GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 20, 2023

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

RE: License #: AS740370242
Investigation #: 2023A0580035
Wells Street

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.
- 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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

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 #:	AS740370242
Investigation #:	2023A0580035
Complaint Receipt Date:	05/03/2023
Investigation Initiation Date:	05/04/2023
Report Due Date:	07/02/2023
Licensee Name:	Impact Inc.
Licensee Address:	1001 Military St Port Huron, MI 48060
Licensee Telephone #:	(810) 985-5437
Administrator:	Aaron Foote
Licensee Designee:	Kristine Curtis
Name of Facility:	Wells Street
Facility Address:	1027 Wells Street Port Huron, MI 48060
Facility Telephone #:	(810) 216-6489
Original Issuance Date:	03/19/2015
License Status:	REGULAR
Effective Date:	09/19/2021
Expiration Date:	09/18/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 05/02/23, Resident A was struck in the face by Resident B. He had a handprint across his face that has since healed.	Yes

III. METHODOLOGY

05/03/2023	Special Investigation Intake 2023A0580035
05/03/2023	APS Referral This complaint was opened by APS for investigation.
05/04/2023	Special Investigation Initiated - Telephone Spoke with the license administrator, Mr. Aaron Foote.
05/04/2023	Contact - Document Received An emailed copy of the incident report was received.
05/05/2023	Contact - Document Received A copy of the 24-hour discharge given to Resident B was received.
05/09/2023	Contact - Telephone call made Spoke with Ms. Marnie Debell of APS in St. Clair County.
05/11/2023	Inspection Completed On-site An onsite inspection at Wells Street Home. Contact was made with direct staff, Ms. Rebecca Sarazan.
05/11/2023	Contact - Face to Face Observation of Resident A.
06/13/2023	Contact - Document Sent Email to Mr. Aaron Foote, License Administrator,
06/14/2023	Contact - Telephone call made Spoke with Ms. Amanda Banouch, Home Manager.
06/14/2023	Contact - Telephone call made Spoke with Relative Guardian A
06/14/2023	Contact - Telephone call made Spoke with Ms. Marnie Debell of APS.

06/16/2023	Contact - Telephone call made Call to Ms. Tyanna Haskins, staff.
06/20/2023	Exit Conference An exit conference was held with both the licensee, Ms. Kristine Curtis and the license administrator, Mr. Aaron Foote.

ALLEGATION:

On 05/02/23, Resident A was struck in the face by Resident B. He had a handprint across his face that has since healed.

INVESTIGATION:

On 05/04/2023, I received complaint via BCAL Online complaints. This complaint was opened by APS for investigation.

On 05/04/2023, I spoke with the license administrator, Mr. Aaron Foote, license administrator. Mr. Foote had contacted me the day prior informing me of the incident which occurred and APS involvement as a result. Mr. Foote shared that Resident A was provided a 30-day discharge notice in December 2022 due to prior instances of violence. St. Clair County Community Mental Health has not located a new placement, nor have they moved him from the home. Mr. Foote was advised to provide an emergency discharge and to provide a copy to me once written.

On 05/04/2023, I received an emailed copy of the incident report, signed, and dated on 05/04/2023, by the home manager Ms. Amanda Banouch and the license's administrator, Mr. Aaron Foote. It states that on 05/02/2023, around 4:30pm, Resident B opened the office door and started staring at the supervisor, Ms. Amanda Banouch. Staff, Ms. Tyanna Haskins prompted Resident B to step out of the office. Resident B then stepped out of the office, gave staff Ms. Haskins the middle finger, and stated "fuck off". Resident B then returned to his room for 25 minutes. Once he came out, he went to the kitchen counter where Resident C was standing. Resident B then hit Resident C on the right side of his mid neck and shoulder area. Resident B then picked up a metal stool and threw it on the floor next to himself. Once Resident B calmed down, he was invited to eat dinner in his room or at the dining table with the other residents. Resident B did not respond. Instead, he went towards Resident A, walking into him and pushing him with his shoulder. Resident A did not respond. Two minutes later, Resident B walked back over to Resident A and hit him across the left side of his face, with an open hand. Resident B then walked to his room, yelling, "I will be telling my mom and "drop dead bitch". Staff actions consisted of ensuring the other residents felt safe and had no injuries, followed plan regarding behaviors, and contacted CMH and guardians. Corrective measures include a 24-hour emergency discharge will be given to Resident A on 5/4/23 which follows a 30-day discharge notice given 12/16/22.

