



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 20, 2025

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

RE: License #: AL810007467
Investigation #: 2025A0116049
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (313) 456-0439.

Sincerely,

A handwritten signature in blue ink that reads "Pandrea Robinson". The signature is written in a cursive, flowing style.

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
 BUREAU OF COMMUNITY AND HEALTH SYSTEMS
 SPECIAL INVESTIGATION REPORT
 REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

| | |
|---------------------------------------|--|
| License #: | AL810007467 |
| Investigation #: | 2025A0116049 |
| Complaint Receipt Date: | 09/19/2025 |
| Investigation Initiation Date: | 09/22/2025 |
| Report Due Date: | 11/18/2025 |
| Licensee Name: | St. Louis Center for Exceptional Children & Adults |
| LicenseeAddress: | 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: | 10/21/2024 |
| Expiration Date: | 10/20/2026 |
| Capacity: | 20 |
| Program Type: | PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED |

II. ALLEGATION(S)

| | Violation Established? |
|--|-----------------------------------|
| Resident A was having a behavior and staff, Rita Welch, pushed him in his wheelchair into the quiet room so hard that his wheelchair hit the fireplace. Staff, Rita Welch swears and calls Resident B names. | Yes |

III. METHODOLOGY

| | |
|------------|--|
| 09/19/2025 | Special Investigation Intake 2025A0116049 |
| 09/19/2025 | Adult Protective Services (APS) Referral Received. |
| 09/19/2025 | Referral - Recipient Rights Made on 09/17/2025 by licensee designee, Deana Fischer. |
| 09/22/2025 | Special Investigation Initiated - On Site Licensee designee, Deana Fischer, visually observed Resident A. |
| 09/22/2025 | Contact-Document received Resident A's behavior treatment plan. |
| 09/24/2025 | Contact - Telephone call made Staff, Rita Welch. |
| 09/24/2025 | Contact - Telephone call made Staff, Kaitlynn Leonard. |
| 09/24/2025 | Contact - Telephone call made Staff, Jaylyn Chapman. |
| 09/24/2025 | Contact - Telephone call made Staff, Sierra Lane. Left a message requesting a return call. |
| 09/29/2025 | Contact - Face to Face Resident B. |
| 10/06/2025 | Contact - Telephone call made APS investigator, Kaithlyn McGill. Left a message requesting a return call. |

| | |
|------------|---|
| 10/06/2025 | Contact - Telephone call made Guardian A1. |
| 10/06/2025 | Contact - Telephone call made Co-Guardian B1. |
| 10/06/2025 | Inspection Completed-BCAL Sub. Compliance |
| 10/09/2025 | Contact - Telephone call made APS investigator, Kaitlyn McGill. |
| 10/09/2025 | Contact - Telephone call received Recipient Rights investigator, Leah Raehtz. |
| 10/16/2025 | Exit Conference Licensee designee, Deana Fisher. |

ALLEGATION:

Resident A was having a behavior and staff, Rita Welch, pushed him in his wheelchair into the quiet room so hard that his wheelchair hit the fireplace. Staff, Rita Welch swears and calls Resident B names.

INVESTIGATION:

On 09/22/25, I conducted an unscheduled onsite inspection and interviewed licensee designee, Deana Fisher, and visually observed Resident A. Ms. Fisher reported that she was not at work when the incident occurred on 09/17/25, but was informed the following day, by the assistant program manager, Carly Hardwick. Ms. Fisher reported upon learning the details of what was alleged to have occurred she began an internal investigation, which included interviewing the alleged perpetrator staff, Rita Welch. Ms. Fisher reported that Ms. Welch was alleged to have pushed Resident A in his wheelchair forcefully into the quiet room, causing his wheelchair to collide with the fireplace. Resident A was said to be having a behavior when the incident occurred. I asked Ms. Fisher what the quiet room was. Ms. Fisher reported that it is a room where the residents can go when they become overstimulated, need a quiet place to calm down, or just want to get away from all of the commotion. The room door is not locked; the residents can come out when they are ready and are not forced to go into the room. Ms. Fisher added that Resident A's behavior

treatment plan documents that he goes into a quiet area away from others to calm himself as one of the reactive strategies.

Ms. Fisher further reported that on a separate occasion, it was alleged that Ms. Welch, asked Resident B to move from in front of the refrigerator, and when she didn't, Ms. Welch responded, "You are always in my fucking way, and always up in my shit." Ms. Fisher reported that Ms. Welch denied that she pushed Resident A into the fireplace and denied cursing at Resident B. Ms. Fisher reported that both incidents were witnessed by two different staff. Ms. Welch was immediately suspended pending the outcome of all investigations. Ms. Fisher reported the allegations to APS and recipient rights. Ms. Fisher reported that Ms. Welch is a new staff, however, is trained in all required areas.

I visually observed Resident A as he could not be interviewed due to the severity of his developmental disability. Resident A was neatly dressed and groomed. No concerns noted. Resident B was at school at the time of the onsite inspection.

On 09/22/25, I received and reviewed Resident A's behavior treatment plan dated 06/01/25. The plan does instruct staff to assist and encourage Resident A to move to a quiet place away from others to calm down when he is having a behavior, in addition to several other strategies.

