GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 5, 2024

Renae-Marie Kiehler
Innovative Housing Dev Corp
Suite 5
3051 Commerce Drive
Fort Gratiot, MI 48059

RE: License #:	AS740364562
Investigation #:	2024A0123017
	Hancock

Dear Renae-Marie Kiehler:

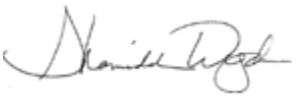
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740364562
Investigation #:	2024A0123017
Complaint Receipt Date:	01/08/2024
Investigation Initiation Date:	01/09/2024
Report Due Date:	03/08/2024
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:	Hancock
Facility Address:	2115 Hancock Port Huron, MI 48060
Facility Telephone #:	(810) 385-4463
Original Issuance Date:	01/20/2015
License Status:	REGULAR
Effective Date:	07/20/2023
Expiration Date:	07/19/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/02/2024. Resident A was being physical with staff attempting to wrestle them and put the staff into headlocks. Resident A punched Staff Chris Campbell in the collar bone/throat area twice. Staff Campbell reacted with a punch back making light contact with Resident A's lower left jaw area. There were no injuries. Staff Campbell notified management of his wrongdoing immediately. Staff Johnanthan Harper also notified management. There were no cuts or bruises.	Yes

III. METHODOLOGY

01/08/2024	Special Investigation Intake 2024A0123017
01/09/2024	Special Investigation Initiated - Telephone I spoke with home manager Stefani Hodgins via phone.
01/09/2024	APS Referral APS referral completed.
01/20/2024	Contact - Telephone call made I left a voicemail requesting a return call from Guardian 1.
01/22/2024	Inspection Completed On-site I conducted an on-site. I interviewed staff Christopher Campbell.
01/24/2024	Contact - Telephone call received I spoke with Guardian 1.
01/24/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Johnathan Harper.
01/24/2024	Contact- Telephone call received I interviewed staff Johnanthan Harper.
02/02/2024	Contact- Telephone call made I conducted a Microsoft Teams call with home manager Stefani Hodges and Resident A.
02/05/2024	Exit Conference I spoke with administrator/designated person Mindy Wiegand.

ALLEGATION: On 01/02/2024. Resident A was being physical with staff attempting to wrestle them and put the staff into headlocks. Resident A punched Staff Chris Campbell in the collar bone/throat area twice. Staff Campbell reacted with a punch back making light contact with Resident A's lower left jaw area. There were no injuries. Staff Campbell notified management of his wrongdoing immediately. Staff Johnanthan Harper also notified management. There were no cuts or bruises.

INVESTIGATION: On 01/04/2024, I received a call from home manager Stefani Hodgins reporting that there was an incident between staff and Resident A, regarding Resident A being punched back by staff Christopher Campbell after Resident A was physically attacking staff. Resident A was punched in the jaw. Resident A is now punching and wrestling staff to the ground. Resident A had punched Staff Campbell twice in the collar bone area. Staff Campbell is a good staff and self-reported the incident. There were no injuries to Resident A.

On 01/09/2024, I called Staff Hodgins back. Staff Hodgins stated that Port Huron Police Department was contacted but they did not take the complaint, just made note of the incident. Recipient Rights is aware of the reported incident. Staff Chris Campbell may have reacted defensively due to having a history of being attacked by a previous resident. Staff Hodgins stated that staff are supposed to attempt to get away to a safer place. In this case, Resident A will seek staff out. Resident A has been targeting Staff Campbell. Staff do complete CPI training. Resident A will jump staff from the side, wrap his legs around staff, and take staff down. The CPI trainer could not instruct staff on how to get out of holds like this. Melina Campbell (administrator) is working with community mental health's placement coordinator to find Resident A a new placement. Guardian 1 was notified. Guardian 1 told Staff Hodgins that she understands. Earlier in the day the incident occurred, Resident A had punched Staff Harper in the chest and brought him down to his knees and got staff Johnathan Harper in a headlock.

