GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2025

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

RE: License #: AS740014805
Investigation #: 2025A0580019
Michigan Rd Home

Dear Kristine 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

I. IDENTIFYING INFORMATION

License #:	AS740014805
Investigation #:	2025A0580019
Complaint Receipt Date:	02/19/2025
Investigation Initiation Date:	02/19/2025
Report Due Date:	04/20/2025
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:	Michigan Rd Home
Facility Address:	2962 Michigan Rd Port Huron, MI 48060
Facility Telephone #:	(810) 984-3553
Original Issuance Date:	02/01/1993
License Status:	REGULAR
Effective Date:	08/18/2023
Expiration Date:	08/17/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
• **Staff Nora Miller blocked Resident A in Resident A's room.** • **Staff Cassey Cadreau bear-hugged Resident B to Resident B's room and did not allow Resident B to exit**.	Yes No
• **Staff Cassey Cadreau recorded Resident A with her phone**.	Yes
• **Staff Nora Miller dumped Resident A from a chair, grabbed Resident A by his wrists and took Resident A to his room.** • **Staff Nora Miller knocked Resident A off the trampoline and dragged Resident A across the ground by Resident A's armpits.** • **Staff Cassey Cadreau bear-hugged Resident B and dragged Resident B by the ankles**.	Yes Yes Yes
• **Resident A's food is withheld as punishment.**	No
• **Additional Findings**	Yes

III. METHODOLOGY

02/19/2025	Special Investigation Intake 2025A0580019
02/19/2025	Special Investigation Initiated - Telephone Call to Sandy O'Neill, Recipient Rights, ST. Clair Co.
03/03/2025	Inspection Completed On-site Unannounced onsite. Interview with Manager, Nora Miller.
03/03/2025	Contact - Face to Face Interview with staff, Toni Assante.
03/03/2025	Contact - Face to Face Interview with Resident B.
03/04/2025	APS Referral Call from Steven Dutcher, APS, St. Clair Co.
03/12/2025	Contact - Telephone call received Call from Tracy Duncan, Recipient Rights, St. Clair Co.

03/26/2025	Contact - Telephone call received Call from Detective Haley Bonner of the St. Clair County Sheriff's Department.
03/27/2025	Contact - Telephone call made Call to staff, Gretchen Lee.
03/27/2025	Contact - Telephone call made Call to staff, Cathey Schultz.
03/27/2025	Contact - Telephone call made Call to staff, Rachel Sayre.
04/02/2025	Contact - Telephone call made Call to Sean Horran, former staff.
04/02/2025	Contact - Telephone call made Call to Aaron Foote, License Administrator.
04/02/2025	Contact - Telephone call made Call to staff, Cassey Cadreau.
04/02/2025	Contact - Telephone call made Call to Relative Guardian B.
04/07/2025	Contact - Document Received Documents received.
04/09/2025	Contact - Document Received Email from Steven Dutcher of APS.
04/10/2025	Contact - Telephone call received Call from Detective Bonner.
04/11/2025	Contact - Document Received Email from Aaron Foote, Admin.
04/11/2025	Contact - Telephone call made Call to Tricia Gapshes, Case Manager for Resident A.
04/17/2025	Contact - Telephone call made Call to Tracy Duncan, Recipient Rights.
04/17/2025	Exit Conference Exit with Aaron Foote, License admin.

ALLEGATION:

- **Staff Nora Miller blocked Resident A in Resident A's room.**
- **Staff Cassey Cadreau bear-hugged Resident B to Resident B's room and did not allow Resident B to exit.**

INVESTIGATION:

On 02/19/2025, I received a complaint via LARA-BCHS-Complaints.

On 02/19/2025, I spoke with Sandy O'Neill, Recipient Rights (RR) Director in St. Clair County. Sandy O'Neill shared that the investigation is assigned to Tracy Duncan. Tracy Duncan has been investigating the allegations for a few weeks, having determined that staff have taken videos of residents and have been using bad holds/restraints on residents. Director O'Neill added that it appears as if these events have been happening, however their office is just finding out.

