GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2021

Addendum Report

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

RE: License #: AS810409206
Investigation #: 2022A0122010
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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

I. IDENTIFYING INFORMATION

License #:	AS810409206
Investigation #:	2022A0122010
Complaint Receipt Date:	12/06/2021
Investigation Initiation Date:	
Report Due Date:	02/04/2022
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?
On 12/03/2021, Resident A snuck out of the facility, obtained pizza from the garbage, and choked on it.	Yes

III. METHODOLOGY

12/06/2021	Special Investigation Intake 2022A0122010
12/06/2021	Contact - Telephone call made APS Referral made
12/08/2021	Contact - Telephone call made Completed interview with Relative A.
12/09/2021	Contact – Telephone call made Completed interview with Amanda Miller, Direct Care Staff. Contact – Telephone call made Father Franklin – unavailable, left message requesting return phone call.
12/09/2021	Contact – Telephone call made Completed interview with Father Franklin.
12/10/2021	Contact – Telephone call made ORR Referral made
12/14/2021	Exit Conference Discussed findings with Deana Fisher, Licensee Designee.

ALLEGATION: On 12/03/2021, Resident A snuck out of the facility, obtained pizza from the garbage, and choked on it.

INVESTIGATION: On 12/06/2021, Licensee Designee, Deana Fisher, reported that Resident A had "snuck out of the house, grabbed pizza out of the garbage and shoved it in his mouth, proceeded to choke on it, and stopped breathing, heart stopped. Staff got his heart restarted and ambulance was able to clear the pizza." At the reporting Resident A was placed on a ventilator due to his lungs collapsing.

On 12/08/2021, I completed an interview with Relative A. Relative A stated she had been notified that Resident A was sent out to the hospital due to choking on food, but she was not aware that he had snuck out of the facility until she spoke with the Adult Protective Services Worker assigned to investigate the incident. Relative A stated she had no further information to report but stated Resident A returned home on 12/08/2021.

On 12/08/2021, I reviewed the following documents from Resident A's file: Person Centered Plan dated 09/14/2021. It documents that one of Resident A's goal was to improve using utensils. In the progress section it stated that Resident A "was found trying to get food out of the trash to eat."

Resident A's Assessment Plan dated 06/11/2021 documents that Resident A is not able to move independently while out in the community, he requires "staff for monitoring and supervision." His plan also states that he is not alert to his surroundings and needs to be "supervised closely while out in the community." Resident A requires staff assistance with eating/feeding his plans states that he requires "direct supervision and constant verbal prompts. He is on a chopped diet."

Resident A's Diagnosis List states the following diagnosis for Resident A: Profound Intellectual Disabilities and Attention Deficit – Hyperactivity Disorder. Due to Resident A's diagnosis', he is unable to be interviewed.

On 12/09/2021, I completed an interview with Amanda Miller, Direct Care Staff. Ms. Miller confirmed that she and Father Franklin were assigned to provide care to the residents of Knights of Columbus House on 12/03/2021. Ms. Miller reported the following: On 12/03/2021, while she was in the laundry room unbeknownst to her Resident A went out of the side door, grabbed a piece of pizza out of the garbage, and came back into the facility. As Ms. Miller was coming out of the laundry room, she observed Resident A with the pizza in his hand. She asked Resident A to give her the pizza and began walking towards him. As she walked towards him Resident A shoved the whole piece of pizza in his mouth. Per Ms. Miller he began choking.

Her co-worker, Father Franklin, began assisting her with Resident A. They patted him on the back, completed the Heimlich, and attempted to give him water. Ms. Miller stated after failed attempts with previous interventions, they began CPR. At that time additional staff members came in to assist with CPR and they continued until emergency personnel arrived and took over proving medical care to Resident A.

