GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

April 27, 2022

Cynthia Williams
Samaritas Shelter Grand Rapids
2361 Knapp ST SE
Grand Rapids, MI 49505

RE: License #: CI410409653
Investigation #: 2022C0103009
Samaritas Shelter Grand Rapids

Dear Ms. Williams:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing on the attached form (CWL-4617). 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 area manager at (616) 204-6992.

Sincerely,

Rorie Dodge-Pifer, Licensing Consultant
MDHHS\Division of Child Welfare Licensing
235 Grand, Ste 1305
P.O. Box 30650
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	CI410409653
Investigation #:	2022C0103009
Complaint Receipt Date:	02/22/2022
Investigation Initiation Date:	02/22/2022
Report Due Date:	04/23/2022
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenu Detroit, MI 48214-2691
Licensee Telephone #:	(231) 936-1012
Administrator:	Cynthia Williams
Licensee Designee:	Cynthia Williams
Name of Facility:	Samaritas Shelter Grand Rapids
Facility Address:	2361 Knapp ST SE Grand Rapids, MI 49505
Facility Telephone #:	(517) 763-1485
Original Issuance Date:	10/22/2021
License Status:	ORIGINAL
Effective Date:	10/22/2021
Expiration Date:	04/21/2022
Capacity:	45
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

	Violation Established?
Youth A used staff member's personal phone and did not want to return it. Staff member attempted to take youth to the ground in order to obtain the phone. Youth resisted the restraint. Staff pulled off youth's shirt and made youth strip down to their underwear. Youth A put phone in their underwear and staff retrieved it. An LIRS staff twisted a youth's arm.	Yes
The Youth are not provided with adequate dental, medical, or mental health services.	No
Grievances are not in the youth's language.	No
Staff belittle the youth and laugh at them when in crisis.	Yes
Additional Findings	
A youth was left alone in the van while the group went into the trampoline park for 2 hours.	Yes
The youth in the program have needs that are outside the scope of the program.	Yes

III. METHODOLOGY

02/22/2022	Special Investigation Intake 2022C0103009
02/22/2022	Special Investigation Initiated - Telephone Chief Administrator (CA)
02/22/2022	Contact - Telephone call made Staff 1
02/22/2022	Contact - Document Received E-mails from Staff 1
02/22/2022	Contact – E-mail exchanges DHHS Worker
02/22/2022	Contact - Telephone call made CA
02/22/2022	Contact - Document Sent E-mail to CA and Program Manager (PM)
02/22/2022	Contact – E-mail exchanges Clinical supervisor
02/23/2022	Contact – E-mail exchanges CA
02/23/2022	Contact - Document Received E-mail from PM
02/23/2022	Contact - Document Received E-mails from Staff 1
02/24/2022	Contact - Document Received Office of Refugee Resettlement (ORR)

02/24/2022	Contact – E-mail exchanges CA
02/24/2022	Contact - Document Received ORR Field Specialist
02/24/2022	Contact - Face to Face Supervisor
02/24/2022	Inspection Completed On-site
02/25/2022	Contact - Face to Face Interview of Youth D and Youth E
02/25/2022	Contact - Telephone call made CA
02/25/2022	Contact - Telephone call made ORR
02/25/2022	Contact - Document Received DHHS Worker
02/25/2022	Contact - Face to Face Virtual Meeting with CA, Chief Operations Officer (COO), Program Manager, Quality, ORR, and DCWL
02/25/2022	Contact - Face to Face Program Manager
02/25/2022	Contact - Face to Face ORR Field Specialist
02/25/2022	Contact - Document Sent E-mails to Program manager
02/25/2022	Contact - Document Received E-mail from ORR Field Specialist
02/26/2022	Contact – E-mail exchanges DHHS Worker
02/26/2022	Contact – E-mail exchanges CA
02/27/2022	Contact – E-mail exchanges COO
02/28/2022	Contact – E-mail exchanges DHHS Worker
02/28/2022	Contact – Document received E-mail from CA
03/01/2022	Contact – Document sent E-mail to CA
03/02/2022	Contact – E-mail exchanges CA, PM, and COO
03/02/2022	Contact – E-mail exchanges DHHS Worker
03/02/2022	Contact – E-mail exchanges Administrative Assistant
03/03/2022	Contact – E-mail exchanges DHHS Worker

03/04/2022	Contact – E-mail exchanges CA, PM, and COO
03/04/2022	Contact – E-mail exchanges Lutheran Immigration and Refugee Services (LIRS)
03/04/2022	Contact – Virtual Meeting CA, PM, COO, LIRS, and DCWL
03/07/2022	Inspection completed on-site Observed House 1, documentation of dental and psychiatric appointments provided.
03/07/2022	Contact – Face to Face PD and Staff 1
03/07/2022	Contact – E-mail exchanges CA
03/07/2022	Contact – Telephone call received COO
03/08/2022	Contact – Virtual Meeting LIRS Staff and DHHS Worker
03/08/2022	Contact – E-mail exchanges DHHS Worker
03/08/2022	Contact – Telephone call received CA
03/08/2022	Contact – E-mail exchanges CA
03/09/2022	Inspection completed on-site Observed houses
03/09/2022	Contact – Telephone call made CA
03/10/2022	Contact – E-mail exchanges CA
03/10/2022	Inspection completed on-site Observed houses
03/10/2022	Contact – Telephone calls made/received CA
03/10/2022	Contact – Virtual Meeting Area Manager, DCWL Director, and Bureau Director
03/12/2022	Contact – E-mail exchanges PM
03/13/2022	Contact – E-mail exchanges PM
03/14/2022	Contact – Face to Face Viewed videos and met with PM
03/14/2022	Contact – E-mail exchanges Administrative Assistant
03/14/2022	Contact – E-mail exchanges PM
03/15/2022	Contact – Telephone call received

	CA
03/15/2022	Contact – E-mail exchanges CA
03/16/2022	Contact – E-mail exchanges DHHS Worker
03/16/2022	Contact – Telephone call made CA
03/16/2022	Contact – E-mail exchanges CA
03/17/2022	Contact – E-mail exchanges PM
03/18/2022	Contact – Face to Face Administrative Assistant. Reviewed employee files.
03/18/2022	Contact – Virtual Meeting Pre-exit with CA, PM, and Quality
03/22/2022	Contact – Telephone call made DHHS Case Conference – no findings

ALLEGATION:

Youth A used staff member's personal phone and did not want to return it. Staff member attempted to take youth to the ground in order to obtain the phone. Youth resisted the restraint. Staff pulled off youth's shirt and made youth strip down to their underwear. Youth A put phone in their underwear and staff retrieved it.

