GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2024

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

RE: License #: AL810007467
Investigation #: 2024A0122027
Fr Guanella Hall

Dear Ms. Fisher:

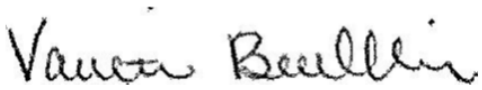
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL810007467
Investigation #:	2024A0122027
Complaint Receipt Date:	06/13/2024
Investigation Initiation Date:	06/13/2024
Report Due Date:	08/12/2024
Licensee Name:	St. Louis Center for Exceptional Children & Adults
Licensee Address:	16195 Old US-12 Chelsea, MI 48118
Licensee Telephone #:	(734) 495-8430
Administrator:	Deana Fisher
Licensee Designee:	Deana Fisher
Name of Facility:	Fr Guanella Hall
Facility Address:	16195 Old US-12 Chelsea, MI 48118
Facility Telephone #:	(734) 475-8430
Original Issuance Date:	02/01/1991
License Status:	REGULAR
Effective Date:	10/21/2022
Expiration Date:	10/20/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 06/09/2024, Resident A was left unsupervised in the bathroom and was found running naked around the facility.	Yes

III. METHODOLOGY

06/13/2024	Special Investigation Intake 2024A0122027 APS Referral
06/13/2024	Special Investigation Initiated - Letter Email sent to Deana Fisher, Requesting information - resident file, facility where he resides, etc.
06/17/2024	Inspection Completed On-site Completed interview with Deana Fisher, Licensee Designee. Observed Resident A in adult daycare program.
06/21/2024	Contact – Telephone calls made. Left voice message for Janet Best, Staff Member. Completed an interview with Kelsey Case, Staff Member.
06/25/2024	Contact – Telephone call made. Completed interview with Barbara Fairchild, Staff Member.
07/09/2024	Contact – Telephone call made. Left voice message for Janet Best, Staff Member.
07/10/2024	Exit Conference Discussed findings with Deana Fisher, Licensee Designee.

ALLEGATION: On 06/09/2024, Resident A was left unsupervised in the bathroom and was found running naked around the facility.

INVESTIGATION: On 06/17/2024, I completed an interview with Deana Fisher, Licensee Designee. Ms. Fisher stated the following was reported to her: on 06/09/2024, Kelsey Case, staff member was assigned to assist Resident A in the bathroom while showering. Ms. Case got nauseous, ran out of Resident A's bathroom leaving him alone, but called for the other staff member assigned to work

with her, Janet Best, to come and supervise Resident A. Ms. Best responded to Ms. Case, however, by the time Ms. Best got to Resident A he was out of the bathroom, running around the facility without clothes. Per Ms. Fisher, Resident A was directed back into the bathroom without injury.

Resident A's Assessment Plan dated 07/31/2023 documents that he receives assistance from staff members with getting in and out of the shower. He uses a shower chair, wheelchair, and walker to assist in bathing and mobility.

Resident A's Individual Plan of Service dated 08/24/2023 documents that staff are to "assure that Resident A is not left home alone or in the community." When it comes to bathing/showering the form states that staff will ensure proper shower water temperature, assist with dispensing shampoo, and ensure that he cleans himself with physical and verbal assistance.

On 06/21/2024, I completed an interview with Kelsey Case, Staff member. Ms. Case confirmed that she worked on 06/09/2024 and was assigned to assist Resident A with taking a shower. Ms. Case stated Resident A was sitting on the toilet and as she was helping him undress, she became nauseous. Per Ms. Case, she directed Resident A to stay seated and ran to another bathroom. Ms. Case reported that when she went back to check on Resident A, another staff member Barbara Fairchild, had found Resident A in the hallway undressed and placed him in the shower.

Ms. Case stated that when she became nauseous, she could not find her coworker, Janet Best, who was working in the facility to request assistance. Ms. Case also acknowledged that Resident A should not be left unattended while showering as stated in his individual plan of service.

On 06/25/2024, I completed an interview with Barbara Fairchild, Staff Member. Ms. Fairchild confirmed that she assisted Resident A on 06/09/2024. Ms. Fairchild stated she entered the facility on 06/09/2024 and observed Resident A wandering in the hallway undressed. Ms. Fairchild stated she did not see staff members, Kelsey Case or Janet Best in the area. Per Ms. Fairchild, she directed Resident A back into his bathroom and assisted him in the shower. According to Ms. Fairchild, as she was getting Resident A dressed staff member, Kelsey Case returned and finished assisting Resident A.

Ms. Fairchild stated neither she nor Ms. Case discussed the incident. Ms. Fairchild stated at a later date it was bought to her attention that staff member, Janet Best, was assisting other residents of Fr Guanella Hall during the incident involving Resident A.

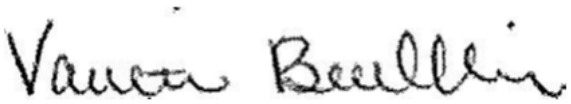
On 06/21/2024 and 07/09/2024, I contacted staff member, Janet Best to complete an interview, however, she was unavailable on both dates. I left voice messages requesting that she contact me. As of 07/10/2024, I have received no contact from Ms. Best.

On 07/10/2024, I completed an exit conference with Deana Fisher, Licensee Designee. I discussed my findings with Ms. Fisher and she reported that she would submit a corrective action plan to address the rule violation found.

APPLICABLE RULE	
R 400.15303	**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 06/09/2024, Resident A was left unattended in the bathroom by staff member, Kelsey Case. Resident A's Individual Plan of Service dated 08/24/2023 documents that staff are to "assure that Resident A is not left home alone or in the community." When it comes to bathing/showering the form states that staff will ensure proper shower water temperature, assist with dispensing shampoo, and ensure that he cleans himself with physical and verbal assistance. On 06/21/2024, Kelsey Case, confirmed that she left Resident A unattended in the bathroom on 06/09/2024. Ms. Case also confirmed that Resident A should not be left unattended while showering as stated in his individual plan of service. Based upon my investigation I find that on 06/09/2024, Resident A's supervision was not attended to as specified in his Individual Plan of Service as staff member, Kelsey Case, left him unattended in his bathroom and he was found wandering the facility hallway by another staff member.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



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Vanita C. Bouldin Date: 07/10/2024
Licensing Consultant

Approved By:

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Ardra Hunter Date: 07/15/2024
Area Manager