On 12/09/2021, I completed an interview with Father Franklin. He confirmed that he worked with Amanda Miller on 12/03/2021. Father Franklin stated he had shaved Resident A right before his choking incident and when he had completed the task, he went into another resident's bedroom, and he assumed that Resident A went into the living room. Per Father Franklin, he was walking out of a resident's bedroom, and he observed Resident A with a piece of pizza in one hand and it looked as if he was trying to communicate. Father Franklin identified that Resident A was choking,

he observed Ms. Miller come out of the laundry room and they both began assisting Resident A.

Father Franklin stated that he and Ms. Miller called for assistance by contacting 911 and using job issued radios. As other staff members came to assist and give CPR, Father Franklin stated he cleared the area from additional residents and stayed with them to make certain they were fine. Father Franklin stated his coworkers assisted Resident A until emergency medical personnel arrived, and they took over treating Resident A.

On 12/14/2021, I completed an exit conference with Deana Fisher, Licensee Designee and discussed my findings with her. Ms. Fisher stated she understood my findings and looked forward to reviewing the approved report.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	On 12/03/2021, Resident A snuck out of the facility, retrieved a piece of pizza from the garbage, ate and choked on the pizza. On 12/09/2021, both direct care staff, Amanda Miller, and Father Franklin both admitted that Resident A went outside of the facility without their knowledge, retrieved a piece of pizza from the garbage, and choked on it. Resident A's Person Centered Plan dated 09/14/2021 documented that he "was found trying to get food out of the trash to eat." Resident A's Assessment Plan dated 06/11/2021 documents that Resident A is not able to move independently while out in the community, he requires "staff for monitoring and supervision." His plan also states that he is not alert to his surroundings and needs to be "supervised closely while out in the community." Resident A requires staff assistance with eating/feeding; his plans states that he requires "direct supervision and constant verbal prompts. He is on a chopped diet." On 12/03/2021, Resident A was able to leave the facility unsupervised by direct care staff members, Amanda Miller, and Father Franklin, retrieve a piece of pizza from the garbage and choke on it. Per Resident A's written assessment plan, he requires supervision while out in the community as he is not alert to his surroundings and must be closely monitored. Resident A also requires direct supervision and constant verbal prompts while eating. Based upon my investigation I find the licensee did not provide supervision and protection to Resident A on 12/03/2021 as specified in his written assessment plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED; SIR #2021A0122032 dated 10/21/2021 and CAP dated 10/13/2021**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

Vanita C. Bouldin
Licensing Consultant
Date: 12/14/2021

Approved By:

Ardra Hunter
Area Manager
Date: 12/22/2021

ADDENDUM SIR #2022A0122010

I. IDENTIFYING INFORMATION

License #:	AS810409206
Investigation #:	2022A0122010
Complaint Receipt Date:	12/06/2021
Investigation Initiation Date:	
Report Due Date:	02/04/2022
Licensee Name:	St. Louis Center for Exceptional Children & Adults
Licensee Address:	16195 Old US-12 Chelsea, MI 48118
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Licensee Designee:	Deana Fisher
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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. PURPOSE: To include additional information about fencing surrounding the facility backyard, a side exit door alarm and clarify that failure to supervise the resident occurred when the resident exited the facility to the side/backyard and was able to access pizza in the trash cans.

III. METHODOLOGY

02/08/2022	Onsite Inspection Contact – Face to face Deana Fisher, Licensee Designee – requested documentation of implementation of fence and door alarm system. Contact – Document sent Email sent to Deana Fisher, Licensee Designee
02/08/2022	Contact - Telephone call made Completed interview with Amanda Miller, staff member Father Franklin – unavailable, left message requesting return phone call.
02/09/2022	Contact - Telephone call made Completed interview with Father Franklin.
12/09/2021	Contact – Telephone call made

	Completed interview with Amanda Miller, Direct Care Staff. Contact – Telephone call made Father Franklin – unavailable, left message requesting return phone call.
12/09/2021	Contact – Telephone call made Completed interview with Father Franklin. Contact – Email from Deana Fisher

IV. DESCRIPTION OF FINDINGS AND CONCLUSION

On 02/08/2022, I completed an onsite inspection. I observed a black fence around the perimeter of the facility with the capability of closure by the facility side door. Also, confirmed a door alarm that sounded upon opening the facility side door.

