. Hawkins by phone on June 30, 2022. I told him what the residents had told us during our site visit.

I received a telephone call from CMH recipient rights officer Ms. Lisa Jones on June 30, 2022. She informed me that she was from a different CMH entity than Ms. McKay. She said that Resident B is their client. I shared with her what Resident B said happened to him.

I spoke with licensee/administrator Ms. Laura Hopkins by phone on July 7, 2022. I told her that I could not share exactly what had been told to me by the residents because APS has an open investigation and law enforcement possibly being involved. I did share that it involved physical mistreatment of the residents. Ms. Hopkins confirmed that Mr. Higgens no longer works at any of their facilities.

I spoke with CMH recipient rights officer Ms. McKay by phone on July 12, 2022. She said that she spoke with Joseph Higgens who denied any wrongdoing. He also denied that he had needed to perform any physical restraints on any of the residents. Mr. Higgens told her that they listened to him and he seemed to know which of the residents had said were struck by him. Mr. Higgens said that they have a history of “false reporting”. She said that she did not find any CMH documentation of this except that one of the residents was working on “not lying”. Ms. McKay went on to say that she spoke to a former staff person Renardo Lemons, who often worked with Mr. Higgens. He said that he had heard something that sounded like a slap when Mr. Higgens was in a room with Resident A. This happened on at least one occasion. Mr. Lemons told her that he had been afraid to tell her this information “without incriminating myself”. None of the other staff told her that they had heard or seen Mr. Higgens mistreat any of the residents.

I spoke with former direct care worker Joseph Higgens by phone on July 12, 2022. He told me that he never “laid hands” on a resident. He said that he heard that there were “three complainants”. He said that the only thing he could think of was that he was “constantly badgering” them for not following their CMH Care Plans. Mr. Higgens said that he has had to do physical restraints before. I asked him to explain the circumstances when he has had to do a physical restraint. He said that he had to push Resident D behind him into a corner when another resident was being aggressive. He denied that he pushed Resident D to the floor or that Resident D ended up on the floor. He denied hitting Resident D in any way. He denied ever having to knock, push or convey a resident to ground during a physical restraint. Mr. Higgens stated that there was only one time, four or five years ago that he had used a physical restraint with a resident. The resident he named was not one of the residents we had spoken to. Mr. Higgens stated that there had never been a time that he had needed to strike a resident except 26 years ago when a resident was biting him. He did strike the resident. This was investigated by AFC Licensing and

CMH resident rights at the time. Mr. Higgens stated that otherwise he has only had to break up fights between residents which only involved him getting between them and putting a hand on their chest. He denied that there was ever a time when he would have struck a resident in the face or head since the incident 26 years before. He said that three years before, he had accidently run into Resident F who was standing right behind him at the time. He turned quickly not knowing he was there and "rammed him with my shoulder". Resident F had his hands in his pockets and his face hit the floor first. His eyebrow was split open from that. Resident F had gotten treatment at the time.

I then spoke with former direct care worker Renardo Lemons. He was aware of the allegations against Mr. Higgens. He confirmed that he has worked alongside Mr. Higgens at the facility for several years. Mr. Lemons stated that he felt that Mr. Higgens had been there "too long and needed a break from that place". He knew that Mr. Higgens was dealing with some personal issues. Mr. Higgens had told Mr. Lemons that the "pressure was building" and that he needed a change. Mr. Higgens did have a connection with the group of guys who lived at the home and did not want to leave them, though. I asked him if he had ever seen or heard anything at the home regarding Mr. Higgens. Mr. Lemons stated that he had heard something that sounded like a slap coming from a room that Mr. Higgens and Resident A occupied. Mr. Lemons stated that he asked Mr. Higgens what happened and he told him that Resident A "attacked" him. He did not see a mark on either of the individuals. It happened about six months ago. He did not think that an incident report had been written up regarding what had happened. Mr. Lemons denied that he had ever seen or heard anything else of that nature.

I also spoke with direct care worker Joshua Shephard by phone on July 12, 2022. He said that he didn't know what to think about the allegations against Mr. Higgens. He denied that he had ever seen or heard anything like that happen when he was present. Mr. Shephard stated that he only worked alongside Mr. Higgens one day a week. He said that Mr. Higgens would "raise his voice" to get the residents' attention. Mr. Higgens always tells the residents that he is "firm but fair". Mr. Shepard never saw him do a physical restraint with any of the residents. Mr. Shepard said that he knew that a physical restraint can only be used when a resident is a danger to himself or others. He said that they must follow their training in regards to how they perform the restraint.

I also spoke with direct care worker Ryan Minaker by phone on July 12, 2022. I asked him what he thought about the allegation against Mr. Higgens. He said that he didn't know, that he only worked with Mr. Higgens one day a week. Mr. Minaker stated that it is usually him or Mr. Shephard who deal with any residents who are difficult. He said that they just get between the residents who are having the disagreement and each of them tries talking to one of the residents. The biggest challenge is separating the two residents because one of them always wants to get in the last word. They separate them and then talk to each of them individually until they are calm. They do not have to use the physical restraint because the talking

strategy works for them. The residents very rarely get physical with each other, it is only verbal. The last time a resident got physical with another resident was two years ago when one slapped the other. Mr. Higgens was not there when that happened. Mr. Minaker has never seen Mr. Higgens use physical restraint or use physical force with a resident.

I spoke with APS worker Adam Hawkins by phone on July 13, 2022. He said that he is still investigating the matter. He had also referred the matter to the Osceola County Sheriff's Department.

I spoke with CMH recipient rights officer Ms. McKay by phone on July 13, 2022. She said that she is substantiating a recipient rights violation against Mr. Higgens for physical abuse. She felt that what the residents had reported along with former direct care worker Mr. Lemons made her believe that physical mistreatment of the residents by Mr. Higgens had occurred.

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: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner. (e) Withhold food, water, clothing, rest, or toilet use. (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats. (g) Refuse the resident entrance to the home. (h) Isolation of a resident as defined in R400.14102(1)(m). (i) Any electrical shock device.

ANALYSIS:	It was confirmed through this investigation that former direct care worker Joseph Higgens did use a form of punishment and physical force other than physical restraint with several residents. Three residents reported being hit by Mr. Higgens and a fourth confirmed their accounts. Their accounts of what had happened to them were consistent with one another. They all reported Mr. Higgens being angry at them for not doing what they were supposed to be doing during the incidents. Another former direct care worker said that he heard a slap coming from a room that Mr. Higgens and Resident A occupied. Resident A was one of the residents who reported that he had been "smacked" by Mr. Higgens. Mr. Higgens denied needing to perform physical restraints with the residents. The current direct care workers denied that physical restraints were needed with the current residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with licensee/administrator Ms. Laura Hopkins by phone on July 14, 2022. I told her of the findings of my investigation and gave her the opportunity to ask questions. She confirmed that Mr. Higgens is no longer working for the company.

IV. RECOMMENDATION

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

07/14/2022

Adam Robarge — Date
Licensing Consultant

Approved By:

07/14/2022

Jerry Hendrick — Date
Area Manager