GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 22, 2022

Mindy Campbell
Innovative Housing Dev Corp
Suite 5
3051 Commerce Drive
Fort Gratiot, MI 48059

RE: License #: AS740253775
Investigation #: 2022A0572046
Ravenswood Home

Dear Ms. Campbell:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740253775
Investigation #:	2022A0572046
Complaint Receipt Date:	07/27/2022
Investigation Initiation Date:	08/01/2022
Report Due Date:	09/25/2022
Licensee Name:	Innovative Housing Dev Corp
Licensee Address:	Suite 5 3051 Commerce Drive Fort Gratiot, MI 48059
Licensee Telephone #:	(810) 385-4463
Administrator:	Melinda Wiegand
Licensee Designee:	Renae-Marie Kiehler
Name of Facility:	Ravenswood Home
Facility Address:	4166 Ravenswood Port Huron, MI 48060
Facility Telephone #:	(810) 364-8831
Original Issuance Date:	03/18/2003
License **Status:**	REGULAR
Effective Date:	04/12/2021
Expiration Date:	04/11/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Ashley Koehler stated in July 2022, Dawn Nedrow slapped Resident A and "threw" him down the hallway. Staff Heather Provost stated on July 26, 2022, Dawn Nedrow was "striking" Resident A in the head. Incidents took place inside of the home in the hallway area leading to the bedrooms.	Yes

III. METHODOLOGY

07/27/2022	Special Investigation Intake 2022A0572046
08/01/2022	Special Investigation Initiated - Letter Complainant.
08/01/2022	Contact - Document Received Complainant.
08/12/2022	Inspection Completed On-site Staff, Cora Stipp; Staff, Jolene Nielsen; Resident B, C, D and E.
09/12/2022	Contact - Telephone call made Resident A's Family Member #1.
09/12/2022	Contact - Telephone call made Resident A’s Case Manager, Cheyanne Johnson.
09/16/2022	Contact - Telephone call made Staff Dawn Nedrow.
09/20/2022	Contact - Telephone call received Staff, Heather Provost.
09/20/2022	Contact - Telephone call received Staff, Ashley Koehler.
09/20/2022	Contact - Telephone call made Staff, Dawn Nedrow.
09/20/2022	Inspection Completed-BCAL Sub. Compliance

09/20/2022	Exit Conference Acting Licensee, Mindy Campbell.
09/20/2022	APS referral Referral made to APS.
09/21/2022	Contact - Face to Face Resident A.

ALLEGATION:
Staff Ashley Koehler stated in July 2022, Dawn Nedrow slapped Resident A and "threw" him down the hallway. Staff Heather Provost stated on July 26, 2022, Dawn Nedrow was "striking" Resident A in the head. Incidents took place inside of the home in the hallway area leading to the bedrooms.

INVESTIGATION:
On 07/27/2022, the local licensing office received a complaint for investigation. An APS referral was made for further investigation.

On 08/01/2022, contact was made with the complainant. She informed that she was not a witness to the incident and that all of the information had been shared with her. She also indicated that a recipient rights complaint had been filed with St Clair County CMH.

On 08/12/2022, an unannounced onsite was made at Ravenswood Home, located in St. Clair County, Michigan. Interviewed were, Staff, Cora Stipp and Staff, Jolene Nielsen. Residents, B, C, D and E were observed. Resident A was at program during the onsite visit.

On 08/12/2022, I interviewed, Staff, Cora Stipp regarding the allegation. She informed that she was aware that something happened, but she was not a witness to it. It is her understanding that Dawn Nedrow slapped Resident A and threw him to the ground. Prior to this complaint, she had never seen or heard of anything like this regarding Ms. Nedrow. Based on her personality, she is surprised that she would have done something like this. Ms. Stipp informed that there were witnesses but does not believe that any of the residents seen what happened. Resident A has some behavior issues and believes that maybe Ms. Nedrow became frustrated with his behaviors.

On 08/12/2022, I interviewed Staff, Jolene Nielsen regarding the above allegation. She informed that she heard above the alleged incident but was not a witness to it. She heard that Ms. Nedrow slapped Resident A and threw him to the ground. She is unsure if any residents were witnesses to the incident. Ms. Nielsen indicated that Resident A has some behavior issues but is not sure if that was the cause of Ms.

Nedrow being physical with him. Ms. Stipp explained that when Resident A is having some behaviors, they are to redirect him towards something positive.

On 08/12/2022, I observed Resident B sitting in the living room watching tv. Resident C was in bed and getting ready to take a nap. Resident D and E were both in bed taking a nap. Resident A was not at home at the time as he was at program. All of the residents appeared to be in adequate health and receiving appropriate supervision.