A youth's arm was twisted by an LIRS staff member.

INVESTIGATION:

Incident One:

A complaint was received on 2/22/22 that stated Youth A had a cell phone. Program Director (PD) went to collect the phone from Youth A, but Youth A would not give it back. PD tried to take Youth A down to the ground to get his phone. Youth A was resisting the take down. PD then pulled Youth A's shirt off. Youth A was made to strip to his underwear. Youth A then put the phone in his underwear. PD reached into Youth A's underwear and took the phone. Youth A then ran away.

Interviews:

Staff 1 was interviewed on 2/22/22 via telephone and face to face at the facility on 3/7/22 along with the DHHS Worker. He stated the information he received about Youth A was not witnessed by him but was put in a grievance form by Youth B. It was reported Youth B, Youth C, and Youth D all witnessed the incident. The incident was brought up in a meeting the facility had with the youth about the use of cell phones. The meeting happened approximately 1-2 weeks ago. The youth reported the same information indicated in the complaint. A grievance was filled out after the other youth confirmed it happened. This was the first time Staff 1 heard of the

incident. Staff 1 stated all the staff are concerned about PD. The youth do not feel comfortable around him.

Staff 5 was interviewed via 3-way telephone call with the DHHS Worker on 3/4/22. She stated she is a social work assistant. She was told to show all the youth their personal belongings. She showed Youth A his belongings despite not wanting to because of Youth A's behaviors. When she showed him his items Youth A grabbed his cell phone without her knowing. Another youth told Staff 5 that Youth A had his cell phone. She confronted Youth A in the living room of the house. Interpreter 3 helped her talk to Youth A. Youth A went into his bedroom and Staff 5 followed. When she got to his bedroom, Youth A had lifted his shirt up and said not to touch him. Youth A grabbed the cell phone out of his cupboard and said if she got PD then he would hand it over. Staff 5 got PD. When PD came into the bedroom Youth A took off his shirt and stuck the phone in the waistband of his boxers. He said not to touch him, and PD said he would not touch him. Youth A then tried to crawl under his bed. PD grabbed Youth A's arm to keep him from going under the bed. When PD went to grab Youth A, he had one knee on the floor with his other foot flat on the floor and his hand holding Youth A's arm. PD was not over the top of Youth A but rather off to the side. PD was not forcing Youth A to the ground and did not place any pressure on his body. When Youth A went to the floor he was in a crawling position. PD was not hurting Youth A, he just held him to prevent Youth A from going under the bed. She did not see any injuries on Youth A. The other youth appeared and began watching. They were redirected to leave the area, but Youth C and Youth D went into the bedroom and hit PD. Youth A then ran outside without shoes or a shirt on. Youth A still had his cell phone in his pants. After he went outside, she got Youth A shoes and a coat because it was cold out and Youth A was not trying to runaway. She and PD were focused on getting Youth A inside rather than the cell phone. They were outside for 10-20 minutes, then Youth A went inside. They did not get the cell phone from Youth A until the following day. Staff 5 thought Youth A took his shirt off because he was preparing for a fight. The incident with Youth A and PD occurred on 1/25/22 around 4pm.

Youth D was interviewed face to face at his school on 2/24/22 along with the DHHS Worker. Youth D reported Youth A did not have a shirt on. He put the cell phone in his pants pocket and PD took it out of his pocket which was by his groin. Youth A only had pants on. He was laying on the ground. PD had his knee on the ground. PD was pushing Youth A to the ground and Youth A was saying it hurt. He could not see past PD to see where PD's hands were located. Youth D pushed PD's hand away and Youth A ran outside without clothes or shoes. There were other staff present but he could not remember their names. Youth A had red patches on his body.

Youth E was interviewed face to face at his school on 2/24/22 along with the DHHS Worker. He was present when Youth A had his cell phone. Youth A was in his bedroom trying to change when PD went into his bedroom. Youth A was trying to go under his bed. PD was on his knees. Youth A was crying, and PD had Youth A’s arm twisted. Youth A screamed let my arm go. Youth A tried to hide under his bed and

PD pulled Youth A from under the bed by his arm. Youth A put his cell phone in his underwear. He did not notice how PD got the cell phone from Youth A. Youth A's shoulder was scratching against the floor. He was screaming and asking for help. PD was holding Youth A to the ground face down on the floor. Youth E left before the cell phone was taken. He saw Youth A's body was red. He stated it is against their culture to watch someone suffer like that.

Youth C was interviewed face to face at the facility on 2/28/22 along with the DHHS Worker. Youth C stated PD was touching Youth A but did not provide further details of how PD was touching Youth A. PD took his cell phone by force. Youth A put the cell phone in his pocket. Youth A told them not to touch him. PD came and said he would take the cell phone by force if Youth A did not give it up. Youth A was bleeding on his arm. He had scratches from the floor when PD held Youth A to the floor. Youth C stated he was inside the bedroom when this occurred. He tried to get PD away from Youth A. Youth C no longer wanted to be interviewed and left the room.

