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 #: 2022C0103005
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
*****This report contains sexually implicit information*****

I. IDENTIFYING INFORMATION

License #:	CI410409653
Investigation #:	2022C0103005
Complaint Receipt Date:	01/31/2022
Investigation Initiation Date:	01/31/2022
Report Due Date:	04/01/2022
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenue Detroit, MI 48214-2691
Licensee Telephone #:	(231) 936-1012
Administrator:	Cynthia Williams
Licensee Designee:	Cynthis 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 are engaging in sexual activity with one another. One youth offered Youth A money and jewelry in exchange for sexual contact and was refused.	No
The facility is not following their safety plan set up to protect Youth A.	Yes
Additional Findings:	**Yes**
Staff 2 is not completing her 15-minute interval checks at night.	Yes
The facility utilizes federal employees to provide supervision of the youth, but they do not have employee files for the federal employees.	Yes
The federal employees utilized by the facility do not have the required training.	Yes
The Chief Administrator (CA) did not ensure compliance with the rules.	Yes
Staff falsified documentation.	Yes

III. METHODOLOGY

01/31/2022	Special Investigation Intake 2022C0103005
01/31/2022	Special Investigation Initiated - Telephone Program Director (PD)
02/01/2022	Inspection Completed On-site Met with Program Director, interviewed Youth A, Youth I, Youth J, Youth G, and Youth F.
02/01/2022	Contact - Document Received E-mail from PD
02/02/2022	Contact – E-mail exchanges PD and Chief Administrator (CA)
02/03/2022	Contact - Document Received E-mail of safety plan and proof of phones received from PD.
02/03/2022	Contact - Face to Face Meeting via Teams with the PD, CA, and director of quality.
02/07/2022	Contact – E-mail exchanges CA
02/09/2022	Inspection Completed On-Site Interviews conducted at the facility with Youth B, Youth C, Youth D, Youth E, Youth H, and Youth K. Also reviewed case files and met with PD.
02/10/2022	Contact - Document Sent E-mail to PD with request for further information.

02/11/2022	Contact - Telephone call made Interview with Interpreter 1
02/11/2022	Contact - Document Sent E-mail to PD asking for additional policies
02/11/2022	Contact - Telephone call made Interview with USCRI employee.
02/11/2022	Contact - Document Received Policy
02/15/2022	Contact - Document Sent E-mail to PD asking about the status of my request for information
02/18/2022	Inspection Completed On-site Unannounced visit to the facility to get items from PD
02/18/2022	Contact - Telephone call made CA
02/18/2022	Contact - Document Received Safety Plan from CA
02/22/2022	Contact - Document Received Policies from consultant
02/22/2022	Contact – E-mail exchanges CA and Program Manager (PM)
02/23/2022	Contact – E-mail exchanges CA and PM
02/23/2022	Contact – E-mail exchanges DHHS Worker
02/24/2022	Contact – E-mail exchanges Office of Refugee Resettlement (ORR)
02/24/2022	Contact – Document Received E-mail and text from DHHS Worker
02/24/2022	Contact – Document Received E-mail from CA requesting meeting
02/24/2022	Contact – Document Received E-mail from ORR Field Specialist
02/24/2022	Inspection completed on-site Observation of youth and staff, interview with the Clinical Supervisor, Supervisor, and Volunteer Coordinator.
02/24/2022	Contact – Telephone call made CA
02/24/2022	Contact – Telephone call made ORR
02/24/2022	Contact – Document Received E-mail from CA
02/25/2022	Inspection completed on-site Observation of youth and staff, review case files, and interview with PM.
02/25/2022	Contact – Face to face Virtual meeting with CA, PM, COO, ORR, and DCWL