On 05/05/2023, I received an emailed copy of the 24-hour discharge given to Relative Guardian B guardian, case manager, Ms. Ellen Drowns of CMH in St. Clair County, and St. Clair County CMH Director, Ms. Kristen Thompson, signed and dated by the licensee, Ms. Kristine Curtis, on 05/04/2023. It states that *on 12/16/2023, I.M.P.A.C.T. issued a 30-day discharge notice to B from the Wells Street Group Home. The 30-day notice was issued due to Resident B's acts of physical aggression which pose a substantial risk of serious injury to other residents living in the home. IMPACT has maintained regular communication with St. Clair County Community Mental Health on their progress in finding an alternative placement. On 05/23/2023, Resident B had an incident of physical aggression towards 2 other residents who live in the home. As previously stated, the Wells Street Group Home cannot meet Resident B's needs or assure the safety and well-being of the other residents living in the home as required by Adult Foster Care Licensing Rules. It is for these reasons that I.M.P.A.C.T. finds it necessary to issue a 24-hour emergency discharge notice.*

On 05/09/2023, I spoke with Ms. Marnie Debell of APS in St. Clair County. Resident A is non-verbal and was slapped by Resident B. Resident B had been given a 30-day notice some time ago, however, he remained in the home. She stated that she received a call from Ms. Kristen Thompson, Assistant Division Director at St. Clair County CMH, indicating that Resident B has been moved from the facility.

On 05/11/2023, I conducted an onsite inspection at Wells Street Home. Contact was made with direct staff, Ms. Rebecca Sarazen. She shared that Resident A is currently in his room sleeping while Resident B has been moved from the home. The other residents in the home were away at day program. She shared that direct staff, Ms. Amanda Banouch is currently on sick leave. She does not know her anticipated date of return.

On 05/11/2023, while onsite I observed Resident A in room, while taking a nap in his bed. Resident A is non-verbal and unable to participate in an interview. Resident A was under the covers, however, he was clothed and appeared to be clean. No bruising on his face, or otherwise was observed. He appeared to be receiving appropriate care.

On 06/13/2023, I sent an email to Mr. Aaron Foote, license administrator, requesting additional staff contact information.

On 06/14/2023, I spoke with Ms. Amanda Banouch, Home Manager. She stated that from what she recalls, Resident B was drooling a lot and staff asked him to wipe his mouth. As a result, he began calling the staff "bitches," stormed over to where Resident A was sitting and smacked him on both the head and face areas. Resident A did not require any medical treatment. She stated that Resident B moved from the home on 05/04/2023. Since the move things have been going well, the other residents seem happy, and they are now coming out of their rooms more to socialize. A new resident has not moved in the home as of this date.

On 06/14/2023, I spoke with Relative Guardian A. She shared that to her knowledge, the May 2023 aggressive behavior towards Resident A was the first time Resident B targeted him physically. She recalled that a year ago, Resident B was going around pulling Resident A's pants down. She expressed concern that Resident A was hit in his head by Resident B, which could have activated his seizures. She stated that since Resident B's departure from the home, things seem to be doing much better. She adds that staff do a good job with Resident A and with Resident B gone it will free up a lot of the staff's time to meet the other residents needs.

On 06/14/2023, I spoke with Ms. Marnie Debell of APS. She shared that she will be substantiating the allegations of abuse against Resident B.

On 06/16/2023, I placed a call to Ms. Tyanna Haskins, staff. She recalled the events on the date of in as it was explained in the incident report dated 05/04/2023.

SIR #2023A0580003 dated 12/13/2022 cited violation to R 400.14305(3) due to Resident B assaulting a resident in the home. The corrective action plan dated 12/28/2022, signed by Mr. Aaron Foote, License Administrator, stated a 30-day notice was given to Resident B on 12/16/2022. Resident B remained in the home until 05/04/2023.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A was struck in the face by Resident B, leaving a handprint across his face that has since healed. License administrator, Mr. Aaron Foote, license administrator. stated that Resident A was provided a 30-day notice in December 2022 due to prior instances of violence. St. Clair County Community Mental Health has not located a new placement, nor have they moved him from the home. The incident report dated 05/04/2023 was reviewed. Staff, Ms. Rebecca Sarazen shared that Resident A is currently in his room sleeping while Resident B has been moved from the home. Resident A is non-verbal and was observed as having no bruising during the onsite inspection.

	Staff, Ms. Amanda Banouch and Ms. Tyanna Haskins both recalled the event as it was stated in the incident report. Relative Guardian A expressed concern that Resident A was hit in his head by Resident B, which could have activated his seizures. Ms. Marnie Debell of APS stated that she will be substantiating the allegations of abuse against Resident B. Based on my observation of Resident A, a review of the incident report dated 05/04/203, the 30-day discharge notice issued on 12/13/2022, interviews conducted with staff, Ms. Amanda Banouch, Ms. Tyanna Haskins, and Ms. Rebecca Sarazen, Relative Guardian A, Ms. Marnie DeBell of APS, and the license administrator, Mr. Aaron Foote, there is enough evidence to support the rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR 2023A0580003 dated 12/13/2022.**

On 06/16/2023, an exit conference was conducted with both the licensee, Ms. Kristine Curtis and the license administrator, Mr. Aaron Foote. Both were informed of the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

Sabrina McGowan June 20,2023

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton June 20, 2023

Mary E. Holton Date
Area Manager