GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2023

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

RE: License #: AS810409206
Investigation #: 2023A0122017
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

I. IDENTIFYING INFORMATION

License #:	AS810409206
Investigation #:	2023A0122017
Complaint Receipt Date:	01/30/2023
Investigation Initiation Date:	01/30/2023
Report Due Date:	03/31/2023
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 01/27/2023, staff member, Payge Carpenter, dragged Resident A towards his bedroom by his legs.	Yes

III. METHODOLOGY

01/30/2023	Special Investigation Intake 2023A0122017 APS Referral
01/30/2023	Special Investigation Initiated - Letter Sent email to Deana Fisher, Licensee Designee, requesting documents from Resident A's file. Scheduled an onsite inspection.
01/30/2023	Contact - Document Received Requested documents received.
01/31/2023	Inspection Completed On-site Observed Resident A. Reviewed Employee files.
01/31/2023	Telephone call made Completed interview with staff member, Megan Ivey.
02/01/2023	Telephone call made and received Completed interview with staff member, Eric Kasper.
02/01/2023	Contact – document received Behavior intervention policy from Deana Fisher, Licensee Designee.
02/02/2023	Telephone call made Completed interview with staff member, Payge Carpenter.
02/06/2023	Telephone call made Completed interview with Guardian A.
02/08/2023	Exit Conference Discussed findings with Deana Fisher, Licensee Designee. Contact – Telephone call made Recipient Rights Referral made

ALLEGATION: On 01/27/2023, staff member, Payge Carpenter, dragged Resident A towards his bedroom by his legs.

INVESTIGATION: On 01/27/2023, Deana Fisher, submitted an email stating the following, we submitted an adult protective services referral for a "situation where a resident was dragged towards his room by his legs by a staff member. She thought it was funny. She is suspended until the investigation is over."

I reviewed an incident report dated 01/26/2023, which documents on that day Resident A was sitting on the couch with another staff member when Payge Carpenter redirected Resident A to go to bed, but he refused to follow directions. "Staff PC took a hold of Resident A's legs, and he was pulled from the living room heading to the hallway all the way to his room."

The facility nurse completed a skin wound assessment on 01/26/2023 and no wounds were observed on Resident A's body.

On 01/31/2023, I reviewed Resident A's file. His Assessment Plan dated 06/20/2022, documents under the social/behavior assessment section, where the assessor should "check yes or no and complete where appropriate," under the heading follows instructions, no has been checked. It states that Resident A is "able to follow instructions but often times refuses even with many verbal prompts." The assessment plan also documents that Resident A receives assistance from staff members with toileting, bathing, and dressing.

Resident A's Behavior Treatment Plan dated 04/06/2022 documents that it addresses, "refusal to comply with direction (e.g., showering, toileting, redirection)." Reactive Strategies for "noncompliance with tasks," suggest staff should "remain calm, do not show frustration, anger, or power-struggle, utilize positive contacts to elicit cooperation when he does not want to do something that is asked of him," etc. Other verbal suggestions are given to address Resident A's refusal to comply with directions but there is no physical intervention suggested under this topic.

On 01/31/2023, I observed Resident A in his day program classroom. He was sitting calmly and quietly waiting for the staff member to bring his lunch. Once his lunch was brought out, he began eating while staff member observed and assisted as needed. Resident A is diagnosed with profound intellectual disability and is therefore nonverbal.

On 01/31/2023, I completed an interview with staff member Megan Ivey. Ms. Ivey reported the following: she was sitting on the couch with Resident A when Payge told Resident A it was time for bed, he stayed on the couch, and I sat with him. Per Ms. Ivey, she stayed seated on the couch with Resident A and Ms. Carpenter went and assisted the other residents with getting them ready for bed. Ms. Ivey stated Ms. Carpenter retuned later and "in a playful way grab Resident A by his ankles and

pull him off the couch." Ms. Ivey stated Resident A landed on his butt and Ms. Carpenter continued to pull him by his ankles down the hallway."

I asked Ms. Ivey what Resident A's response to Ms. Carpenter's actions was, Ms. Ivey stated that Resident A was "trying to get away from her" as she observed him leaning back. I asked Ms. Ivey what made her describe Ms. Carpenter's actions as playful and she responded by stating that the "tone of Payge's voice was not aggressive" when she was redirecting Resident A.