02/25/2022	Contact – Document Received E-mail from DHHS Worker
02/26/2022	Contact – Document sent E-mails and documents forwarded to DHHS Worker
02/26/2022	Contact – Document Sent Safety Plan to DHHS Worker, DCWL Consultant, AM, PM, CA, and COO.
02/26/2022	Contact – E-mail exchanges ORR Field Specialist
02/28/2022	Inspection Completed On-site Interviewed Youth A, Youth J, and Interpreter 2. Observed youth and staff. Reviewed case files.
02/28/2022	Contact – Document received E-mail from COO regarding safety plan
02/28/2022	Contact – Document sent Request for staff information and video footage to CA and PM
03/01/2022	Contact – E-mail exchanges CA, PM, and COO
03/02/2022	Contact – E-mail exchanges CA, PM, COO, and administrative assistant
03/03/2022	Contact – E-mail exchanges DHHS Worker
03/03/2022	Contact – E-mail exchanges CA, PM, and COO
03/07/2022	Inspection Completed On-site Observed House 1 and interview with PD
03/09/2022	Inspection Completed On-site Observed youth. Interviewed Therapist and Staff 1.
03/09/2022	Contact – Telephone call made CA
03/09/2022	Contact – E-mail exchanges CA
03/10/2022	Inspection Completed On-site Observed houses and interviewed Interpreter 1 and Interpreter 3
03/10/2022	Contact – Telephone call made CA
03/10/2022	Contact – E-mail exchanges CA
03/10/2022	Contact – Virtual Meeting AM, DCWL Director, and Bureau Director
03/11/2022	Contact – E-mail exchanges CA, PM, and COO
03/12/2022	Contact – E-mail exchanges PM
03/13/2022	Contact – E-mail exchanges PM

03/14/2022	Contact – Face to Face Viewed video at Lansing office and met with PM
03/14/2022	Contact – E-mail exchanges PM
03/14/2022	Contact – E-mail exchanges DHHS Worker
03/14/2022	Contact – Document Received Staff list
03/15/2022	Contact – E-mail exchanges DHHS Worker
03/15/2022	Contact – E-mail exchanges PM
03/15/2022	Contact – Telephone call received CA
03/15/2022	Contact – Document received Program closing letter
03/15/2022	Contact – E-mail exchanges LIRS and CA
03/16/2022	Contact – E-mail exchanges CA
03/16/2022	Contact – E-mail exchanges DHHS Worker
03/16/2022	Contact – E-mail Staff 1
03/16/2022	Contact – E-mail exchanges CA, PM, and COO
03/16/2022	Inspection Completed On-site Observed both houses
03/16/2022	Contact - Telephone call made CA
03/17/2022	Contact – Document received Outline for 3/5
03/17/2022	Contact – E-mail exchanges CA, PM, and COO
03/18/2022	Contact – Face to face Pre-exit with CA, PM, and Quality
03/18/2022	Contact – Telephone call made DHHS Case Conference – No findings

ALLEGATION:

Youth are engaging in sexual activity with one another. One youth offered Youth A money and jewelry in exchange for sexual contact and was refused.

INVESTIGATION:

A complaint was received on 1/31/22 alleging Youth A's peers were doing sexual things with Youth A in bedrooms and bathrooms at the facility. Youth K tried to get Youth A to have sex with him and offered Youth A money and jewelry, but Youth A would not have sex with Youth K. Youth K was jealous because Youth A was doing sexual acts with the other youth in the house but would not with Youth K.

Interviews:

A phone call was placed to the Program Director (PD) on 1/31/22. He reported an interpreter told him about the allegations last night around 9pm. The conversation between the youth occurred while in the van to go bowling. There was Interpreter 1, Federal Employee 3, and a Samaritas staff in the van with the youth. He was unsure which Samaritas staff was present. PD said this happened around 4pm on 1/29/22. He was unsure why Interpreter 1 did not tell him immediately. He stated the Samaritas staff was driving the van at the time. PD asked Youth A a few questions about it and the youth denied anything happened.

All youth interviewed are from Afghanistan and required the use of an interpreter for their interviews.

