GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2022

Michael Houck
Adapt St. Joe, Inc.
907 N. Clay
Sturgis, MI 49091

RE: License #: AS750402074
Investigation #: 2022A1030060
Polaris Home

Dear Mr. Houck:

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.
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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 (616) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS750402074
Investigation #:	2022A1030060
Complaint Receipt Date:	09/12/2022
Investigation Initiation Date:	09/12/2022
Report Due Date:	11/11/2022
Licensee Name:	Adapt St. Joe, Inc.
Licensee Address:	907 N. Clay Sturgis, MI 49091
Licensee Telephone #:	(269) 651-7900
Administrator:	Michael Houck
Licensee Designee:	Michael Houck
Name of Facility:	Polaris Home
Facility Address:	1610 W. Chicago Road Sturgis, MI 49091
Facility Telephone #:	(269) 651-1838
Original Issuance Date:	12/10/2019
License Status:	REGULAR
Effective Date:	06/10/2022
Expiration Date:	06/09/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II ALLEGATION(S)

	Violation Established?
A staff member used excessive force with Resident A causing injury.	Yes
Additional Findings	No

II. METHODOLOGY

09/12/2022	Special Investigation Intake 2022A1030060
09/12/2022	Special Investigation Initiated - Telephone Phone call with Michael Houck
09/12/2022	Contact - Document Received Received Incident Reports
09/14/2022	Contact - Face to Face Interview with Resident B
09/14/2022	Contact - Telephone call made Interview with Emily Edgington
09/14/2022	Contact - Telephone call made Interview with Tarrah Davison
09/20/2022	Contact - Telephone call made Interview with Shelby Halferty
09/21/2022	Contact - Document Received Received training record
09/22/2022	Contact - Telephone call made Interview with Jason Milliman
09/23/2022	Exit Conference Exit Conference by phone

ALLEGATION:

A staff member used excessive force with Resident A causing injury.

INVESTIGATION:

On 9/12/22, I interviewed licensee designee Michael Houck by phone. Mr. Houck called to inform me of an incident between a direct care staff member (DCSM) and a resident resulting in the resident injured. Mr. Houck reported he will send an Incident Report (IR) and stated that the DCSM in question was suspended pending the investigation.

On 9/12/22, I received three IR's dated 9/10/22. All three IR's documented DCSM Jason Milliman pushing, shoving, and dragging Resident A into her bedroom and Resident A suffering a bloody lip in the process. I also received a picture taken of Resident A's lip and there appeared to be a small cut on the inside of her lip.

On 9/14/22, I conducted an on-site investigation. It should be noted Resident A was unable to be interviewed due to her limited cognitive abilities. I interviewed Resident B as he witnessed the incident. Resident B reported Resident A was "throwing rocks at cars and staff" and in response Mr. Milliman pushed Resident A. Resident B reported Mr. Milliman "grabbed her by her pants and shirt" and brought her into the home. Resident B reported Resident A was dragged into her bedroom by Mr. Milliman and when she came out of the bedroom, she had a "split lip."

On 9/14/22, I interviewed Resident A's therapist by phone. Therapist 1 provides Autism therapy and coaching for Resident A. Therapist 1 reported she has been working with Resident A since May 2022. Therapist 1 reported she has observed Mr. Milliman grab Resident A by her clothing and "pick her up to physically move her." Therapist 1 reported feeling uncomfortable with his methods and gave him advice about how to use different techniques. Therapist 1 reported she informed her supervisor of her concerns and noted a small cut on her lip after the incident with Mr. Milliman.

On 9/14/22, I interviewed DCSM Tarrah Davison by phone. Ms. Davison reported she was working the evening shift of 8/24/22 and witnessed the incident between Resident A and Mr. Milliman. Ms. Davison reported she and DCSM Shelby Halferty's shift began at 8:00pm. Ms. Davison reported Mr. Milliman had Resident A by the shoulder guiding her into the home and then began dragging her "really hard." Ms. Davison reported Resident A fell down a couple of times when she was shoved by Mr. Milliamn. Ms. Davison reported he "yanked her up by her clothing pretty hard" after one of the times she fell to the floor. Ms. Davison reported Resident was dragged into her bedroom by Mr. Milliamn and she want to check on her and noted she had blood on her face from a cut on her lip. Ms. Davison reported Mr. Milliman denied knowing how she was injured. Ms. Davison reported she took Resident A into the staff office and cleaned her lip. Ms. Davison reported Mr. Milliamn told her Resident A had been outside throwing rocks and cars and DCSM's.

Ms. Davison reported Resident A did not have any blood on her face when she was initially brought into the home by Mr. Milliman and believes she split her lip during one of the times she fell to the ground after being pushed by Mr. Milliman. Ms. Davison reported she does not believe he meant to cause the injury. Ms. Davison reported she has witnessed previous times where Mr. Milliman physically managing Resident A but "never this rough." Ms. Davison reported they are MANDT trained and are not supposed to grab clothing, push or shove a resident.

On 9/20/22, I interviewed DCSM Shelby Halferty by phone. Ms. Halferty provided a similar account to what occurred as Ms. Davison. Ms. Halferty reported Mr. Milliman did not use MANDT techniques during the incident with Resident A.

On 9/21/2022, I received and reviewed verification that Mr. Milliman successfully completed MANDT training on 8/30/22.

On 9/22/22, I interviewed DCSM Jason Milliman by phone. Mr. Milliman reported that near the end of his shift on 9/1/22 he was outside with Resident A and she was "playing with rocks." Mr. Milliman reported she was throwing rocks in the air and then began throwing them at him. Mr. Milliman reported he asked Resident A to "go to her safe space" and that she then began going into the home. Mr. Milliman reported he followed her and used body position between Resident A and two other residents as he thought she would hit them. Mr. Milliman reported Resident A continued to walk to her bedroom and grabbed her blanket which was sitting on a chair in the hallway. Mr. Milliman reported that at that time two staff members from third shift had entered the home. Mr. Milliman reported he continued to follow Resident A toward her bedroom and accidentally stepped on her blanket and she fell down when he lifted his foot. Mr. Milliman reported he and the other two staff members noted that she was bleeding when she came out of her bedroom. He stated that at no time was he alone in the bedroom with Resident A. Mr. Milliman reported he could not have caused the injury as he was behind Resident A the entire time and never touched her. Mr. Milliman speculated that Resident A hit herself with a rock when she was outside throwing them up in the air. Mr. Milliman reported Resident A has a history of harming herself and then becoming aggressive with staff and residents.

APPLICABLE RULE	
R 400.14305 (3)	**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:	It was alleged Resident A was physically abused by a DCSM. According to three eyewitness accounts of the incident, DCSM Jason Milliman grabbed, pushed, and shoved Resident A

	several times as she was brought inside of the home and taken to her bedroom. The eyewitnesses also reported Resident A fell to the ground several times due to the rough treatment by Mr. Milliman and Resident A suffered a bloody lip. In addition to this incident, it was reported by one of Resident A's therapists that Mr. Milliman has a history of using inappropriate techniques to physically manage her. While Mr. Milliman was trained on MANDT, his actions were not consistent with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/23/22, I shared the findings with licensee designee Michael Houck. Mr. Houck acknowledged and agreed with the findings and will submit a corrective action plan to address the violation.

III. RECOMMENDATION

Nile Khabeiry, LMSW

10/5/22

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

10/5/22

Russell B. Misiak Date
Area Manager