On 02/09/2022, I received an invoice prepared by Digital Protection Systems dated 03/12/2018 documenting that a "door chime system" had been installed to St. Louis Center/Guanella Village Children's Home #2 1659 Hayes – which is the same address of Knights of Columbus House. I also received a sworn statement dated 07/18/2017 between the parties of A.Z. Shmina Inc (contractor) and St. Louis Center Civil documenting that a "Nationwide Construction Group Fencing" was included as a project assignment.

On 02/08/2022, I completed an interview with Amanda Miller. Ms. Miller confirmed that there has always been a fence on the property. Regarding the door alarm, Ms. Miller stated that she was not aware that the facility had an alarm, nor did she hear it during the incident that involved Resident A on 12/03/2021.

On 02/09/2022, I completed an interview with Father Franklin. Father Franklin confirmed that a fence has always been on the property of the adult foster care facility. Regarding the door alarm, Father Franklin stated the facility has always had a built in door alarm. On 12/03/2021, Father Franklin stated he heard the alarm prior to the incident with Resident A, however he was not aware of who entered/exited the door as he was helping other residents.

Resident A's Person Centered Plan dated 09/14/2021 addresses his personal goal including improving utensil use. In the comments section it states that "during this reporting period he was found trying to get food out of the trash can to eat it."

Resident A's Assessment Plan dated 06/11/2021 documents that Resident A is not able to move independently while out in the community, he requires "staff for monitoring and supervision." His plan also states that he is not alert to his surroundings and needs to be "supervised closely while out in the community." Resident A requires staff assistance with eating/feeding his plans states that he requires "direct supervision and

constant verbal prompts. He is on a chopped diet." On 12/03/2021, Resident A was not out in the community but left the adult foster care facility and was able to access pizza in the trash cans without the knowledge of the two assigned staff members, Amanda Miller, and Father Franklin; therefore, he was not supervised in accordance with the resident's assessment plan while on the property of the adult foster care group home.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	On 12/03/2021, Resident A snuck out of the facility, retrieved a piece of pizza from the garbage, ate and choked on the pizza. On 12/09/2021, both direct care staff, Amanda Miller, and Father Franklin both admitted that Resident A went outside of the facility without their knowledge, retrieved a piece of pizza from the garbage, and choked on it. On 02/08/22, direct care staff, Amanda Miller stated that she was not aware that the facility had a door alarm and on 12/03/2021 she did not hear a door alarm during the incident that involved Resident A. On 02/09/2022, Father Franklin confirmed that there he was aware that the facility had a door alarm. On 12/03/2021, Father Franklin stated he heard the door alarm prior to the incident with Resident A, however he was not aware of who entered/exited the door as he was helping other residents. Resident A's Person Centered Plan dated 09/14/2021 documented that he "was found trying to get food out of the trash to eat." Resident A's Assessment Plan dated 06/11/2021 documents that he is not alert to his surroundings. Resident A requires staff assistance with eating/feeding; his plans states that he requires "direct supervision and constant verbal prompts. He is on a chopped diet." On 12/03/2021, Resident A was able to leave the facility unsupervised by direct care staff members, Amanda Miller, and Father Franklin, retrieve a piece of pizza from the garbage and choke on it. Per Resident A's written assessment plan, he is not alert to his surroundings and must be closely monitored. Resident A also requires direct supervision and constant verbal prompts while eating. Based upon my investigation I find the licensee did not provide supervision and protection to Resident A on 12/03/2021 as specified in his written assessment plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED; SIR #2021A0122032 dated 10/21/2021 and CAP dated 10/13/2021**

V. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

Vanita C. Bouldin Date: 02/17/2022
Licensing Consultant

Approved By:

Ardra Hunter Date: 02/17/2022
Area Manager