Youth A was interviewed face to face at the facility on 2/1/22. He does not have any problems with the youth or staff. He reported the staff keep a good eye on the youth. He feels safe at the facility and there is never a time when staff are not supervising him. When Youth A was asked about being touched, he became frustrated. He asked why I was asking. He said "no" when asked if anyone touched him. He then walked out of the room saying he had already talked to someone about this, and he was done talking.

Youth J was interviewed face to face at the facility on 2/1/22. He stated he gets along with both staff and youth at the facility. His roommate is Youth A. Staff supervise them all the time except when they use the bathroom. Staff watch the youth when they are in their bedroom. He reported he has not been touched or heard of anyone at the facility who has been touched in a sexual way. He feels safe at the facility.

Youth F, Youth G, and Youth I were interviewed face to face at the facility on 2/1/22. Youth B, Youth C, Youth D, Youth E, Youth H, and Youth K were all interviewed face to face at the facility on 2/9/22. They all reported staff keep a close eye on them including watching the hallways when they are in their bedrooms. They all denied anything sexual was happening between any of the youth.

Interpreter 1 was interviewed by telephone on 2/11/22 and again face to face at the facility on 3/10/22 along with the DHHS Worker. While in the van going bowling, the youth were talking about having sex with Youth A. Interpreter 1 did not know all of

the youths' names. Out of 11 youth there were three youth who did not have a sexual relationship with Youth A. The youth said they had sex with Youth A in his bedroom closet. Interpreter 1 stated he was not sure if the youth were just joking around. The following day, Interpreter 1 was sitting in the room with the youth when they were talking about a meeting they had in which they discussed not telling anyone what they talked about. The youth asked Interpreter 1 not to say anything. This led Interpreter 1 to believe something had happened between Youth A and the other youth. He contacted his manager who advised him to talk to PD. He contacted PD the day after he heard the youth talking.

Federal Employee 3 was interviewed by telephone on 2/11/22. He stated when they were on their way to go bowling, he was in the last seat next to one of the youths. Federal Employee 3 did not know any of the youth's names as it was his first day at the shelter. The youth were having a casual conversation when one of them said he offered another youth a necklace and money to have sex with him, but the youth would not. It was said that the youth who denied him was having sex with all the other youth but refused him. Federal employee 3 stated he reported the conversation to his supervisor the following day.

The Volunteer Coordinator for the federal employees was interviewed face to face at the facility on 2/24/22 she reported the staff do a good job watching the youth.

Staff 6 was interviewed via three-way telephone call on 3/3/22. She reported she did not have any concerns about the supervision provided by the staff.

PD was interviewed face to face at the facility on 3/7/2022 and he reported staff watch the hallway.

Therapist was interviewed face to face at the facility on 3/9/22. She reported the staff do a good job of supervising the youth.

Documents Viewed:

- An e-mail from PD dated 1/30/22 reported the above allegations. Youth A refused to leave his bedroom which he shared with Youth J. PD wrote Youth A would be staffed one-on-one until further notice.
- E-mail's from PD on 2/3/22 indicated the safety plan was to staff Youth A with a one-on-one staff.
- 15-minute varying room check logs from 1/23/22 to 1/29/22 were viewed and all logs were completed.
- Youth Case files: All 11 case files were reviewed. All the youth were admitted to the Shelter on 1/4/22. Many of them have been verbally and physically aggressive toward both youth and staff. They also have destroyed property, threatened self-harm, and ran away. None of the youth had any sexual acting out or sexual abuse history indicated.

- E-mail from Staff 1 indicating Youth J needed a staff member to sit outside the bathroom while he showered because Youth J was afraid the other youth would enter.
- Facility policies and procedures. None of the policies address supervision of the youth.
- Shelter Handbook: Youth need to be in staff's line of sight and when in their bedrooms staff will complete checks not to exceed 15-minutes.
- Significant Incident Reports (SIR): The SIR from this incident indicated the same information that PD reported in his e-mail.