On 01/10/2024, I received requested documentation via email from Staff Hodgins. An *AFC Licensing Division- Incident/Accident Report* dated 01/02/2024. In summary, the incident report states that Resident A arrived home from an outing with Guardian 1. Resident A was behavioral but ate some soup. Resident A continued his behaviors (i.e. puking, urinating on floor, slamming doors etc.) Staff encouraged Resident A to take a bath. Resident A was in the tub about five minutes, and also threw water at Staff Campbell. Resident A's behaviors continued (i.e. puking, flipping chairs, attempted putting Staff Campbell in a headlock, screaming, stripping naked, etc.) Resident A punched Staff Campbell in the collar bone twice. Staff Campbell punched Resident A without putting his body weight into the punch. Resident A went to the living room in shock and began crying in the chair. All three staff comforted Resident A and were able to get Resident A dressed and back into bed.

Resident A's St. Clair County Community Mental Health *Individual Plan of Service* dated 12/14/2023 was obtained as well. Under *Responding to Aggression Towards*

Others it states in summary that staff should not make eye contact, use re-directive statements, attempt to create spaces between themselves, others, and Resident A, and redirect Resident A to a preferred calming activity.

On 01/22/2024, I conducted an on-site at the facility. Resident A was not present. I interviewed staff Christopher Campbell. Staff Campbell stated that he is a direct care worker with five years of experience. Staff Campbell works both first and second shift. He stated that on the day of the incident (01/02/2024), Resident A was behavioral and had attacked a staff person on the previous shift before Staff Campbell's shift started. Resident A left the home with Guardian 1 around 1:30 or 2:00 pm. After receiving a PRN from Guardian 1, Resident A was still amped up when Resident A arrived back at the facility around 8:00 pm. Resident A was fine for about five to ten minutes after Guardian 1 left. Resident A ate some soup, and then within minutes Resident A was throwing things, stripped down out of his clothing, and was puking and urinating on the floor. Staff Harper came down the hallway to assist Staff Campbell with Resident A. Staff Amber was present as well and was doing chores and making sure the other residents was taken care of and escorted to safety. Staff Campbell stated that he and Staff Harper observed Resident A for about 20 to 30 minutes. Resident A then began spitting and urinating at staff. Resident A then punched Staff Campbell twice, and without thinking or being upset or angry, Staff Campbell stated that he punched Resident A on the left side of Resident A's mouth. Resident A was in shock and went to sit in a chair in the living room for about 30 minutes and was crying. Staff Campbell stated that he thinks Resident A was crying due to the shock of being hit back. Resident A was not hurt. Resident A did not attack Staff Campbell after this. Staff Campbell stated that the next day it was like nothing ever happened, and Resident A hugged him. Staff Campbell stated that the punch was to the left side of Resident A's mouth, a quick right jab, more of a tap, because he was trying to dodge Resident A. Staff Campbell stated that he has been attacked by Resident A and two previous residents. He stated that they tried to use CPI and tried redirecting/ escorting Resident A to minimize damage. Staff Campbell stated that they mostly used verbal redirecting. Staff Campbell stated that Resident A's aggressiveness comes and goes in waves. Resident A's behavior was good for about six months, and now Resident A has high behaviors for up to ten hours a day for weeks at a time. Resident A punched Staff Campbell in the collar bone two times, and punched Staff Harper in the chest and put Staff Harper in a headlock earlier in the day. Staff Campbell stated that Resident A's behaviors ended at about 9:30 pm that day. Guardian 1 gave Resident A a PRN while on the home visit, and he received another PRN at 8:00 pm, and may have received one at 10:00 pm. Resident A is allowed three PRN a day, every two hours.

On 01/24/2024, I received a return call from Guardian 1. Guardian 1 stated that on the day of the incident, Resident A was really high strung, and was hitting and kicking Guardian 1 while they were at home. Guardian 1 stated that she thinks Staff Campbell hitting Resident A was a reflexive reaction, and not something Staff Campbell does on a regular basis. Guardian 1 stated that they were upset about what happened but understood how it happened. Staff Campbell apologized.