On 03/03/2025, I conducted an unannounced onsite inspection. Contact was made with Nora Miller, Home Manager. Staff Miller denied that she blocks Resident A in his room at night, adding that she more so tries to redirect Resident A to remain in Resident A's room.

The AFC Assessment Plans for Residents A and B were reviewed. The assessment plan for Resident A indicates that Resident A is non-verbal and gestures to communicate. Resident A does not require assistance with mobility and per the assessment plan, Resident A does not require as escort when moving around in Resident A's bedroom, nor the facility.

The Behavior Treatment Plan developed for Resident A by Community Mental Health (CMH) in St. Clair County indicates that If staff have determined that Resident A is engaging in physical aggression, verbal aggression, property destruction, inappropriate urinating and/or defecating, or another inappropriate behavior that does not involve a safety risk, to acquire staff attention or due to being upset about wanting something tangible, staff should grant these requests only when Resident A calmly and appropriately communicates the request. This technique—called "waiting for calm"—will help Resident A know that staff can help Resident A get Resident A's needs met when Resident A uses calm communication or communicates Resident A's wants and needs appropriately and functionally.

The assessment plan for Resident B indicates that Resident B is non-verbal and gestures to communicate. Resident B does not require assistance with mobility and per the assessment plan, Resident B does not require as escort when moving around in his bedroom, nor the facility.

The Behavior Treatment Plan developed for Resident B by Community Mental Health (CMH) in St. Clair County indicates that if staff have determined that Resident B is engaging in physical aggression, verbal aggression, property destruction, intentional vomiting, self-injury, or another inappropriate behavior that does not involve an imminent health and safety risk, to acquire staff attention or due to being upset about wanting something tangible, staff should grant these requests only when Resident B calmly and appropriately communicates the request. Staff should not respond/engage with Resident B when inappropriate attempts are made to acquire the desired outcome (i.e. attention, tangible, etc.). This technique—called “waiting for calm”— will help Resident B knows that staff can help Resident B get Resident B’s needs met when Resident B uses calm communication or communicates Resident B’s wants and needs appropriately and functionally.

When Resident begins to engage in significant property destruction or other severe challenging behaviors, and staff have determined that Resident B is unable to deescalate on Resident B’s own, staff should ensure that all others are removed from the immediate environment and ensure their safety. Staff should try to keep peers as far away from Resident B as possible, as well as maintain a safe distance from Resident B for their own safety but should always have line of sight (without providing eye contact) to ensure that Resident B is also remaining as safe as possible. Once all housemates/peers are safe and staff are able to maintain a safe distance from Resident B, items such as glassware, picture frames, lamps, electronics, personal belongings, and other fragile items, should be placed in safe places where they are not immediately accessible. It's highly recommended that staff avoid placing demands, presenting choices, and/or socially engaging directly with Resident B, or with one another within Resident B’s immediate vicinity, unless necessary, during intense challenging behaviors, as to limit the potential of further escalation or continuation. Staff should allow Resident B at least 8 minutes (void of precursor behaviors) to fully regulate himself before they begin engaging with Resident B and/or placing demands on him. If a demand was placed prior to the challenging behavior.

On 03/03/2025, while onsite, I interviewed direct staff, Toni Assante. Staff Assante denied ever witnessing staff, Nora Miller block Resident A in Resident A’s room.

While onsite I observed Resident B, who was 1 of 2 residents at the home. Resident B was observed adequately dressed as Resident B moved about the home. No concerns regarding the care being received were noted. Resident B was not able to be interviewed. Resident B is non-verbal and uses gestures to communicate. Resident A was at program and not present at the home.

On 03/04/2025, I spoke with Steven Dutcher, assigned Adult Protective Services (APS) worker in St. Clair County, who stated that he has been assigned an investigation. Steven Dutcher shared the name of the assigned RR (Recipient Rights) Investigator. Investigator Dutcher has not yet been to the home.

On 03/12/2025, I spoke with Tracy Duncan, assigned RR Investigator. Tracy Duncan stated that she was not able to cite any substantiations regarding the residents allegedly being confined to their room.

On 03/26/2025, I spoke with Detective Haley Bonner of the St. Clair County Sheriff's Department. Detective Bonner confirmed she is conducting a joint investigation with APS in St. Clair County. Detective Bonner shared that she still has interviews that need to be conducted, however, she will provide a copy of her report with the information that she has, by 04/10/2025.