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:	According to the youth and staff interviewed staff were supervising the youth adequately.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLIGATION:

The facility is not following their safety plan set up to protect Youth A.

INVESTIGATION:

During the unannounced visit on 2/18/22, it was discovered the safety plan put in place on 2/1/22 for the above allegation was not being followed. Youth A and Youth B were sharing a bedroom again and the facility was not staffing Youth A with one-on-one supervision.

Interviews:
PD was interviewed face to face at the facility on 2/18/22. He reported Youth A and Youth J are sharing a bedroom. He said the facility is not staffing the one-on-one nor was a staff sitting in the youth's bedroom doorway when they were in the bedroom together. The bedroom door was left open, and staff were checking on the youth throughout the night every 15 minutes. PD reported they provided one-on-one staffing when they could but did not have enough staff to do it all the time. He stated it was also difficult to get the federal employees to sit in the youth's doorway.

Youth A was interviewed face to face at the facility along with the DHHS Worker on 2/28/22. He reported he is happy he has his own bedroom, as previously, Youth J shared the bedroom with him. He reported he never felt uncomfortable with Youth J in the bedroom. They each had their own bed and never shared a bed.

Youth J was interviewed face to face at the facility on 2/28/22 along with the DHHS Worker. Youth J stated he often fights with Youth A. He never slept in the same bed as Youth A. They did share a bedroom. The youth would sleep with the door open because they were scared. The staff would walk by with a flashlight about every 2 minutes. They also leave the light on in the bedroom. Now that he is no longer sharing a bedroom with Youth A, he does not let Youth A in his bedroom. He was given a new bedroom because he and Youth A fought a lot.

The Clinical Supervisor was interviewed face to face at the facility on 2/24/22 along with the DHHS Worker. She had been informed by PD on 2/18/22 that this investigation was completed and there were no findings. PD told her the investigation was over but that the one-on-one supervision of Youth A needed to continue. The staff were under the impression that the sexual assault did not occur. When the safety plan was first put in place it was verbally communicated to staff and was sent in an e-mail. The one-on-one log was sent out after 2/18/22. She confirmed there were not enough Samaritas youth specialists to provide one-on-one staffing for Youth A. Youth J would move back and forth from Youth A's bedroom. There was no way to stop the youth from sharing a bedroom. The staffing in both houses include 3 staff from 7am-5pm, 2 or 3 staff from 3pm-11pm, and 2 staff from 11pm-7am. Samaritas staff were aware of the safety plan, but it was not communicated to the federal employees. She was not sure if the Samaritas staff were aware of why Youth A needed one-on-one staffing. An e-mail regarding the one-on-one staffing for Youth A was sent to staff the night of the allegation. She reported Samaritas staff do not know what the federal employees can and cannot do and what information they can and cannot have.

The Volunteer Coordinator (VC) was interviewed face to face at the facility on 2/24/22 along with the DHHS Worker. She is a federal employee who coordinates the other federal employees. The federal employees work twelve-hour shifts and there is one in each house at a time. The federal employees are to provide line of sight supervision of the youth. They can conduct one-on-one supervision if they are instructed too. She had not had any communication with PD, only the direct care staff. She was not informed of any safety plans with the youth. She knew Youth A needed one-on-one staffing but was never informed why. When she is around, she has observed the staff performing the one-on-one staffing and have the youth in line of sight. VC reported the Samaritas staff are experiencing challenges because the youth in the program are of a different culture than they are used to serving. She does not believe any of them would intentionally hurt the youth.

Therapist was interviewed face to face at the facility along with the DHHS Worker on 3/9/22. She is the therapist for Youth A and Youth J. Youth A and Youth J have not

disclosed anything sexual to her. She was aware of the allegations and always looks for any concerns. Therapist completes a risk assessment with the youth every 30 days that asks them about sexual activity. The youth have not reported any concerns. When the allegations first became known, the facility had issues with maintaining the one-on-one staffing for Youth A, but she reported it has been better the last few weeks. She was informed PD tried to get Youth A to move bedrooms, but he would not. Eventually they were able to get Youth J to switch bedrooms, but he would go back and forth from his bedroom to Youth A's. Staff did not sit in the youth's doorway when the youth were together in Youth A's bedroom. She feels the Samaritas staff are adequately supervising the youth.