Youth A was interviewed face to face at the facility along with the DHHS Worker on 2/28/22. He reported the only person that ever touched him was PD after Youth A took his cell phone. Youth A was changing his clothes when PD came in and pulled Youth A's arm behind his back and swiped his foot out from under him so he would fall to the floor. Youth A put the cell phone in his underwear and lifted his legs to his chest so PD could not get the cell phone. PD reached into Youth A's underwear to retrieve the cell phone. Youth A tried to go under his bed, but PD pulled him out. PD pressed Youth A to the ground. Youth C and Youth D grabbed PD. Youth A then ran outside. He wanted to call the police, but PD would not let him. PD took Youth A to another house and showed him a card saying he could touch Youth A. Youth A was hurt. He had a scratch on his shoulder that had a bit of blood. He showed us his shoulder and there were no marks.

Interpreter 3 was interviewed face to face at the facility along with the DHHS Worker on 2/28/22. Staff 5 asked him to interpret. She asked Youth A to give her the cell phone. Youth A took his cell phone and would not give it back. The cell phone could be seen in Youth A's pocket. PD then asked for the cell phone and Youth A went to his bedroom. Youth A went to go under his bed, but PD would not let him. PD was holding Youth A's hand. PD had his body over top of Youth A and holding Youth A's opposite hand. One of PD’s hands was on the ground, and one was holding Youth A. He did not know how Youth A got on the ground. Youth A then ran outside without shoes. Him and PD went after Youth A. Youth A tried to hit PD. Interpreter 3 told PD to get the cell phone some other time. PD told the Interpreter 3 that he is the director, and he knows what to do. He thought Youth A had a shirt and sweatpants on. The cell phone was in Youth A's sweatpants, and he could see the outline of the cell phone in his pocket. Someone gave Youth A shoes and a coat. PD was mostly quiet but occasionally would ask Youth A to give him the cell phone. He did not see any injuries on Youth A. Interpreter 3 said he did not see PD twist Youth A's arm or sweep Youth A’s leg. He did not see PD abuse Youth A in anyway.

PD was interviewed face to face at the facility on 3/7/22 along with the DHHS Worker. He reported Staff 5 informed him that Youth A had his cell phone. ORR wanted them to inventory the youth's stored belongings. These were things the youth were not allowed to have. Staff 5 was doing the inventory with Youth A when she became distracted. Youth A took his cell phone out of his belongings. Staff 5 went to PD and stated Youth A would not return his cell phone. PD went to talk to Youth A. Youth A was being playful and running around. Youth A went into his bedroom and PD followed. PD told Youth A he would not leave Youth A's bedroom until he gave up the cell phone. Youth A became upset and pushed PD, and then hit him. Youth A went to hit PD and PD moved his hands up to stop him. Youth A then dropped to the floor. PD sat on the floor next to Youth A. Youth A went to sneak under his bed and PD put his legs out to stop Youth A from going under the bed. PD had one knee up and one leg stretched out. He never held Youth A. He only blocked him. He also never tried to pull Youth A out from under the bed. Youth A was screaming and got the attention of the other youth. PD tried to grab the cell phone out of Youth A's hand but when Youth A would pull his hand away, he would let go. Once Youth A put the cell phone in his pants, PD was done trying to retrieve the cell phone. Youth C and Youth D came into Youth A's bedroom and punched PD. Youth A ran out of his bedroom and out of the house. Youth A had pants on, but he did not have a shirt on. Youth A did not have any injuries and never stated anything hurt. Youth A still had the cell phone when he went outside. PD denied showing Youth A a card or badge saying he could put his hands on Youth A.

Video Reviewed:

- In the video footage reviewed of the incident on 1/25/22, Staff 5 is seen talking to Youth A in the hallway and common area of the house. Youth A has on sweatpants and a t-shirt. Youth A and PD go into Youth A's bedroom. Youth C and Youth D also enter Youth A's bedroom. Youth A is observed running out of his bedroom followed by Youth C and Youth D. PD's hand is observed holding either Youth C or Youth D's arm trying to pull them back into the bedroom, but the youth break free. Youth C and Youth D could not be distinguished in the video.

Documents Reviewed:

- Grievance form: The grievance indicated the information that was in the complaint.
- Youth Case Files: Youth A has a history of verbal and physical aggression and taking people's cell phones.
- Significant Incident Reports (SIR): All SIRs were reviewed and none could be found for this incident.
- Internal Incident Reports: All Incident reports for Youth A were reviewed and none were found for this incident.
- Aegis Training Material: a review of the restraint training (Aegis) taught by the facility found it did not include pulling a youth by the arm, grabbing a youth's

hand, twisting a youth's arm, or wrapping arms around a youth to bear hug him as their restraint techniques.

Incident Two:
A youth's arm was twisted by an LIRS staff member.

INVESTIGATION:

During Staff 1's interview on 2/22/22 he reported at night there was a riot and when he pulled up to the facility, the police were there. The youth broke into the case managers office and took their belongings. The staff were then directed to search the youth's bedrooms. During the search, Youth D put his hand through a window and the Lutheran Immigration and Refugee Services (LIRS) staff grabbed his arm and twisted it until he agreed to go upstairs. Youth D was not harming himself or others at the time. During a second interview with Staff 1 on 3/7/22, conducted with the DHHS Worker, he changed his story regarding the incident on 2/21/22. He reported the LIRS staff was close to Youth D when he was picking up glass pieces from a broken window. She stood in front of Youth D to keep him from getting at the broken window. The LIRS staff held Youth D's hand as he handed her the glass he had in his hand, and she took it from him. This was the only touch he saw between the LIRS staff and Youth D.