On 03/27/2025, I placed a call to direct staff, Cathey Schultz, who shared that she has worked for the corporation a little under 1 year. Staff Schultz stated that while she does not recall the specific date, she recalled witnessing an incident in which Resident A was attempting to exit his room, adding that for some reason, Staff Miller can hear when Resident A opens his door. When Resident A does so, staff Miller will literally run to Resident A's room door to keep him from coming out to the living room. Staff Schultz states that Staff Miller prevented Resident A from exiting the room by putting her hands on Resident A's chest, physically shoving Resident A back into his room. Staff Schultz added that she has witnessed very intense shoving matches between Staff Miller and Resident A.

Staff Schultz stated that several times while working the afternoon shift, she has witnessed staff Cassey Cadreau grab Resident B by the wrists, drag Resident B to Resident B's room and hold Resident B's door shut so Resident B couldn't come out if Resident B was having a behavior. Staff Cadreau is quick-tempered and primarily gets into altercations with Resident B. Staff Schultz stated that she primarily works the afternoon shift and Staff Cadreau mostly works midnights, however, at times she and Staff Cadreau would work together on the afternoon shift.

On 03/27/2025, I placed a call to direct staff Rachel Sayre, who shared that she previously worked at the home, however, she has been moved to a different facility within the corporation. Staff Sayre stated that she and Staff Schultz have witnessed Staff Miller's mistreatment of the residents the most because they typically work the same schedule, which is afternoons. Staff Sayre shared that she has observed Staff Miller trap Resident A in his room to keep Resident A from coming out in the common area after residents are in bed. During this particular incident, Staff Sayre recalled that Resident A wanted to watch TV in the living room, however, Staff Miller insists that the residents are in their rooms by 9 pm and cannot come out. On the day in question, Staff Miller blocked Resident A so that Resident A could not exit Resident A's room. The two then began a shoving match in which Staff Miller pushed Resident A so hard that Resident A fell and almost hit Resident A's head. Staff Sayre stated that she has directly addressed Staff Miller and her treatment of Resident A, to which she always responds, "he doesn't know his rights". Staff Sayre stated that she cannot recall exactly when this occurred, however, it occurs regularly. Staff Sayre has also observed Staff Cassey Cadreau blocking Resident B in Resident B's room. Staff Sayre stated that

these actions against Residents A and B, by Staff Miller and Staff Cadreau, have been problems for a very long time. Staff Sayre reported the information on 01/10/2025.

On 04/02/2025, I spoke with staff Cassey Cadreau who denied that she has ever observed staff Nora Miller block Resident A in Resident A's bedroom. Staff Cadreau denied ever blocking Resident B in Resident B's room.

On 04/02/2025, I spoke with license administrator, Aaron Foote regarding the allegations. Admin Foote stated that this is Staff Miller's second recipient rights violation, having previously been written up for confining a resident's movement.

On 04/02/2025, I spoke with Relative Guardian B. Guardian B stated that prior to this investigation Guardian B had no concerns with the care being provided to Resident B while at this home. Guardian B would have never suspected Resident B was being mistreated.

On 04/09/2025, APS Investigator Dutcher was contacted. APS Dutcher indicated based on evidence, consisting of eyewitness testimony from other staff in the home at this point the case is leaning towards a protective services substantiation of both abuse and neglect, naming staff Cassey Cadreau and Nora Miller.

On 04/10/2025, Detective Bonner was contacted. Detective Bonner stated that although her investigation is not complete, she will be referring the case to the prosecutor's office for Abuse of a Vulernable/Disabled Adult, using the eyewitness testimony of staff Rachel Sayre, Cathey Schultz, and Relative Guardian B's testimony regarding what was said to her by staff Cassie Cadreau.

On 04/11/2025, I spoke with Tricia Gapshes, Case Manager (CM) at Community Integration Services, assigned to Resident A. CM Gapshes, stated that she was surprised when informed of the allegations, adding that prior to the allegations, there were no concerns with staff. Resident A does have a history of eloping and while staff cannot block Resident A in Resident A's room, they are encouraged to attempt to block Resident A's path and/or redirect when attempting to keep Resident A from eloping.

