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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 13, 2022

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

RE: License #: AS740370242
Investigation #: 2023A0580003
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.
- 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. 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 #:	2023A0580003
Complaint Receipt Date:	10/21/2022
Investigation Initiation Date:	10/24/2022
Report Due Date:	12/20/2022
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 10/19/22, LE (Law Enforcement) was called to the home due to Resident A being assaulted by another resident in the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/21/2022	Special Investigation Intake 2023A0580003
10/21/2022	APS Referral This complaint was opened by APS for investigation.
10/24/2022	Special Investigation Initiated - Telephone A call was made to Ms. Marnie DeBell, assigned APS worker in St. Clare County.
10/24/2022	Contact - Telephone call received A call was received from Mr. Andrew Foote, license administrator.
10/25/2022	Inspection Completed On-site An onsite inspection was conducted. Interviews held with direct staff, Ms. Dessalee Adams, Ms. Tyanna Haskins, and home manager, Ms. Amanda Baunoch.
10/25/2022	Contact - Face to Face Contact with Mr. Andrew Foote.
10/25/2022	Contact - Face to Face Contact was made with Ms. Ellen Drowns, St. Clair Co CMH Case Manager for Resident B.
10/25/2022	Contact - Face to Face An observation of Residents A, B, C was made.
12/08/2022	Contact - Telephone call made A call was made to Relative Guardian A.
12/08/2022	Contact - Document Received An email was received from Ms. DeBell of APS.

12/08/2022	Contact - Telephone call made A call to Mr. Ryan Gladfelter, assigned CMH case manager for Resident A, was made.
12/08/2022	Contact - Telephone call made A call to Officer Schwiehoffer of the Port Huron Police Department was made.
12/08/2022	Contact - Telephone call made A call was made to Relative Guardian B.
12/09/2022	Contact - Telephone call made A call was made to Relative Guardian C.
12/09/2022	Contact - Telephone call made A call was made to Ms. Marnie DeBell.
12/09/2022	Contact - Telephone call made A call was placed to Ms. Banouch, Home Manager.
12/09/2022	Contact - Telephone call made A follow-up call to Ms. Ellen Drowns was made.
12/09/2022	Exit Conference An exit conference was held with the licensee designee, Ms. Kristine Curtis and the license administrator, Mr. Aaron Foote.
12/12/2022	Contact - Telephone call made A call was made to the license administrator, Mr. Aaron Foote.

ALLEGATION:

On 10/19/22, LE was called to the home due to Resident A being assaulted by another resident in the home.

INVESTIGATION:

On 10/21/2022, I received a complaint via BCAL Online Complaints. This complaint was opened by APS for investigation.

On 10/24/2022, I spoke with Ms. Marnie DeBell, assigned Adult Protective Services (APS) worker in St. Clair County. She shared that Resident A was slapped by Resident B. This is his 2nd time slapping this resident. Other residents and staff have been

assaulted as well. She attended a meeting held on Friday,10/21/2022 with CMH and AFC staff, to come up with a safety plan and ways to address Resident B's behavior more efficiently. Currently, residents are isolating in their room when Resident B begins attacking due to their fear. A joint onsite visit was scheduled for the following day.

On 10/24/2022, I received a call from the license administrator, Mr. Aaron Foote. He wanted to report that Resident A was assaulted by Resident B. APS has been in contact.

On 10/25/2022, I conducted an onsite inspection at Wells Street Home. An interview was conducted with staff, Ms. Dessalee Adams. She recalled on the day of the alleged incident that she was attempting to pass meds to the residents. When Resident B got to the med room he started swinging. He then left the med room. She thought he was heading back to his room. Next thing she heard was a load smack. She then saw Resident A's tablet fly down the hall (as a result of being thrown by Resident B).

On 10/25/2022, I conducted an interview with staff, Ms. Tyanna Haskins. She recalled that Resident B went to get his meds, saw Ms. Dessalee Adams, and hit her. Resident B then walked by Resident A. She then saw Resident B slap Resident A really hard. She went to tend to Resident A, next thing you know the tablet comes flying towards the couch. All the residents were then cleared out of the room.

On 10/25/2022, I conducted an interview with staff, Ms. Amanda Baunoch. On the day of the alleged incident, she recalled that it was time to pass meds and Resident B had refused his medication. She then heard a commotion, saw staff, Ms. Dessalee Adams standing there, and Resident B attempted to hit her. She was able to block the hit. He then kicked her in the thigh. Resident B then went over to the table and poured out a cup of milk. Resident A was sitting nearby playing with his tablet. She then heard a loud smack. Resident B then took Resident A's tablet and threw it down the hall. She adds that this is the 3rd incident involving Resident B either slapping or biting Resident A. Resident B has hit other residents in the home as well. Currently, when Resident B gets out of control, staff are either corralling the residents in the activity room located off the living room or returning residents to their room. The police are sometimes called. There are 6 residents total in the home. Resident A was the last resident to enter the home on 06/22/2022.