Ms. Ivey further stated she was "shocked when she was getting him off the couch." Ms. Ivey reported that she directed Ms. Carpenter to stop by stating, "Hey, I don't think this is good, Resident A is leaning back, and you need to stop." Ms. Ivey stated Ms. Carpenter stopped, she assessed Resident A for injury. Ms. Ivey stated the incident "didn't sit right with me, it was very uncomfortable for me," so she reported it the next day.

On 02/01/2023, I completed an interview with Erik Kasper, staff member. Mr. Kasper confirmed that he worked with Megan Ivey and Payge Carpenter on 01/26/2023 and observed the incident between Ms. Carpenter and Resident A. Mr. Kasper reported the following, on 01/26/2023 after he had administered Resident A's evening medication and snack, Resident A refused to go to bed and began having behaviors. Mr. Kasper described Resident A's behavior as "on the ground, dead weight, and refusing to stand." He then observed Payge Carpenter "grab a hold of Resident A's legs and pull him on his back from the living room to his bedroom."

Mr. Kasper described the incident as "playful and not intentional." I asked why he described the incident as playful and Mr. Kasper stated, by the way Ms. Carpenter was laughing and smiling, "I knew she wasn't doing it intentionally." I asked Mr. Kasper if Ms. Carpenter was trying to get Resident A to his bedroom at that time to which he replied, "Yes." I asked Mr. Kasper what was Resident A's response to Ms. Carpenter's actions and he replied that Resident A is nonverbal, could give no input, and he did not observe his facial expression.

I reviewed Payge Carpenter, Megan Ivey, and Erik Kasper's employee files on 01/31/2023. They received training on the following topics: Gentle Teaching, Knowledge & Needs of the People, Nonviolent Crisis Intervention, Prevention of Challenging Behaviors, Reacting to Challenging Behaviors, etc. Under the topic of Knowledge & Needs of the People all employees acknowledged that "pushing or pulling a resident," is an example of abuse. Under the topic of Reacting to Challenging Behaviors all employees acknowledged that it was "false" to "do whatever necessary to stop a behavior example yelling or threatening" displayed by a resident.

On 02/02/2023, I completed an interview with Payge Carpenter. Ms. Carpenter denied dragging Resident A by his legs towards his bedroom. Ms. Carpenter stated that when Resident A was seated on the couch, she began tickling his feet and he

began to squirm. As she continued tickling Resident A he wiggled on the floor, held his legs up so they could continue to be tickled, and scooted on the floor to his room. Per Ms. Carpenter she was on her knees, facing Resident A tickling him with her fingertips, and moving backwards towards his bedroom.

Once they got close to his bedroom, she stood up, and asked Resident A to stand up. Ms. Carpenter reported that Resident A complied with her request, he stood up, and they continued hygiene tasks of getting him ready for bed.

I asked Ms. Carpenter how she could explain that her two co-workers, Ms. Ivey, and Mr. Kasper, describe the event differently and she responded by stating, “I don’t know I feel like I’m being targeted.” She stated that they “mistakenly saw him wiggle to the floor and me trying to prevent injury.”

On 02/06/2023, I completed an interview with Guardian A. Guardian A reported that she had been notified of the incident involving Resident A and Payge Carpenter. She stated she did not understand Ms. Carpenter’s response to Resident A’s refusal to follow directions and what the harm would have been if Resident A would have been allowed to stay up a little longer. Guardian A reported Resident A’s medication has been adjusted and she has noticed that he appears calmer. She reported no other concerns other than this most recent incident.

On 01/31/2023, I completed an interview with Deana Fisher, Licensee Designee. Ms. Fisher stated once she was informed of the incident, she made an Adult Protective Services Referral along with notifying the Licensing and Regulatory Affairs Department. Ms. Fisher reported that her company does not support Ms. Carpenter’s action to obtain direction compliance from Resident A. Ms. Fisher stated she would submit a copy of the company’s behavior management policies.

On 02/06/2023, I reviewed St. Louis Center for Exceptional Children and Adults’ behavior management policies. The policies give examples of behavior management such as examples of decreasing behaviors, increasing positive behaviors, prevention of negative behaviors, etc. There is nothing in the behavior management policies that support the action of Payge Carpenter towards Resident A on 01/26/2023.