On 04/17/2025, I spoke with RR Investigator Tracy Duncan who stated that she did not investigate allegations involving Residents A and B being blocked in their room. These allegations were investigated in a prior investigation by Recipient Rights Officer Joslyn Henderson, who substantiated the recipient rights violation against Nora Miller, for confining a resident's movement. This investigation closed on 02/07/2025. Their office did not receive any allegations that staff, Cassey Cadreau blocked any residents in their room.

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: **(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.**
ANALYSIS:	It was alleged that Staff Nora Miller blocked Resident A in his room. Staff Miller, Staff Assante, and Staff Cadreau denied the allegations. Staff Schultz and Staff Sayre confirmed the allegations were true. Recipient Rights reported substantiated Staff Miller confining a resident in an investigation that closed on 2/11/2025. Admin Foote stated that this is Staff Miller's second recipient rights violation, having previously been written up for confining a resident's movement. Based upon my investigation, which consisted of interviews with multiple staff members, License Administrator, Aaron Foote, APS Investigator, Steven Dutcher, Detective Haley Bonner, St. Clair Sheriff Department, Case Manager for Resident A, Tricia Gapshes, Relative Guardian B, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(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.**

ANALYSIS:	It was alleged that Staff Cassey Cadreau bear-hugged Resident B to his room and did not allow Resident B to exit. Staff members Nora Miller, Toni Assante, Cathy Schultz, Rachael Sayre, and Cassey Cadreau were interviewed regarding the allegations. Staff Miller, Staff Assante, and Staff Cadreau denied the allegations. Staff Sayre confirmed the allegations were true. Based upon my investigation, which consisted of interviews with multiple staff members, License Administrator, Aaron Foote, APS Investigator, Steven Dutcher, Detective Haley Bonner, St. Clair Sheriff Department, Case Manager for Resident A, Tricia Gapshes, Relative Guardian B, as well as a review of relevant facility documents pertinent to the allegation, there is not enough evidence to substantiate the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff, Cassey Cadreau recorded Resident A with her phone.

INVESTIGATION:

On 03/12/2025, I spoke with Tracy Duncan, assigned RR (Recipient Rights) Investigator who shared that in her investigation, Staff, Cassey Cadreau received a substantiation for the video recording of Resident A. Staff Cadreau initially lied about the video until she was confronted with the evidence. It is Tracy Duncan's understanding that staff Cassey Cadreau was written up by the corporation.

On 03/27/2025, Rachel Sayre, Direct Staff, stated that while working in the home, she received a video, sent to her by staff, Cassey Cadreau. The video consisted of Resident A lying on the couch with a blanket over his head, something Resident A often does in the mornings while waiting for the bus, and staff Cassey Cadreau, pulling the blanket off Resident A's head, which aggravated Resident A. Staff Sayre is not sure why staff Cadreau sent her the video. Staff Sayre no longer has the video as she was made to delete it.

On 04/02/2025, I spoke with license administrator, Aaron Foote regarding the allegations. Admin Foote stated that due to the video taken of Resident A, by staff Cassey Cadreau and the recipient rights substantiation for unreasonable force, staff Cadreau was given a written reprimand and will be re-trained in Resident Rights.

On 04/02/2025, I spoke with staff, Cassey Cadreau who stated that she has been trained regarding Resident's Rights, however, admittedly that she took a video of Resident A and sent it to another staff. Staff Cadreau had no answer as to why, stating that it was a "stupid mistake".

On 04/17/2025, I conducted an exit conference with the licensee designee, Aaron Foote, informing him of the findings of this investigation. Administrator Foote shared that staff, Nora Miller no longer works for the corporation. A corrective action was requested.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	It was alleged that Staff, Cassey Cadreau recorded Resident A with her phone. RR Investigator, Tracy Duncan, shared that in her investigation, staff, Cassey Cadreau received a substantiation for the video recording of Resident A. Staff Rachel Sayre was interviewed and confirmed receiving a video of Resident A from Staff Cadreau. License Admin, Aaron Foote reported due to the video Staff Cadreau made of Resident A, Staff Cadreau received a written reprimand and was required to completed training. Staff, Cassey Cadreau admitted to making the video of Resident A and sending it to another staff person.