Also present on 10/25/2022, was the licensee administrator, Mr. Aaron Foote. Mr. Foote stated that the home is a high behavior home, and these are expected behaviors. He also adds that due to the CMH contract, they do not choose which residents are placed in the home. Resident B was placed in the AFC on 06/08/2022. Ms. Drowns, the assigned Community Mental Health (CMH) case manager for Resident B visits the home 2 times a week, while Mr. Ryan Gladfelter, the assigned CMH case manager for Resident A, visits once a week.

On 10/25/2022, Ms. Ellen Drowns, assigned Community Mental Health (CMH) worker for Resident A was also present. She stated that she is aware of the escalating

incidents involving Resident B. A meeting was held on 10/21 between CMH and the AFC staff to address the issue, due to the frequency that this has been occurring. Resident B does not have a behavior plan. She states that due the fact that it's a high behavior home, these are expected behaviors.

A copy of the incident reports (IR) involving Resident B were requested. IR dated 10/18/2022 states that Resident A was in the middle of the room playing with his tablet when Resident B smacked him on the left side of his face. Resident A then began screaming, running, and smacking himself. Resident B then proceeded to grab Resident A's tablet and broke it. Actions taken by staff indicate that Resident A was checked for bumps and bruises. No corrective measures were taken.

IR dated 10/21/2022 states that staff was assisting Resident A in preparing an overnight bag for a weekend visit. As staff handed Resident A his bag, Resident B hit Resident A. Resident A then started screaming, hitting himself, and running down the hall. Resident A then went and into the kitchen and Resident B proceeded to smack him in the face, kicked his knees and bit his right shoulder. Staff and caseworker intervened. Resident B was checked for injury. No corrective measures were taken.

IR dated 10/23/2022 states that Resident B requested that staff call his mom. As she was doing so Resident B picked up a cup of orange juice and threw it on staff. Later that same day Resident B apologized to staff and sat down to eat lunch. When finished, he got up to put his dirty dishes in the dish bin. Resident B then proceeded to smack Resident C across the face. Resident then grabbed some laminated paper from the corkboard in the hallway, tried ripping it and threw it at staff. Resident B then told stated to staff, "fuck you" and "drop dead bitch". Each resident was then accompanied by staff for safety.

Resident Medication Log reviewed for the month of October 2022 indicates that Resident B refused his evening medications on 10/10, 10/14, and 10/20/2022. The log for the month of November 2022 does not reflect that Resident B refused any of his medication. Resident B has a current Standing Missed Medication Order. The order indicates that the resident's medication can be given up to 2 hours late, with the exception of two medications which are allowed to be given 12 hours late. After the time lapse, omit missed dose and resume medication at next scheduled dosage.

The assessment plan for Resident B was provided. The assessment plan provided was created and completed by CMH. It indicates that Resident B struggles with making safe choices. Resident B is easily upset or unsettled. When agitated Resident B needs 2 staff when aggressive towards others or property. It also states that Resident B has aggression, either verbally or physically. When aggressive, Resident B needs 2 staff to monitor his safety and housemates. This assessment was completed on 09/30/2022. This plan was only signed by the home manager, Ms. Amanda Baunoch on 10/24/2022. It does not allow signatures for the licensee designee, nor the resident or their designated representative.

On 12/08/2022, I spoke with Relative Guardian A, assigned guardian for Resident A. She stated that there were multiple incidents involving Resident B attacking her son prior to the 11/18 incident. The home has not done a thing to address these attacks which is why she has filed a police report against Resident B. There have been 21 written incidents involving Resident B attacking others with no resolve. She shared that Resident B has threatened to kill a staff's unborn child. Staff and Residents cower in the office or other places throughout the home when Resident B goes on a tirade. In addressing her concerns with the administrator, Mr. Aaron Foote, she sent him an email, to which he responded that the social workers are trying to implement a behavior plan for Resident B. She stated that she believes that Resident B's actions are not behavioral, they are intentional and purposeful. Relative Guardian A states that she does not know why they thought it was a good idea to place this higher functioning resident with non-verbal residents. The residents are witnessing this occur and their behaviors are regressing. She adds that Resident A is now abusing himself and cursing.

On 12/08/2022, I received an email from Ms. Debell sharing that Mr. Gladfelter, assigned CMH case manager for Resident A, sent her an email on today, indicating that as far as he is aware, Resident B is continuing to struggle with aggression towards the other individuals and staff in the home. Ms. Downs is currently seeking an out of county placement for Resident B. Ms. Debell also shared that Officer Schwiehoffer of the Port Huron Police Department indicated that he could refer the assaultive behaviors to court if they continue or increase. He had concerns about if Resident B is a good fit in the home.