On 09/24/25, I interviewed staff, Rita Welch, and she reported that the allegations are not true and that the other staff are trying to get her fired because they don't like her. She reported that she is new to this company but has worked in this field for years and knows how to treat people. Ms. Welch reported that she is stressed out and wants to get back to work. She reported that Resident A was having a behavior and was hitting and out of control. Ms. Welch reported she pushed Resident A in his wheelchair into the quiet room to see if that would help calm him down, and eventually it did. She denies that Resident A's wheelchair hit the fireplace, table or any other object as alleged. Ms. Welch reported that the incident with Resident B, "simply just didn't happen". Ms. Welch reported that she wants all this to be over so that she can return to work.

On 09/24/25, I interviewed staff, Kaitlynn Leonard, and she reported that on or about 09/11/25, she observed Resident B standing in front of the refrigerator and when asked to move, by Ms. Welch, she didn't. Ms. Welch responded to Resident B by saying, "You are always in my fucking way and up in my shit." Ms. Leonard reported that Ms. Welch has a bad and vulgar mouth and is always cussing and using foul language around the residents. She reported that this was the first time hearing her cuss directly at a resident. Ms. Leonard reported her belief that Ms. Welch has worked in the facility for about a month.

On 09/24/25, I interviewed staff, Jaylyn Chapman, and she reported that she was the person who observed the incident involving staff, Rita Welch, and Resident A. Ms. Chapman reported that she was actually shadowing another staff at the time

and observed Resident A having a behavior. She reported that she saw Ms. Welch grab Resident A's wheelchair aggressively and began pushing him very fast into the quiet room. Ms. Chapman reported that Resident A's feet were dragging on the floor, and his wheelchair hit the fireplace. It was clear that Resident A did not want to go into the room, and everyone knows that Residents have a choice whether or not to use the quiet room to calm down or get away from everyone, as it is not a punishment, but a place of calm. Ms. Chapman reported that Ms. Welch actually escalated Resident A's behaviors by the way she handled him and the matter. Ms. Chapman reported that Resident A was not physically hurt in any way and at no time fell out of his wheelchair.

On 09/29/25, consultant, Vanita Bouldin, made face to face contact with Resident B. Resident B was not able to be interviewed due to the severity of her developmental disability. Ms. Bouldin reported that Resident B was neatly dressed and groomed and was observed in the den watching television and appeared well.

On 10/06/25, I interviewed Guardian A1, and she reported that licensee designee, Deana Fisher, immediately informed her of the incident. Guardian A1 reported that she has no concerns regarding the care the staff at the facility provide. Guardian A1 reported that although she hates that this happened, she is glad the staff who observed it did the right thing by reporting it. She reported she is glad that Ms. Fisher took action and suspended the staff. Guardian A1 reported that direct care is not for everyone, and the management team often has no way of pre-determining what may agitate or set off a particular staff. Guardian A1 reported being thankful that Resident A was not physically harmed.

On 10/06/25, I interviewed Co-Guardian B1, and she reported that she was not aware of the matter but reported that she is sure that her ex-husband is aware as the facility staff normally call and inform him of things. She reported that she would like to be notified when things happen like this happen and reported that she would be calling Ms. Fisher to discuss. Co-Guardian B1 reported that overall, she has not had any concerns regarding the care the staff provide to Resident B and reported she has done well there.

On 10/09/25, I interviewed APS investigator Kaitlyn McGill, and she reported that she is still investigating the allegations and has not the opportunity to interview everyone.

On 10/09/25, I interviewed recipient rights investigator, Leah Raehtz, and she reported that she is still investigating the allegations but will likely be substantiating as both incidents were witnessed by other staff.

On 10/16/25, I conducted the exit conference with licensee designee, Deana Fisher, and informed her of the findings of the investigation. Ms. Fisher reported an understanding.

| APPLICABLE RULE | |
|------------------------|---|
| R 400.15308 | Resident behavior interventions prohibitions. |
| | <p>(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:</p> <p>(f) Subject a resident to any of the following:</p> <ul style="list-style-type: none"> (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats. |
| ANALYSIS: | <p>Based on the findings of the investigation, which included interviews of staff, Kaitlynn Leonard, Jaylyn Chapman, Rita Welch, and recipient rights investigator, Leah Raehtz, there is a preponderance of evidence to substantiate the allegations.</p> <p>Staff, Kaithlynn Leonard, witnessed the incident involving Resident B and staff, Rita Welch. Ms. Leonard reported that when Resident B failed to move from in front of the refrigerator when asked by Ms. Welch, she responded, "You are always in my fucking way and always up in my shit."</p> <p>Staff, Jaylyn Chapman reported Resident A was having a behavior, and she witnessed staff, Rita Welch, aggressively grab Resident A's wheelchair pushing him into the quiet room. Ms. Chapman reported Resident A's feet were dragging on the floor and she observed his wheelchair hitting the fireplace. Ms. Chapman reported that Ms. Welch's behavior escalated Resident A's behavior.</p> <p>Recipient rights investigator, Leah Raehtz, reported that she will likely be substantiating the allegations at the conclusion of her investigation, as both incidents were witnessed by other staff.</p> <p>This violation is established as direct care staff, Rita Welch, subjected Resident A and B to mental and emotional cruelty and verbal abuse, which is prohibited by these rules.</p> |
| CONCLUSION: | VIOLATION ESTABLISHED |

IV. RECOMMENDATION

Contingent upon receipt of an acceptable action plan, I recommend the status of the license remain unchanged.



Pandrea Robinson
Licensing Consultant

10/17/25
Date

Approved By:



10/20/2025

Ardra Hunter
Area Manager

Date