Youth D was interviewed face to face at his school, along with the DHHS Worker, on 2/24/22. Youth D stated when he and his peers wanted to go downstairs to get their cell phones there was a window in a door that was broken. Youth D put his arm through the window and the LIRS staff jokingly twisted his arm. He knew she was joking because she had a smile on her face, and she was not wearing a mask. He said his entire hand was twisted, but it was not painful. The LIRS staff did not say anything. He did not have any injuries. He was searching for his cell phone and joking around with the LIRS staff telling her to let him go.

PD stated during his interview he was not present for the incident on 2/21/22. The LIRS staff did talk to him. He was called by the staff and told them to call the police. He called the LIRS staff and told her what was going on and asked what he should do. She told PD she would go to the facility instead of him. PD stated he did not think the LIRS staff would be allowed to restrain the youth. She came to the facility as an administrator, so she did not need the training. The LIRS staff did not indicate to him she needed to restrain anyone.

DHHS Case Conference was attended on 03/22/22 and they had no findings.

Incident Three:
Interviews:
On 2/22/22 Staff 1 reported Youth E was self-harming and attacked Program Director (PD). Two interpreters had to restrain Youth E. Only Samaritas staff can restrain the youth. Samaritas Staff stood by and watched Youth E harm himself

without intervening. PD ran out of the house. Staff 1 was not present when this occurred but was told by Federal Employee 2 and did not know what staff or federal employees were present.

Staff 6 was interviewed via three-way telephone call along with the DHHS Worker on 3/3/22. Staff 6 is a therapist who usually works for another program within Samaritas but has been helping at the shelter. Staff 6 reported there are a lot of people at the shelter but very few of them are actually trained to perform restraints. Staff 6 was present for the incident with Youth E. Early in the day Youth E had run away and then returned. He was barricading himself in his bedroom and smashed a phone. She picked up the pieces of the phone and was in the hallway when she saw Youth E peak out the door and observed his arm bleeding. Staff 6 got an interpreter and then saw there was a broken razor on the floor. Youth E left his bedroom and began to kick the office door requesting to talk to PD. Youth E banged his head into the wall. Staff 6 was trying to get people to help her. Someone, she did not recall who, came to help and walked Youth E to the couch. Staff 6 began to clean Youth E's wounds. PD then came out of the office and Youth E threw a chair at him. Staff 6 told PD to leave. Youth E calmed down and they were able to finish cleaning his arm. An ambulance came and transported Youth E to the hospital. Staff 6 could not recall who helped her with Youth E, but it could have been an interpreter She had to yell to get someone to help her. She reported it is the Samaritas staff's responsibility to address youth behaviors not the interpreters or the federal employees. She could not recall if another Samaritas staff was present. Samaritas was having a shortage of staff (This is addressed in special investigation 2022C0103005). Youth E attempted to cut his arms again as staff were unable to get the razor from him. Staff 6 and the interpreters held Youth E so the blade could be pried out of his hand. This was not a typical hold as Youth E is much taller than Staff 6. She had her arm locked in with his and they were both being dragged around by the interpreters who were holding Youth E. Staff 6 reported that nothing they did was overly aggressive. Youth E was being held in a bear hug by Staff 6 and the interpreter. Staff 6 admitted she held Youth E in a half bear hug herself. There were two interpreters, although she could not recall their names, who pried the razor out of his hand.

Youth E was interviewed face to face at his school along with the DHHS Worker. He stated he did hurt himself. He did this because PD was not listening to him or keeping his promises. Youth E was worried about his family and their financial state at home. He cut himself with scissors while in his bedroom. He only did this the one time. He showed his arms which were observed to have new scabs and old scars. PD was trying to get into his bedroom. PD promised he would do something about his family's finances. He opened the door and went to PD. He hit his head against the wall 3 times. He then got dizzy, and the police came. No one helped him but Interpreter 1 and Interpreter 2 who were trying to communicate with him. One of them told him to sit on the couch. He denied that anyone held onto him. PD came out and stood in front of him. He became upset again and stood up. PD ran to his office. Youth E sat for about an hour then he was taken to the doctor in an

ambulance. Interpreter 1 and Therapist went with him. That night the staff removed the scissors from his bedroom and staff supervised him.

Interpreter 1 was interviewed face to face at the facility on 3/10/22 along with the DHHS Worker. He was in House 2 when a federal employee asked for help because Youth E was cutting himself. When he entered House 1, he saw Youth E punching PD's office door. Youth E then began to hit his head on the wall. Staff 6 held Youth E who also had a blade in his hand. She asked for help, so Interpreter 2 took Youth E and walked him to the couch with his arms wrapped around Youth E. Youth E still had the blade in his hand. Youth E started to cut himself. Interpreter 2 was holding Youth E and Interpreter 1 was standing in front of Youth E. Youth E grabbed a chair to throw. Interpreter 2 helped Youth E to the couch again by wrapping his arms around him. Interpreter 1 took a towel and wrapped it around Youth E's arm. Each time Interpreter 2 held Youth E it was for Youth E's safety and the safety of those around him.

Interpreter 2 was interviewed face to face at the facility on 3/10/22 along with the DHHS Worker. He was in House 2 when Youth E cut himself. Someone called for help. He went to House 1 and Youth E had a razor blade and was punching and kicking the wall. When Youth E hit the wall with his head, he stumbled backwards so Interpreter 2 helped Youth E to the couch. Youth E still had the razor blade and was cutting his arms. No staff were intervening to stop Youth E, so Interpreter 2 stepped in and grabbed Youth E's hand to take the razor blade. A Samaritas staff, he did not know which one, brought bandages to clean the blood and then the police arrived. Interpreter 2 said he was not the only person holding Youth E when he was on the couch. There were 2-3 others holding Youth E, but he did not know who they were He reported if the Samaritas staff present would have done their job then he would not have had to step in. He did not know the names of the Samaritas staff who were present.