On 02/08/2023, I completed an exit conference and discussed my findings with Deana Fisher, Licensee Designee. Ms. Fisher was in agreement with my findings and stated she would submit a corrective action plan to address rule violations found in this investigation.

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:	An incident report dated 01/26/2023, documented staff member Payge Carpenter "took a hold of Resident A's legs, and he was pulled from the living room heading to the hallway all the way to his room." On 01/31/2023 and 02/01/2023 respectively, staff members, Megan Ivey, and Erik Kasper, confirmed that they observed staff member, Payge Carpenter, drag Resident A by his legs to his bedroom. Ms. Ivey stated that Resident A was "trying to get away from her" as she observed him leaning back. Ms. Ivey stated she was shocked by the incident and directed Ms. Carpenter to stop. Resident A is diagnosed with profound intellectual disability and is nonverbal. On 02/02/2023, Payge Carpenter denied dragging Resident A by the legs to his room. Staff members, Megan Ivey, Erik Kasper, and Payge Carpenter received training regarding population served. Employee files were reviewed. Under the topic of Knowledge & Needs of the People all employees acknowledged that "pushing or pulling a resident," is an example of abuse. Resident A's Behavior Treatment Plan dated 04/06/2022 addresses Resident A's "refusal to comply with direction (e.g., showering, toileting, redirection)." It gives strategies for staff members to use with Resident A to address his noncompliance, but there is no physical intervention suggested under this topic. Based upon my investigation I find that Resident A was not treated with dignity as staff members, Megan Ivey, and Erik Kasper, observed staff member, Payge Carpenter, drag Resident A by his legs to his bedroom. Ms. Ivey stated Resident A was "trying to get away" from Ms. Carpenter as she observed him leaning back. Ms. Ivey stated she was shocked by the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.

ANALYSIS:	Resident A's Behavior Treatment Plan dated 04/06/2022 addresses Resident A's "refusal to comply with direction (e.g., showering, toileting, redirection)." Reactive Strategies for "noncompliance with tasks," suggest staff should "remain calm, do not show frustration, anger, or power-struggle, utilize positive contacts to elicit cooperation when he does not want to do something that is asked of him," etc. Other verbal suggestions are given to address Resident A's refusal to comply with directions but there is no physical intervention suggested under this topic. An incident report dated 01/26/2023, documented staff member Payge Carpenter "took a hold of Resident A's legs, and he was pulled from the living room heading to the hallway all the way to his room" as a response to his refusal to follow directions. On 01/31/2023 and 02/01/2023 respectively, staff members, Megan Ivey, and Erik Kasper, confirmed that they observed staff member, Payge Carpenter, drag Resident A by his legs to his bedroom. Staff members, Megan Ivey, Erik Kasper, and Payge Carpenter received training regarding population served. Employee files were reviewed. Under the topic of Knowledge & Needs of the People all employees acknowledged that "pushing or pulling a resident," is an example of abuse. Based upon my investigation I find there is evidence to support that staff member, Payge Carpenter, did not employ interventions specified in Resident A's Behavior Treatment Plan dated 04/06/2022. On 01/26/2023, she dragged Resident A from the living room to his bedroom by his legs for refusing to comply with directions.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:

	(b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	An incident report dated 01/26/2023, documented staff member Payge Carpenter "took a hold of Resident A's legs, and he was pulled from the living room heading to the hallway all the way to his room." On 01/31/2023 and 02/01/2023 respectively, staff members, Megan Ivey, and Erik Kasper, confirmed that they observed staff member, Payge Carpenter, drag Resident A by his legs to his bedroom. Ms. Ivey stated that Resident A was "trying to get away from her" as she observed him leaning back. On 02/02/2023, Payge Carpenter denied dragging Resident A by the legs to his room. Staff members, Megan Ivey, Erik Kasper, and Payge Carpenter received training regarding population served. Employee files were reviewed. Under the topic of Knowledge & Needs of the People all employees acknowledged that "pushing or pulling a resident," is an example of abuse. Based upon my investigation I find that their evidence to support the allegation that staff member, Payge Carpenter, dragged Resident A by his legs to his bedroom thereby using physical force with him. The incident was observed and reported by staff members, Megan Ivey, and Erik Kasper, who were also on duty that day.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

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Vanita C. Bouldin Date: 02/08/2023
Licensing Consultant

Approved By:

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Ardra Hunter Date: 02/15/2023
Area Manager