GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 22, 2021

Deana Fisher
St. Louis Center for Exceptional Children & Adults
16195 Old US-12
Chelsea, MI 48118

RE: License #: AS810409206
Investigation #: 2022A0122005
Knights of Columbus House

Dear Ms. Fisher:

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) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810409206
Investigation #:	2022A0122005
Complaint Receipt Date:	11/05/2021
Investigation Initiation Date:	11/05/2021
Report Due Date:	01/04/2022
Licensee Name:	St. Louis Center for Exceptional Children & Adults
Licensee Address:	16195 Old US-12 Chelsea, MI 48118
Licensee Telephone #:	(734) 475-8430
Administrator:	Deana Fisher
Licensee Designee:	Deana Fisher
Name of Facility:	Knights of Columbus House
Facility Address:	1659 Hayes Rd Chelsea, MI 48118
Facility Telephone #:	(734) 475-8430
Original Issuance Date:	08/11/2021
License Status:	TEMPORARY
Effective Date:	08/11/2021
Expiration Date:	02/10/2022
Capacity:	5

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A's personal needs were not attended to by staff members.	Yes
On 11/05/2021, Residents A and B were assaulted.	Yes

II. METHODOLOGY

11/05/2021	Special Investigation Intake 2022A0122005
11/05/2021	Special Investigation Initiated - Letter Email sent to Deana Fisher, Requesting additional information. Names of resident and staff member. APS and ORR referrals made.
11/05/2021	Contact - Telephone call made Completed interviews with staff members, Dominique Whitehead and Krista Harmon.
11/08/2021	Contact – Telephone call made Completed interview with staff member Brenda Shellhart.
11/08/2021	Onsite Inspection Completed interviews with Cynthia Hoard, Supervisor. Received Resident A and Resident B file information.
11/10/2021	Contact – Telephone call made Completed interview with staff member, Christopher Hinton.
11/10/2021	Contact – Telephone call made Completed interviews with Relatives A and B.
11/19/2021	Exit Conference Discussed findings with Deana Fisher, Licensee Designee.

ALLEGATION: Resident A's personal needs were not attended to by staff members.

INVESTIGATION: On 11/05/21021, direct care staff, Dominique Whitehead, reported the following: On 11/05/2021, she observed Resident A standing naked in the facility for approximately one hour in the presence of staff members Teri Allan and Brenda Shellhart. Ms. Whitehead reported what she observed and Supervisor, Cindy Horde, assisted Resident A.

Ms. Whitehead stated she observed this incident from a different facility, Kay and Russ House, which is adjacent to Knights of Columbus House where Resident A and direct care workers Teri Allan and Brenda Shellhart were located.

On 11/08/2021, I completed an interview with direct care staff, Brenda Shellhart. Ms. Shellhart confirmed that she worked with co-worker, Teri Allan, and provided personal care for Resident A on 11/05/2021. Ms. Shellhart stated she and Ms. Allan verbally prompted Resident A to go into his room so that he could be assisted with bathing and dressing.

Per Ms. Shellhart Resident A refused verbal prompts for approximately 30 minutes and during that time he was naked in a common area of the facility with other residents present. Ms. Shellhart stated Resident A did smell of urine, but she is uncertain if he had remnants of feces on his person. Ms. Shellhart stated since Resident A refused to enter his room, she continued to monitor the other residents and prepare breakfast. Ms. Shellhart stated she did not call administration for assistance and is uncertain if Ms. Allan called for assistance.

On 11/08/2021, I completed an interview with Teri Allan. She reported the same as coworker Ms. Shellhart. Ms. Allan stated on that day, Resident A was naked in a common area of the facility due to his refusal to enter his bedroom so that he could be assisted in personal hygiene and dressing tasks. Ms. Allan stated she didn't want to use physical force on Resident A to get him to enter his bedroom, so he was allowed to stay in the common area naked. Ms. Allan stated it was approximately 1 hour before supervisor, Cynthia Hoard came to assist. Ms. Allan stated she did not call the administration office for assistance with Resident A.

On 11/08/2021, I completed an interview with Cynthia Hoard, Supervisor. Ms. Hoard confirmed that she was called to assist with Resident A on 11/05/2021. Ms. Hoard reported that she when she entered the facility, she observed that Resident A was naked in the common area. She asked both Ms. Shellhart and Ms. Allan why Resident A was not assisted by either of them to which they both replied that he would not move. Ms. Hoard stated she "motioned for Resident A to follow her" and he complied with no resistance. Per Ms. Hoard, Resident A had feces on him, and

she assisted him with bathing and dressing. Ms. Hoard stated that she has never observed Resident A refuse assistance with personal hygiene tasks.