Interpreter 3 was present for the incident with Youth E on 2/17/22. He thinks Staff 6 was also present. Youth E barricaded himself in his bedroom and Staff 6 was able to get in by pushing the door. Youth E had at least 20 cuts on his arm. Staff 6 asked for the blade, but he would not give it up. Youth E then left his bedroom and went to the office door. Youth E began to hit his head on the wall next to the office door. He almost went unconscious. Staff 6 and some other youth helped Youth E walk to the couch. He still had the blade in his hand and cut himself again, approximately 10 times. Interpreter 2 held Youth E from behind while he was standing, and Youth E was sitting. Interpreter 3 then got the blade out of Youth E's hand. PD came to get the blade and Youth E tried to throw chairs at PD. Interpreter 1, Interpreter 2, and Interpreter 3 held the chairs so he could not throw them. PD was asked to leave. PD was not seen for the rest of the day. Someone called 911 and Youth E was taken to the Emergency Room. Interpreter 3 stated there were only female Samaritas staff working, and they could not manage the situation. Federal Employee 1 was also there helping hold Youth E.

During her interview on 3/9/22 Therapist stated she was not present for the incident with Youth E but came in to take him to the hospital. She reported PD was a trigger for Youth E.

Federal Employee 1 was interviewed face to face at the facility along with the DHHS Worker on 3/9/22. He remembered the incident with Youth E. He was there but he did not engage with Youth E. He saw the blood on Youth E and did not want to get near him. Youth E was anxious and angry at PD. Youth E had also hit his head on the wall. He then laid down on the couch. Federal Employee 1 stated another youth helped clean Youth E's wounds but did not know who. He was going to help but was told Youth E still had the blade, so he did not go near him. One of the interpreters, he could not recall which one, took the razor blade from Youth E. He never saw how the blade was removed from Youth E. He said a Samaritas staff was also helping but he did not recall who it was. An ambulance came and took Youth E to the hospital.

PD was interviewed face to face at the facility on 3/7/22 along with the DHHS Worker. He reported Youth E threatened PD. PD did not touch Youth E. PD tried to talk to Youth E, but Youth E raised his fist at PD. PD backed up which allowed Youth E to close his door more and barricade himself in his bedroom. He smashed the cell phone he had and threw the pieces out his bedroom door. PD had a meeting he needed to attend and told the staff to keep an eye on Youth E. The next thing PD knew Youth E was banging on PD's office door trying to get to PD. PD did not know why Youth E was upset with him. There were several Samaritas staff, federal staff, and interpreters, the PD did not know specifically which ones, who were with Youth E. PD stated if he came out of his office it would have just escalated Youth E further. Youth E had fallen backwards after hitting his head and Staff 6 held onto him. PD came out of the office and Staff 6 was helping Youth E to the couch. He had a staff member call 911. While Youth E was on the couch, PD was able to get the blade from Youth E and throw it away in the office. An interpreter tried to get the blade from Youth E as well, but he could not remember which interpreter. He tried to help get Youth E cleaned up, but when Youth E realized it was PD, he swung at PD. PD then left the building. Staff 6 was present for the incident as well as three case managers and federal employees, he did not indicate which ones. PD reported he left as there were plenty of staff present and Staff 6 was pushing for PD to leave.

PD stated the interpreters are not allowed to restrain youth as they did not receive restraint training. The first time the interpreters put their hands on Youth E was when they helped him to the couch. The second time was when Youth E was on the couch with the blade. PD stated that several of the youth have it out for him. If PD were to restrain Youth E the other youth would get involved. He reported the other Samaritas staff that were working should have intervened with Youth E, but he did not remember what specific staff were present. PD reported staff are not supposed to be in the house if they are not trained on how to restrain a youth. PD did not know what staff were scheduled to work direct care as he reported he does not complete the staff schedule.

Video Reviewed:
In review of the video of the incident with Youth E, Youth E is observed banging his head on the wall. Interpreter 2, Interpreter 3 and Staff 6 help walk Youth E to the couch by wrapping their arms around him. Youth E tries to pull away from them on the way to the couch, but they manage to sit him down. Youth E begins to cut his arm. Interpreter 1, Interpreter 2, Interpreter 3, and Staff 6 try to stop him by holding his arms. When PD enters the scene, Youth E gets up and tries to pick up a chair. Interpreter 1, Interpreter 2, and Interpreter 3 hold the chairs and PD leaves.

Incident Four:
Interviews:
The Volunteer Coordinator (VC) was interviewed face to face at the facility on 2/24/22 along with the DHHS Worker. She coordinates the federal employees. The VC does not oversee the interpreters. The federal employees work twelve-hour shifts and there is one federal employee in each house at a time. Federal employees are to provide line of sight supervision of the youth. They can assist with meals, take youth for walks, and do activities. They are not allowed to perform physical managements.

Therapist reported since the youth met with Office of Refugee Resettlement (ORR) on 3/9/22 things have been very difficult. Prior to the meeting Youth A has had issues since 2/16/22 with ORR Field Specialist. ORR Field Specialist, who speaks their language, called Youth A's father to report his behavior and this triggered Youth A' s behavior. ORR Field Specialist wanted to meet with the youth and PD told him not to meet with the youth at school so there could be better support when he talked to the youth. ORR Field Specialist met with the youth at their school anyways. The youth did not respond well and rioted at the school. Youth A tried to harm himself by jumping from the 4th floor balcony. Therapist and Federal Employee 1 held Youth A back from jumping by wrapping their arms around his torso. The other youth from the facility that were present also helped hold Youth A back, but she could not recall who those youth were. They were able to pull him down. Therapist said she has had restraint training. Even though this was not an actual restraint technique it was still a restraint. She knows she did not perform the appropriate restraint technique, but she reported they did not have any other alternative. PD was informed of the incident.