On 09/12/2022, phone contact was made with Resident A's Family Member #1 regarding the allegation. He informed that he was notified by the facility and Recipient Rights as to what happened. He is unsure why this incident occurred. Family Member #1 knows that Resident A can be difficult at times. To his knowledge, there has never been an incident like this before. He had spoken with Ms. Nedrow a few times and he had always had a pleasant and favorable contact with her and was hoping that she was not the staff that was involved in this incident. This incident made him think to himself about a previous incident when Resident A allegedly was having some behaviors and threw himself onto the floor. Resident A was with Ms. Nedrow at the time of that incident, so he now wonders if he actually threw himself onto the floor or did something else happen. Despite this incident, Family Member #1 is pleased with Ravenswood Home. He informed that the Home Manager contacted him immediately when they found out about the incident. He has always had a good impression of this facility and believe that they are doing all they can in order to keep Resident A safe and out of harm's way.

On 09/12/2022, a phone message was left for Resident A's Case Manager, Cheyanne Johnson.

On 09/12/2022, a phone message was left for staff, Dawn Nedrow.

On 09/16/2022, I reviewed the incident report. The incident occurred on 07/26/2022 and Staff, Ashley Koehler and Dawn Nedrow were working. It indicated that Resident A had been aggressive most of the day, grabbing at staff and residents. Resident began opening all of the other resident's bedroom doors and taking things off of their dressers. Staff redirected Resident A out of the other resident's bedrooms. Resident A then began to run up and down the hallway and then outside through a side door. A PNR was administered after 30 minutes of trying to get him to stop running down the hallways and out the door. He continued this behavior for approximately 2 hours and 45 minutes. Once he had gotten tired, he went into his room and fell asleep. No other incidents on remainder of the shift.

On 09/20/2022, a phone call was received from Staff, Heather Provost. Ms. Provost witnessed Ms. Nedrow slapping Resident A on 07/26/2022 but was not aware of the other allegations. Ms. Provost informed that Resident A had ate and took his medications with no problem. After he was done, Ms. Nedrow took her four fingers and slapped him across the face and then said, "Good job Buddy." She denied that

it was an angry slap, but it was overly playful and very disrespectful. Ms. Provost is not sure if Ms. Nedrow has ever been physically aggressive towards any residents and was not aware of her hitting Resident A and throwing him to the ground. Prior to the incident that she witnessed, Ms. Provost had never seen an issue between Ms. Nedrow and any of the residents but recalls that one of the residents would always ball up his fists whenever Ms. Nedrow comes near him. That resident never does this with any other staff.

On 09/20/2022, a phone call was received from Staff, Ashley Koehler. Ms. Koehler informed that she witnessed Ms. Nedrow slapping Resident A in the face sometime in July 2022 and she reported it to management. She described Resident A as high functioning and on this particular night, he would not go to sleep. Resident A kept opening and closing his door and then he started digging in his buttocks. He had poop all over his fingers, so she and Ms. Nedrow cleaned him up and put him back to bed. Resident A got back out of bed around 3:15am and Ms. Nedrow swatted Resident A across the face unto the floor. Ms. Nedrow began yelling at Resident A in an aggressive manner. It was far more than just a stern voice. Then she started tapping his face as if to be chastising him. She has never seen or known for Ms. Nedrow to do anything like this but has heard her talk about tapping them (residents) on the face and calling them “little (F word)”. Seeing Ms. Nedrow do this to a resident was hard to watch because they are supposed to take care of them, plus she is friends with Ms. Nedrow outside of work.

On 09/20/2022, a phone message was left for staff, Dawn Nedrow.

On 09/20/2022, Acting Licensee Designee, Mindy Campbell informed that Ms. Dawn Nedrow is currently serving a suspension, and is off the schedule pending the results of the licensing investigation.

On 09/21/2022, I visited with Resident A in the emergency room. He was pacing the floor while watching Barney on a tablet. I spoke to him, but he is non-verbal. He appeared to be in adequate health.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**

ANALYSIS:	In speaking with two of the staff that witnessed two separate incidents of physical abuse by Ms. Nedrow, there is enough evidence to support a rule violation. Ms. Nedrow has not returned my phone calls, so I am unable to get her perspective on the events. Resident A was not present during my onsite, but I was able to observe the other residents in the household and they appeared to be well-taken care of. I spoke with Resident A's Family Member #1 and he informed that Ravenswood Home contacted him immediately regarding the incident and believes that the home is doing what they can to keep Resident A safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/20/2022, an Exit Conference was held with Acting Licensee Designee, Mindy Campbell, for Licensee Designee Renae-Marie Kiehler, regarding the result of the special investigation.

IV. RECOMMENDATION

Continent upon receipt of an acceptable plan of correction, I recommend no changes to the licensing status of this small adult foster care group home (Capacity 1-6).

09/22/2022

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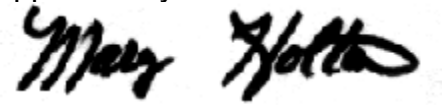
Anthony Humphrey Date
Licensing Consultant

Approved By:



09/22/2022

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Mary E. Holton Date
Area Manager