	Based upon my investigation, which consisted of interviews with facility staff members, Cassey Cadreau and Rachael Sayre, Tracy Duncan, RR Investigator, License Administrator Aaron Foote, APS Investigator, there is enough evidence to substantiate the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Staff Nora Miller dumped Resident A from a chair, grabbed Resident A his wrists and took Resident A to his room.**
- **Staff Nora Miller knocked Resident A off the trampoline and dragged Resident A across the ground by Resident A's armpits.**
- **Staff Cassey Cadreau bear-hugged Resident B and dragged B by the ankles.**

INVESTIGATION:

On 03/03/2025, while onsite staff Miller denied the allegations that she has shoved Resident A or that she has dumped Resident A from his chair. Staff Miller also denied allegations that knocked Resident A off the trampoline and dragged him across the concrete, as alleged.

On 03/12/2025, I spoke with Tracy Duncan, assigned RR Investigator who shared that in her investigation, she was able to substantiate abuse/unreasonable force against both staff members Nora Miller and Cassey Cadreau. Based on witness testimony, Staff Nora Miller has been seen dumping Resident A from a chair and grabbing him by the wrists, while staff Cassey Cadreau has been seen pulling Resident B up by his armpits in a bear-hug manner.

On 03/27/2025, I spoke with direct staff Gretchen Lee, who stated that the only thing she can attest to is having observed staff Cadreau placing her hands under Resident B's armpits while being guided to Resident B's room. Staff Lee denied that Resident B was being drug across the floor, indicating that Resident B was standing upright. Staff Lee denied witnessing Staff Cadreau bear hug Resident B.

On 03/27/2025, Staff Cathey Schultz stated that while a working shift with staff Rachel Schultz and Nora Miller, she has witnessed staff Nora Miller grab Resident A by the wrists in attempts to yank Resident A up from Resident A's chair. When unsuccessful, Staff Schultz then observed Staff Miller tip the chair over to get Resident A from the chair. Staff Miller then grabbed Resident A by the wrist making Resident A go to Resident A's room. Staff Schultz stated that she has also witnessed Staff Cassey Cadreau grab Resident B by Resident B's wrist and drag Resident B and/or reverse

bear hug Resident B. While Staff Schultz has not witnessed Staff Cadreau drag Resident by his ankles to get Resident B to Resident B's room, Staff Cadreau called and told her that she'd done so. Staff Schutz does not know the exact date when these events occurred because it was typical treatment of these 2 residents. Staff Schultz stated that she moved from the home on 12/13/2024 to another home within the corporation, therefore the events would have occurred within the months prior.

On 03/27/2025, Staff Sayre stated that while working a shift with Staff Schultz and Staff Miller, she witnessed staff, Nora Miller dump Resident A from his chair in an effort to get Resident A to get up and go back to Resident A's room. Resident A had slid onto the floor. Resident A was terrified and started screaming. Staff Sayre added that on another occasion, while outside with Resident A (who was sitting on the ground), she was prompting Resident A to go use the bathroom, and Resident A was refusing. Staff, Nora Miller overheard and intervened and stating, "she asked you nicely". Staff Miller then proceeded to grab Resident A by the wrists and attempt to pull Resident A up from the ground. Resident A began screaming. Staff Miller then proceeded to grab Resident A under the armpits and dug Resident A across the ground. Resident A did smack Staff Miller and was able to get away, running over to the trampoline. Staff Miller then flipped the trampoline over so Resident A would fall off. Staff Sean Morran was working at the time; however, Staff Morran was inside dealing with another resident's behavior and did not witness the alleged incident. Staff Sayre has also observed staff Cassey Cadreau snatch Resident B by his wrists from Resident B's chair. Staff Sayre cannot recall the date this occurred, adding that there have been so many incidents, however, she recalls contacting Recipient Rights on 01/10/2025. While this information is specifically related to incidents in the home, Staff Sayre stated that the staff mistreatment of the residents is not new and happens on a consists basis.