During Federal Employee 1’s interview he reported while at the school he held Youth A when Youth A tried to jump. Youth A was upset with ORR Field Specialist. Federal Employee 1 wrapped his arms around Youth A in a bear hug. One of his peers also tried to stop Youth A. Federal Employee 1 did not know what the youth’s name was.

APPLICABLE RULE	
R 400.159	**Resident restraint.**
	(1) An institution shall establish and follow written policies and procedures regarding restraint. These policies and procedures shall be available to all residents, their families, and referring agencies. (2) Resident restraint shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of trauma, and done in a manner consistent with the resident's treatment plan.
ANALYSIS:	Incident 1: Witnesses indicated PD pulled on Youth A's arm restricting his movement to keep him from going under the bed. He was also observed on video restricting the movement of another youth. The techniques utilized by PD were not Aegis approved techniques. PD, Staff 5, and Interpreter 3 all indicated PD did not reach into Youth A's underwear to grab the cell phone, nor did he make Youth A strip, or take Youth A to the ground to get the cell phone. Incident 2: There is not enough information to indicate the LIRS staff twisted the youth's arm as Staff 1 accounts of the incident changed, the LIRS staff denied she twisted Youth D's arm, and Youth D said LIRS staff twisted his arm in a joking manner. Incident 3: The interpreters reported they had to hold Youth E to keep himself and others safe. The interpreters are not Samaritas staff and should not be restraining the youth. Because the interpreters are not trained in restraints, the holds they did were not Aegis approved techniques. Per facility policy only Aegis approved restraints can be performed and only Aegis trained staff can perform the restraints. Incident 4: Therapist and Federal Employee 1 both indicated they had to restrain Youth A to keep him from hurting himself. Federal Employee 1 is not trained to do restraints and Therapist indicated the hold was not an Aegis hold. Per facility policy only Aegis approved restraints can be performed and only Aegis trained staff can perform the restraints. None of the restraints discovered during this investigation were entered into MiSACWIS as required by the facility's policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The Youth are not provided with adequate dental, medical, or mental health services.

INVESTIGATION:

Interviews:
During his interview on 2/22/22 Staff 1 reported the Program Director (PD) will not schedule dental appointments for the youth when they are in pain. PD also does not give the youth medication such as pain medication when they ask for it. Staff miss giving youth their medication.

Staff 1 was again interviewed on 3/7/22 face to face at the facility along with the DHHS Worker. He has had several concerns with the facility but the main one is the under reporting of suicidal ideation. About half of the youth at the facility have mental health issues. Staff 1 reported concerns that the psychiatrist does not see the youth in person, the psychiatrist puts the youth on medication, and then will abruptly take them off. Staff 1 was told this was the only psychiatrist that would take the youth's insurance. He told PD and Office of Refugee Resettlement (ORR) that the youth need more mental health support. He told them this prior to Youth E harming himself. He talked to PD about his concerns. PD stated they were limited on what they could do because of the youth's insurance. Staff 1 said he checked with ORR, and they told him they pay for the medical, dental, and mental health treatment for the youth. Some of the youth have tooth infections that they had when they were admitted to the facility. He talked to the medical coordinator about it, and she indicated it was an insurance issue. After he brought it up one of the youths was put on an antibiotic. He overheard a staff asking PD about a youth's medication. The youth did not receive his scheduled antibiotic so PD said he could take two at a time. Staff 1 reported staff are not logging medication correctly.

During Youth D's interview on 2/24/22 he stated he has medication to help him sleep but it does not help so he is not taking it. Youth D did go to the dentist, but they did not fix the problem. He has a black tooth and a cavity. Youth D meets with his therapist at school, but he does not know her name. Youth D tried to cut himself, but he was not serious. He saw a doctor about his sleep but never talked to him about hurting himself.

Youth E said during his interview on 2/24/22 that he did go to the dentist for a cleaning, but he has cavities that hurt.

During PD's interview on 3/7/22 he reported there is a medical coordinator he supervises. She is responsible to schedule the dental appointments. The youth had dental appointments but many of them have extensive problems and they need to schedule additional appointments. Those appointments are harder to schedule. When the youth complain of pain, Samaritas will take them to urgent care. They

must receive prior approval from the insurance company before any appointments and then they have to ask 2-3 times for approval before it gets approved. The facility has a partnership with a psychiatrist who meets with the youth virtually and prescribes medication. The psychiatrist was sent to them from ORR. The youth refuse to take the medication often; seeing it as a sign of weakness or that Samaritas is trying to drug them. Samaritas staff are responsible for passing medication. PD stated he has never refused to provide medication to any youth.

Staff 5 reported during her interview on 3/4/22 that she believes the youths mental health is being taken care of as best they can. The youth do not believe in mental health, so they often refuse services. Some of the youths have had a psychiatric evaluation with the doctor as well as follow-ups.

On 3/3/22 Staff 6 stated the doctor the youth see is a psychiatrist. A couple of the youth are prescribed psychotropic medications, but they often refuse to take them. Some of the youth went to the dentist recently. She knows some of the youths have also gone to urgent care. She believes they are offering all the mental health services they can provide but they are a transitional placement, so their services are limited. She believes they need more well-trained staff and a set routine for the youth.

Medical Coordinator (MC) was interviewed via telephone on 4/6/22. She reported all the youth had physicals completed prior to admission but ORR requested new physicals be completed, so all the youth received physicals. MC got the youth started with a dentist, but the dentist stopped seeing the youth. MC had to find a new dentist. It was difficult to find a dentist who would work with the youth's insurance. A new dental provider was found, but Samaritas did not like working with the provider because they would not provide after visit summaries. She reported Youth J needed a lot of dental work but due to an infected tooth he needed to be on an antibiotic for 10 days. Youth J refused to comply with the antibiotic, so it took him longer to finish it. Youth J and other youth were in the process of getting their dental work appointments scheduled when they left Samaritas.