Resident A can be very moody, and you never know how Resident A will react. Placement was discussed a while ago, but Resident A has been doing better, and his case manager is aware of the incident. Guardian 1 stated that it is hard to judge how bad Resident A's behaviors are, because everyone experiences it different (i.e. perception). Guardian 1 stated that Resident A's behaviors were bad that day. Guardian 1 stated that she picks Resident A up at least weekly and calls daily to check on Resident A. Guardian 1 stated that there are always three staff on shift during the day, two at night, and Resident A goes to program daily.

On 01/24/2024, I interviewed staff Johnanthan Harper. Staff Harper stated that Resident A's behaviors are constantly changing. On 01/02/2024 in the afternoon, Resident A had punched Staff Harper in the chest, it felt like a "coordinated attack" and this is a new behavior for Resident A. That night, Resident A was puking, urinating, and throwing things. The behaviors were extreme. Staff Harper stated that he and Staff Williams tried to encourage Resident A to put his clothing back on. In the previous hour, Resident A had been targeting Staff Campbell, spitting at staff, and putting Staff Campbell in headlocks. Resident A swung at Staff Campbell twice in the shoulder/neck area. Staff Campbell was shocked, caught off guard, and punched back. The punch caught Resident A off guard. Staff Harper stated that everyone felt bad, and Staff Campbell was definitely shocked. Resident A went to the living room, where Staff Harper comforted and reassured Resident A. He stated that he got Resident A to his bedroom and told Staff Campbell that he shouldn't be handling Resident A if he is punching. Staff Harper stated that Staff Campbell is compassionate, goes above and beyond, and is a hard worker. Resident A did not have any noticeable injuries, and it was "*not a full-on I'm going to hurt you type of punch*" but it was enough to shock Resident A. Staff Campbell was ashamed. Both Staff Harper and Staff Campbell reported the incident to management. Staff Harper stated that Resident A had about six milligrams of Ativan at that point, but his behaviors were still escalated.

On 02/02/2024, I conducted a Microsoft Teams video call with home manager Stefani Hodges and Resident A. Resident A was not interviewed due to being non-verbal. Resident A appeared clean and appropriately dressed wearing a t-shirt and pants sitting on his bed, in his bedroom. No marks or bruises were observed. Staff Hodges stated that staff Christopher Campbell was recently re-trained in positive behavior supports, recipient rights, and CPI trainings.

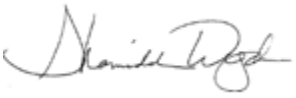
APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b)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

ANALYSIS:	On 01/09/2024, I spoke with home manager Stefani Hodges who reported that staff Christopher Campbell punched Resident A during a behavior where Resident A was targeting staff. Staff Campbell may have reacted defensively. An *AFC Licensing Division- Incident/Accident Report* dated 01/02/2024 confirms that Staff Campbell punched Resident A. On 01/22/2024, I interviewed staff Christopher Campbell. He admitted to hitting Resident A with a “quick right jab” trying to dodge Resident A. Guardian 1 was interviewed and reported being upset but also understanding of how the situation occurred. On 01/24/2024, I interviewed staff Johnathan Harper who confirmed witnessing the incident. On 02/02/2024, I conducted a Microsoft Teams video call with Resident A. Resident A is non-verbal and could not be interviewed. Resident A did not appear to have any visible marks or bruises. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/05/2024, I conducted an exit conference with administrator/designated person Mindy (Wiegand) Campbell. I informed her of the finding and conclusion.

IV. RECOMMENDATION

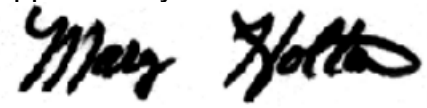
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).



02/05/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



02/05/2024

Mary E. Holton Date
Area Manager