On 04/02/2025, I placed a call to Sean Horran, former staff at Michigan Road Home. A voice mail message was left requesting a return call.

On 04/02/025, I spoke with Relative/ Guardian B who recalled one evening in January of this year, while departing the home after visiting with Resident B, Staff Cadreau ran outside and caught up to her and stated, "You know [Resident B] broke my hand". Relative B stated that she was a bit taken after Staff Cadreau made the statement. Relative B stated that she apologized to Staff Cadreau as she knows Resident B has harmed staff in the past. Staff Cadreau then stated that bear hugging Resident B is the only way she can control Resident B when Resident B begins having a behavior and requested that she speak with CMH and have permission to do so put in Resident B's plan. Relative/Guardian B stated that the request appeared odd to her.

On 04/02/2025, Staff Cadreau denied bear hugging Resident B or dragging Resident B by Resident B's ankles. Staff Cadreau stated that they have a good relationship, to the point where staff have sometimes called Staff Cadreau in to assist with Resident B's behaviors.

On 04/02/2025, I spoke with license administrator, Aaron Foote regarding the allegations. Due to the Recipient Rights substantiation for unreasonable force and this being her second recipient rights violation, Staff Miller was demoted from home manager to direct care staff. Staff Miller will be re-trained in Residents Rights. Staff Miller has put in her resignation with her last day anticipated on 04/09/2025.

On 04/07/2025, I reviewed the both the AFC Assessment and Behavior Treatment Plans for both Residents A and B. The assessment plans for both indicates that neither resident requires assistance with mobility, nor the use of assistive devices.

The Behavior Treatment Plan developed for Resident A by Community Mental Health (CMH) in St. Clair County indicates that If staff have determined that Resident A is engaging in physical aggression, verbal aggression, property destruction, inappropriate urinating and/or defecating, or another inappropriate behavior that does not involve a safety risk, to acquire staff attention or due to being upset about wanting something tangible, staff should grant these requests only when Resident A calmly and appropriately communicates the request. This technique—called “waiting for calm”— will help Resident A know that staff can help Resident A get Resident A’s needs met when Resident A uses calm communication or communicates Resident A’s wants and needs appropriately and functionally.

The Behavior Treatment Plan developed for Resident B by Community Mental Health (CMH) in St. Clair County indicates that if staff have determined that Resident B is engaging in physical aggression, verbal aggression, property destruction, intentional vomiting, self-injury, or another inappropriate behavior that does not involve an imminent health and safety risk, to acquire staff attention or due to being upset about wanting something tangible, staff should grant these requests only when Resident B calmly and appropriately communicates the request. Staff should not respond/engage with Resident B when inappropriate attempts are made to acquire the desired outcome (i.e. attention, tangible, etc.). This technique—called “waiting for calm”— will help Resident B knows that staff can help Resident B get Resident B’s needs met when Resident B uses calm communication or communicates Resident B’s wants and needs appropriately and functionally.

When Resident begins to engage in significant property destruction or other severe challenging behaviors, and staff have determined that Resident B is unable to deescalate on Resident B’s own, staff should ensure that all others are removed from the immediate environment and ensure their safety. Staff should try to keep peers as far away from Resident B as possible, as well as maintain a safe distance from Resident B for their own safety but should always have line of sight (without providing eye contact) to ensure that Resident B is also remaining as safe as possible. Once all housemates/peers are safe and staff are able to maintain a safe distance from Resident B, items such as glassware, picture frames, lamps, electronics, personal belongings, and other fragile items, should be placed in safe places where they are not immediately accessible. It's highly recommended that staff avoid placing demands, presenting choices, and/or socially engaging directly with Resident B, or with one another within

Resident B's immediate vicinity, unless necessary, during intense challenging behaviors, as to limit the potential of further escalation or continuation. Staff should allow Resident B at least 8 minutes (void of precursor behaviors) to fully regulate himself before they begin engaging with Resident B and/or placing demands on him. If a demand was placed prior to the challenging behavior.

On 04/09/2025, I received an email from APS Investigator Dutcher, indicating that he does not yet have a disposition due to waiting to complete interviews with Detective Bonner. However, based on evidence at this point the case is leaning towards a substantiation from Adult Protective Services.