On 11/08/2021, I reviewed Resident A's file. He is diagnosed with Profound Intellectual disability and therefore unable to participate in an interview. I observed Resident A moving comfortably throughout the facility. He showed no signs of discomfort or distress.

On 11/19/2021, I completed an exit conference with Deana Fisher, Licensee Designee. Ms. Fisher stated she understood my findings and would submit a corrective action plan to address rule violations.

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:	On 11/05/2021, Resident A's personal needs were not attended to by direct care staff members, Brenda Shellhart and Teri Allan. On 11/08/2021, Brenda Shellhart and Teri Allan admitted that Resident A was naked in the common area of the facility for approximately one hour with other residents present. On 11/08/2021, Cynthia Hoard, Supervisor, confirmed that Resident A was left naked in the common area by direct care staff members Brenda Shellhart and Teri Allan. Based upon my investigation I find that Resident A was not treated with dignity nor were his personal needs attended to on 11/05/2021 as he was left naked in a common area of the facility for approximately one hour unassisted.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 11/05/2021 Residents A and B were assaulted.

INVESTIGATION: On 11/05/2021, Staff 1 reported the following: On 11/05/2021, she observed two incidents that involved Staff 2 and Residents A and B. At approximately 4:30 p.m. Staff 1 observed Staff 2 hit Resident A in the back of the head as they were entering the adult foster care group home.

Staff 1 questioned Staff 2 regarding his action and he responded by stating that Resident A is a "stupid, fucking, idiot, asshole and I'm never going to take him to another building again." Staff 2 stated that as he was providing supervision to Resident A in another building, he ran into different offices which was frustrating.

At approximately 8:30 p.m. on 11/05/2021 Staff 1 observed an interaction between Staff 2 and Resident B. Per Staff 1 as Resident B was sitting on the couch Staff 2 walked behind him and grabbed him by the neck close to his hairline and grabbed him by the ear.

Staff 1 reported both incidents to administration. Staff 1 stated there were other residents present, however, all are non-verbal including Residents A and B.

On 11/08/2021, I reviewed Resident A and B's file. Resident A is diagnosed with Profound intellectual disability and Resident A is diagnosed with Pervasive developmental disorder and autism. Both Resident A and B are unable to participate in an interview. Both were observed in the facility and appeared to be comfortable showing no signs of discomfort or distress.

On 11/10/2021, I completed an interview with Staff 2. Staff 2 denied hitting/physically assaulting both Residents A and B. Regarding the incident with Resident A, Staff 2 stated he couldn't understand why anyone would state that he would strike Resident A on the head or use profanity describing Resident A.

Staff 2 reported the same regarding Resident B that he did not strike him but sometimes will put his hand on the back of his neck which Resident B interprets to mean it is time for him to get up. He stated Resident B is nonverbal and normally will scream out because that is how he expresses himself verbally.

Staff 2 denied all allegations made against him.

On 11/10/2021, I completed interviews with both Relatives A and B. Both stated they had been informed of the allegations that involved Staff 2 and Residents A and B. Relative A reported that she feels that Resident A is in the best placement, but she is concerned about Staff 2 being assigned to care for him. Relative B stated that a family member had visited with Resident B on 11/07/2021 and was satisfied that he was fine. Relative B also reported that she is concerned about Staff 2 being assigned to take care of Resident B.

On 11/05/2021, Jessica Osowski, RN on staff completed a skin assessment on Resident A. She found "…red marks on side and back of neck. Three small bumps

on left front side of neck." Resident B was assessed but no injuries were found on him.

On 11/19/2021, I completed an exit conference with Deana Fisher, Licensee Designee. Ms. Fisher stated she understood my findings and would submit a corrective action plan to address rule violations.

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 11/05/2021, Residents A and B were assaulted. On 11/05/2021, Staff 1 reported that Staff 2 was observed hitting Residents A and B on the back of the head during different incidents. On 11/05/2021, Staff 2 denied allegations of hitting both Residents A and B on the back of the head during different incidents. On 11/05/2021, Resident A was observed and documented that to have "red marks on side and back of neck" by RN, Jessica Osowski on a skin assessment form. No injuries were found on Resident B. Based upon my investigation there is sufficient evidence to support the allegation that physical force was used on 11/05/2021 as he was observed to have "red marks on side and back of his neck" the same date the allegations were made.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the status of the license.

Vanita C. Bouldin
Licensing Consultant

Date: 11/19/2021

Approved By:

Ardra Hunter
Area Manager

Date: 11/22/2021