On 12/08/2022, I placed a call to Mr. Ryan Gladfelter, assigned CMH case manager for Resident A. A voice mail message was left requesting a return call.

On 12/08/2022, I placed a call to Officer Schwiehoffer of the Port Huron Police Department. A voice mail message was left requesting a return call.

12/08/2022, I placed a call to Relative Guardian B. A voice mail message was left requesting a return call.

12/09/2022, I placed a call to Relative Guardian C. She stated that Resident C has been in the home since 2019. To her knowledge, there have been at least 20-30 incidents in which Resident B has attacked Resident C or others in the home. The home has not done anything about these repeated attacks. When addressed, she gets told that it is a high behavioral home, and these are expected behaviors. She fears that Resident B is seriously going to hurt someone in the home. She has filed a police report regarding Resident B's assault of Resident C. When she last visited Resident C on 12/06, you could see him tense up or get scared whenever Resident B walked into the room. Resident C is non-verbal and will not get up and retaliate. She has filed a police report due to the repeated assaults. Resident B has uncontrollable anger and needs a placement that is a better fit.

On 12/09/2022, I spoke with Ms. Marnie Debell. She stated that she will be substantiating for both physical abuse and neglect.

On 12/09/2022, I placed a follow up call to the home manager, Ms. Banouch. She shared that to her knowledge Resident B has not been issued a 30-day discharge notice. She adds that although the staff are fearful to work with Resident B, no one has quit.

12/09/2022, I placed a follow-up call to Ms. Ellen Drowns, assigned CMH Case manager for Resident B. A voice mail message was left requesting a return call.

She clarified that Resident B has had a behavior plan in place for years
On 12/12/2022, I spoke with Mr. Aaron Foote, licensee designee. He stated that corrective measures after each incident involving Resident A attacking other residents, included contacting his case manager, guardian and continuing to follow his behavioral/service plan. Mr. Foote was advised to submit a completed IR for future reference, completely filled out with the corrective measures included.

On 12/02/2022, I placed a follow-up all to Mr. Foote, license administrator. Mr. Foote, administrator, stated that the home is staffed with a 1-3 ratio (2 staff) during the day and a 1 staff during 3rd shift. Mr. Foote stated that Resident A sleeps throughout the night and has not been aggressive to require 2 staff during sleeping hours.

Mr. Foote denied that there have been multiple incidents of aggression. With the exception of the 3 incidents reports provided, with an additional one having been sent on 11/18/2022, there have been no other incidents in which Resident B has physically attacked other residents.

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 assaulted by another resident in the home. Licensee administrator, Mr. Aaron Foote stated that the home is a high behavior home, and these are expected behaviors. Ms. Ellen Drowns, CMH case manager for Resident B also states that due the fact that it's a high behavior home, these are expected behaviors. IR reports dated 10/18 and 10/21//22 indicate that Resident A was assaulted by Resident B. IR dated 10/23/22 stated that Resident C was assaulted by Resident B. No corrective measures were taken. Home manager, Ms. Banouch stated, when Resident B gets out of control, staff are either corralling the residents in the activity room located off the living room or returning residents to their room. The police are sometimes called. Staff are fearful to work with Resident B. The assessment plan states that Resident B needs 2 staff when aggressive towards others or property, which was provided. Also, when aggressive, Resident B needs 2 staff to monitor his safety and housemates. Relative Guardian A and Relative Guardian C both stated that there have been several written incidents involving Resident B attacking others with no resolve. Ms. Marnie Debell, of APS stated that she will be substantiating for both physical abuse and neglect. Based on the interviews conducted with the license administrator, Mr. Aaron Foote, CMH case manager, Ms. Ellen Drowns, multiple direct staff members, Relative Guardian's A and C, Ms. Marnie DeBell of APS, the Incident Reports dated 10/18, 10/21, and 10/23/2022, and the assessment plan for Resident B, there is enough evidence to support the allegations that Resident A was assaulted by Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The Assessment Plan for Resident B was only signed by the home manager, Ms. Amanda Baunoch on 10/24/2022. This plan was created by CMH. It does not allow signatures for the licensee designee, nor the resident or their designated representative.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the missing signatures for the resident or the resident's designated representative and the licensee, Resident B's assessment plan is incomplete. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

12/09/2022, an exit conference was held with the licensee designee, Ms. Kristine Curtis and the license administrator, Mr. Aaron Foote. Both were informed of the findings of this investigation.

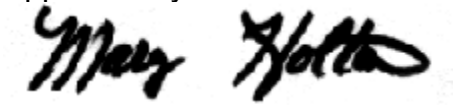
IV. RECOMMENDATION

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

December 13, 2022

Sabrina McGowan — Date
Licensing Consultant

Approved By:



December 13, 2022

Mary E. Holton — Date
Area Manager