On 04/10/2025, I spoke to Detective Bailey who stated that she was able to make contact with former staff Sean Horran, who stated that while he was working on the day staff Miller allegedly dumped Resident A off the trampoline, he did not observe what occurred. Staff Horran stated that once staff Sayre told him what occurred, he did observe that Resident A was sitting on the ground and the trampoline was tipped over, not in its usual place.

On 04/11/2025, I spoke with Tricia Gapshes, Case Manager (CM) at Community Integration Services, assigned to Resident A. CM Gapshes, stated that she was surprised when informed of the allegations, adding that prior to the allegations, there were no concerns with staff. Resident A does have a history of eloping and while staff cannot block Resident A in Resident A's room, they are encouraged to attempt to block Resident A's path and/or redirect when attempting to keep Resident A from eloping.

On 04/17/2025, I conducted an exit conference with the licensee designee, Aaron Foote, informing him of the findings of this investigation. Administrator Foote shared that staff, Nora Miller no longer works for the corporation. Staff Cassie Cadreau will be relieved of her duties, effective immediately. A corrective action was requested.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged that staff, Nora Miller dumped Resident A from a chair, grabbed by his wrists and took him to his room. Staff Miller knocked Resident A off the trampoline and drug Resident A across the ground by Resident A's armpits. Staff, Cassey

	Cadreau bear-hugged Resident B and dragged Resident B by the ankles. Staff Nora Miller and Staff Cadreau denied the allegations. Staff Gretchen Lee denied witnessing Staff Cadreau bear hug Resident B. Staff Lee reported witnessing Staff Cadreau place her arms under Resident B and walk Resident B to Resident B's room. Cathey Schultz and Staff Rachael Sayre were interviewed and confirmed the allegations. Sean Horran reported to the police that the trampoline was tipped over on the date of the alleged trampoline incident with Resident A. License Administrator Aaron Foote reported Staff Miller was demoted from home manager to direct care staff. Staff Miller will be re-trained in Residents Rights. Staff Miller has put in her resignation with her last day anticipated on 04/09/2025. Tracy Duncan, assigned RR Investigator, was able to substantiate abuse/unreasonable force against both staff members Nora Miller and Cassey Cadreau. Based on witness testimony. APS Investigator, Steven Dutcher, indicated based on evidence at this point the case is leaning towards a substantiation from Adult Protective Services. Guardian B reported Staff Cadreau told Guardian B bear hugging Resident B is the only way Staff Cadreau can control Resident B when Resident B begins having a behavior. Staff Cadreau requested that Guardian B speak with CMH and have permission to do so put in Resident B's plan. The Assessment Plans and Behavior Treatment Plans for both Residents A and B were reviewed. Physical force is not authorized for either resident. Based upon my investigation, which consisted of interviews with multiple facility staff members, License Administrator, Aaron Foote, APS Investigator, Steven Dutcher, Detective Haley Bonner, St. Clair Sheriff Department, Tracy Duncan, assigned

	RR Investigator, Case Manager for Resident A, Tricia Gapshes, Relative Guardian B, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's food is withheld as punishment.

INVESTIGATION:

On 03/03/2025, while onsite, Home Manager, Nora Miller, denied the allegations that she withholds Resident A's food for punishment.

On 03/03/2025, while onsite, staff, Toni Assante, denied the allegations that staff Miller withholds Resident A's food for punishment.

On 03/27/2025, staff Cathey Schultz stated that she has witnessed Resident A go all day without eating due to staff, Nora Miller insisting that he eat at the table. Staff Schultz adds that due to past trauma with another resident in the home, Resident A will not eat at the table. When he attempts to take his food to the living room or to his bedroom, Staff Miller takes his food from him and has even thrown his food away. Staff Schultz adds that she has seen Resident A sneak and grab a bite of his food from the table when staff Miller is not looking and run back to his room to eat, which is really sad to watch.

On 03/27/2025, I placed a call to direct staff Rachel Sayre, who stated that Staff Sayre has seen staff Miller deny Resident A his food multiple times. Resident A does not like to eat at the table due to his being scared of another Resident in the home. When Resident A attempted to take his food to eat in the living room, staff Miller grabbed his food and threw it away. On this occasion, Resident a had to wait until the other Residents went to their rooms at 8pm to eat his dinner.