Documents Reviewed:

- Youth Case files: All youth case files were reviewed. All youth were provided with medical, dental, and mental health services. All the youth have seen a therapist at the facility.
- Medication logs: the logs do not indicate if medications were missed or passed late.

APPLICABLE RULE	
R 400.4142	**Health services; policies and procedures.**
	(1) An institution shall establish and follow written health service policies and procedures addressing all of the following: **(a) Routine and emergency medical, and dental, and behavioral health care.** **(g) Methods for dispensing medication when the resident will be off site.**
ANALYSIS:	According to the youth files they are all receiving medical, dental, and mental health services and there is no indication that the youth were not provided their medication as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Grievances are not in the youth's language.

INVESTIGATION:

Interviews:

During his interview on 2/22/22 Staff 1 stated the grievance form was only recently changed to the youth's language. When a youth completed a grievance for the incident with Youth A an interpreter helped him complete the form.

Youth D reported he has not filed a grievance because he knows it will not help. He has seen the form and it is in his language.

The Program Director (PD) reported the grievance forms were changed to the youth's language, but he could not recall when.

Staff 5 reported grievance forms have been translated into the youths' language approximately 2-3 weeks ago.

Staff 6 reported the grievance form used to be in Spanish but is now in Dari. She is not sure when it changed.

Documents Reviewed:

- Grievance Form: The form is in English and Dari.

APPLICABLE RULE	
R 400.4132	**Grievance procedures.**
	(1) An agency shall have and follow a written grievance handling procedure for residents and their families. All of the following apply: **(b) The policy shall be explained in a language the resident and his or her family can understand.**
ANALYSIS:	The grievance forms are in the youth's language. Prior to them being translated into their language they had the help of an interpreter to complete the grievance form.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff belittle the youth and laugh at them when in crisis.

INVESTIGATION:

Interviews:
Staff 1 stated in his interview on 2/22/22 some of the staff belittle the youth and threaten that they will write a Significant Incident Report (SIR) on them if they do not comply.

Youth E reported during his interview that PD laughed at him while he was in crisis and hurting himself.

During his interview on 3/7/22, Program Director (PD) said he never laughed at the youth when they were upset. He has talked to other Samaritas staff about laughing at the youth.

On 3/4/22 when Staff 5 was interviewed she said she has heard federal employees laugh at the youth. They also laugh at the Samaritas staff in how they handle situations.

Staff 6 reported on 3/3/22 she has heard the federal employees say rude things about the youth and laugh at them but not Samaritas staff.

Document Reviewed:

- Staff Code of Conduct: Staff shall treat youth and coworkers with respect and dignity in words and actions.

APPLICABLE RULE	
R 400.4109	**Program statement.**
	(1) An institution shall have and follow a current written program statement which specifically addresses all of the following: **(c) Policies and procedures pertaining to admission, care, safety, and supervision, methods for addressing resident's' needs, implementation of treatment plans, and discharge of residents.**
ANALYSIS:	According to staff interviews both Samaritas staff and the federal staff laugh at the youth which is not in line with the facility's Code of Conduct.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

While at the trampoline Park Youth D was left alone in the van while the group went into the park for two hours.

On 3/5/22 while the youth from both houses went out to dinner a youth was left at the facility without any Samaritas staff supervision.

A youth who was suicidal was allowed to have a razor.

INVESTIGATION:

Incident One:
Interviews:
Staff 1 reported on 2/22/22 a federal employee pulled up next to the van parked at the trampoline park and Youth D was in the van alone. The rest of the group and staff were in the park and had been there for about two hours.

On 3/7/22 PD reported he heard Youth D was left in the van during an outing. The staff reported Youth D was purposefully hiding. He talked to the staff about making sure to complete head counts. He could not remember who the staff was. He did not know if an SIR was completed. PD did not know what the staff are taught during orientation. He stated the staff do learn about supervision during their shadowing shifts. He does not know what trainings staff receive.

Incident Two:
During Staff 2's interview on 3/11/22 she reported she was very frighted by the youth the night of 3/5/22 and she did not know what to do. She reported she was the only Samaritas staff present, along with Interpreter 4. When she pulled over the van the

youth got out and Interpreter 4 followed the youth. When asked, she reported Youth A was in her van and he did not have a one-on-one staff. She had House 1 in her van and the other van had youth from House 2, Staff 11 and Staff 12.

On 3/14/22 Program Manager (PM) was questioned about Staff 2 being the only Samaritas staff in the van the night of 3/5/22. He reported Youth G was left at the house without any Samaritas staff during the outing. He made arrangements for Staff 10 to stay with him but when she got to the house, Staff 10 did not see Youth G and she left. PM stated Staff 10 did not check both houses prior to leaving. She thought the youth went with the rest of the group. When PM discovered what had happened, he sent a staff back to the house. He thought he sent Staff 3 back. By then Youth G had run away from the facility. Youth G returned before the staff could call the police.

Staff 10 was interviewed by telephone on 4/7/22. She stated she remembered the day the youth went on the outing, but she did not work that shift. She reported she worked in the morning and left at 3pm. When she left all the youth were still at the house. She reported she barely ever talked to PM, and she was never asked to stay with a youth who wanted to stay back.