On 04/02/2025, staff Cassey Cadreau stated that she has never seen staff Nora Miller deprive Resident A of food.

On 04/11/2025, I reviewed the Weight Log Record for Resident A, which reflects his weight as 193.2lbs in January 2025. In February 2025, Resident A weighed 189.6lbs., having lost 3.6lbs. In March 2025, Resident A weighed 171.4lbs, having lost 17.6lbs., In the current month, April 2025, Resident A weighed 169.4 lbs., having lost 2 lbs.

On 04/11/2025, CM Gapshes stated that when Resident A initially came to the home he'd put on a lot of weight. Resident A's Primary Care Physician (PCP) is Dr Jason Whateley. Dr. Jason Whateley last saw Resident A on 12/2/2024. Dr. Jason Whateley wrote a Rx for a recommended low fat 2000 calorie diet. Resident A is scheduled to see Dr. Whateley again in June. Resident A sees PCP every 6 months or as needed. To CM Gapshes's knowledge, both Resident A's physician and guardian are pleased with his current weight.

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: **(e) Withhold food, water, clothing, rest, or toilet use.**
ANALYSIS:	It was alleged that Resident A's food is withheld as punishment. Staff members Nora Miller, Toni Assante, Rachel Sayre, Cathey Schultz and Cassey Cadreau were interviewed regarding the allegations. The Weight Log Record for Resident A was reviewed. Case Manager, Tricia Gapshes, was interviewed. Based upon my investigation, which consisted of interviews with multiple facility staff members and CM for Resident A, Tricia Gapshes , as well as a review of relevant facility documents pertinent to the allegation, there is not enough evidence to substantiate the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/12/2025, I spoke with Tracy Duncan, assigned RR Investigator who shared that in her investigation, she was able to substantiate abuse/unreasonable force against both staff members Nora Miller and Cassey Cadreau. Based on witness testimony, Staff Nora Miller has been witnessed dumping Resident A from a chair and grabbing him by the wrists, while staff Cassey Cadreau has been observed pulling Resident B up by his armpits in a bear-hug manner.

On 04/02/2025, License Administrator, Aaron Foote, stated that due to the recipient rights substantiation for unreasonable force, staff Nora Miller was demoted from home

manager to direct care staff and will be re-trained in Residents Rights. This is staff Miller's second recipient rights violation, having previously been written up for confining a resident's movement.

On 04/09/2025, APS Investigator Dutcher indicated based on evidence at this point the case is leaning towards a substantiation from Adult Protective Services, against facility staff, Cassey Cadreau and Nora Miller.

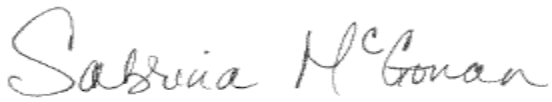
On 04/10/2025, Detective Bonner stated that although her investigation is not complete, she will be referring the case to the prosecutor's office for Abuse of a Vulernable/ Disabled Adult, using the eyewitness testimony of staff Rachel Sayre, Cathey Schultz, as well as Relative Guardian B's testimony regarding what was said to her by staff Cassie Cadreau.

On 04/17/2025, I conducted an exit conference with the licensee designee, Aaron Foote, informing him of the findings of this investigation. Administrator Foote shared that staff, Nora Miller no longer works for the corporation. Staff Cassie Cadreau will be relieved of her duties, effective immediately. A corrective action was requested.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Staff members Cassey Cadreau and Staff Nora Miller have demonstrated that they are not suitable to meet the physical, emotional, intellectual, and social needs of each resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

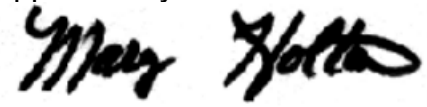
Upon the receipt of an approved corrective action plan, no changes to the status of the license are recommended.



April 17, 2025

Sabrina McGowan — Date
Licensing Consultant

Approved By:



April 17, 2025

Mary E. Holton — Date
Area Manager