Documents Reviewed:

- E-mail from PM on 3/5/22 at 6:37pm indicated Youth G had gone AWOL from the facility.
- E-mail from PM on 3/5/22 at 11:39pm stating the youth went out to dinner at a restaurant. Afterwards the youth stated they wanted to go for a walk downtown. At that time staff told them it was too late and that they had to go back to the shelter. The youth began screaming in the van and attempting to open the doors and jump out. Staff pulled the van over. The youth walked away from the van, while a federal employee and interpreter were following. Staff 2 followed in a van as best she could. A separate incident happened in the other van leaving the restaurant. A youth became upset for not being able to walk as well. The youth opened the van door and jumped out while the van was moving. He then ran away.
- E-mail from PM on 3/17/22 with a timeline of events for 3/5/22. He clarified Staff 3 was the staff who was sent back to the house for Youth G. He also wrote Staff 10 asked staff at the shelter and called the staff on the outing to confirm if they had all the youth. When the staff (he did not indicate who she talked to) said they had all the youth she left the shelter.
- All program policies were reviewed. None of the policies addressed supervision of the youth.
- E-mail from Federal Employee 2 stating he found Youth D alone in the van at the trampoline park.

Incident Three:

Interviews:
Staff 1 reported during his interview on 3/7/22 Youth E made comments about self-harm in early February before he cut himself with a razor.

On 3/7/22 PD reported Youth E entered the facility with the razor. Because the youth were all admitted at once, they did not have the staff to search all their belongings. He further stated they must provide razors for the youth due to religious reasons. He offered electric razors, but they did not like that. The staff are supposed to get the razor back from the youth after youth are done using it.

Staff 6 stated in her interview on 3/3/22 Youth E should not have been allowed to have a razor.

Youth E was interviewed face to face at his school on 2/24/22 along with the DHHS Worker. Youth E reported he had used scissors to cut himself. He stated he brought them from his previous placement.

Interpreter 1 and Interpreter 2 were separately interviewed face to face at the facility on 3/10/22. They both reported Youth E had a razor blade that he was cutting his arms with.

Documents Reviewed:
- Personal Property procedure indicates youth are not allowed to have sharp objects including razors. Staff will inventory all incoming property.
- Significant Incident Reports for Youth E did not indicate any other self-harm.
- Incident Reports for Youth E did not indicate any other self-harm.

APPLICABLE RULE	
R 400.4126	**Sufficiency of staff.**
	The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff on duty to perform the prescribed functions required by these administrative rules and in the agency's program statement and to provide for the continual needs, protection, and supervision of residents.
ANALYSIS:	The facility is found in non-compliance as during two separate incidents youth were left without staff supervision. Additionally, due to the lack of staffing, the facility was unable to search Youth E's belongings as is required by the facility's Personal Property Policy, allowing him to have access to sharp objects that he used to self-harm. **Technical Assistance:** A policy should be created to specifically address supervision of youth. Additionally, youth should not dictate to staff what they will use and not use. If staff determine an electric razor is safest, then they have complied with meeting the youths' needs and it is then the youth's decision to use it or not.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

The youth in the program have needs that are outside the scope of the program.

INVESTIGATION:

Interviews:
During Program Director's (PD) interview on 3/7/22 he stated they were set up to fail by Office of Refugee Resettlement (ORR) because they were not equipped to take nineteen Afghan youth in one day. They did not have the staffing. The youth's behaviors and mental health needs were outside the scope of their program. They have different needs and were of a different culture than what Samaritas staff have worked with in the past, and are knowledgeable about.

Phone conversations occurred with the Chief Administrator on 2/18/22, 2/24/22, 3/9/22, 3/10/22, and 3/16/22. She indicated Samaritas was not equipped to take the youth that ORR placed at Samaritas. They communicated this with ORR from the beginning but since Samaritas is subcontracted with LIRS through ORR, ORR pays for the Samaritas beds, they are required to take placement of the youth.

On 3/14/22 I reviewed a video dated 2/17/22 in which several Samaritas staff were not intervening when a youth was self-harming. A video from 2/21/22 showed staff standing around not engaging with the youth while the youths broke into the locked basement. After reviewing these videos of staff standing around and not engaging youth during two different crisis situations PM stated the staff were afraid of the youth.

Documents Reviewed:

- Program Statement: Youth accepted to the program must demonstrate the ability to manage their behavior. The youth may have mild behavioral and mental health issues, but the program is not designed for high-risk youth, including youth who are physically or sexually aggressive or are not appropriate for a community-based setting.
- Significant Incident Reports: Youth A had an SIR indicating he wanted to harm himself and he had several SIRs indicating he assaulted other peers. Youth D and Youth F had SIRs in which they threatened to harm themselves. Almost all the youth engaged in truancy from the program or from staff while on outings. All the youth in House 1 engaged in property destruction by throwing a chair through a window, hitting the TV causing it to break, and breaking a window to gain access to the basement. All but one youth in House 1 had SIRs indicating they would hurt themselves or someone else if they did not get what they wanted.
- Youth Case files: All 11 casefiles were reviewed. All the youth were admitted to the Shelter on 1/4/22. All but one youth had incidents of being verbally and/or physically aggressive toward both youth and staff. They also have destroyed property, threatened self-harm, and ran away.

Video's Reviewed:

- A video of an incident that occurred on 2/21/22 was reviewed that showed all the youth from House 1 and some youth from House 2 breaking a window and entering the basement. Samaritas Staff did not engage with the youth to attempt to de-escalate the situation.
- A video of an incident that occurred on 2/17/22 was reviewed that showed a youth banging his head into the wall several times causing him to stumble backwards. He also uses a razor to cut his arms. Several Samaritas staff watch the incident without intervening.

APPLICABLE RULE	
R 400.4109	**Program statement.**
	(1) An institution shall have and follow a current written program statement which specifically addresses all of the following: **(a) The types of children to be admitted for care.**
ANALYSIS:	Based on information provided during interviews and the incidents reviewed the youth admitted to the program fell outside the parameters of Samaritas' program statement.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

It is recommended based on the findings of this investigation, in conjunction with the findings of special investigation 2022C0103005, upon receipt of an acceptable corrective action plan the license status be modified to a First Provisional license.

4/7/22

Rorie Dodge-Pifer — Date
Licensing Consultant

Approved By:

April 8, 2022

Jessica VandenHeuvel — Date
Area Manager