Federal Staff 1 was interviewed face to face at the facility along with the DHHS Worker on 3/9/22. He is aware of Youth A and Youth J. He did not have any concerns about them being sexual with each other. He heard rumors from a Samaritas staff that Youth A was a victim of sexual harassment. He did not know who told him this. He was not aware of any safety plans with Youth A. He reported someone is always supervising Youth A because he is aggressive. Youth A usually sleeps in the living room.

I contacted Chief Administrator (CA) on 2/18/22 via telephone. She was informed the safety plan was not being followed and Youth A did not have a one-on-one staff, Youth A and Youth J were back to sharing a bedroom and staff were not siting in their doorway at night to keep an eye on them and that the two youth also had blankets tied to their bed posts making it difficult for staff to see them in their beds. She was informed a new plan needed to be put in place to keep Youth A safe. On 2/24/22 I informed CA Youth A still did not have one-on-one supervision and another youth was able to enter his room without the staff noticing. On 3/10/22 I informed CA the safety plan was not being followed again when Youth A's one-on-one staff was not supervising him. She indicated it was difficult to follow the safety plan because they did not have enough staff.

Staff 2 was interviewed via telephone on 3/11/22. Staff 2 took the youth from House 1 on an outing. On the way back to the house she was the only Samaritas staff in the van at the time and Youth A did not have a one-on-one staff.

On-site Inspections:

- 2/1/22 Unannounced: Safety plan put in place. Youth A would have one-on-one staffing. Because Youth A would not leave his bedroom or house, staff would supervise the bedroom when Youth A and Youth J were in the bedroom together. During this visit Youth A was in the living room with staff.
- 2/9/22 Announced: Per PD, Youth A had one-on-one staffing. Youth J was moved out of the bedroom with Youth A but would often sleep in Youth A's bedroom on the floor. When they did this staff sat in the doorway. Youth A was observed in the living room with staff.
- 2/18/22 Unannounced: Per PD Youth A and Youth J were sleeping in the same bedroom together. They could not provide one-on-one staffing for

Youth A and staff could not sit in the youth's doorway when Youth J and Youth A were in the bedroom together. The youth's bedroom was viewed. Blankets were tied to the posts of the youth's bed so the staff could not see the youth when they were in their beds.

- 2/24/22 Unannounced: Youth J and his bed had been moved from Youth A's bedroom and was in a bedroom in a different hallway. Youth A was sleeping in his bedroom. While at the facility staff were not providing one-on-one staffing for Youth A. Consultant observed when one youth walked into Youth A's bedroom. This consultant watched the youth as he entered and took a stuffed bear from the bedroom. Later in the day, the two youth were still in their bedrooms and no staff were supervising the youth. Staff 5 was sitting in the kitchen on a computer.
- 2/25/22 Unannounced: Staff observed supervising the hallway and Youth A had one-on-one staff assigned to him.
- 2/28/22 Unannounced: Staff observed supervising the hallway and Youth A had one-on-one staff assigned to him.
- 3/9/22 Unannounced: Staff 7 and Staff 8 left the house twice leaving unknown federal employees and interpreters alone with the youth. One of the federal employees was performing the one-on-one supervision with Youth A. At one point when Staff 7 and Staff 8 were out of the house a youth left the house without anyone knowing so this consultant followed him and made sure he made it into the other house where there were staff.
- 3/10/22 Unannounced: At 2:45pm Staff 7 from House 1 left the house and went to House 2 stating she was leaving. At House 1 there was one Samaritas staff, Staff 9, supervising all the youth including Youth A who was to have a one-on-one staffing. The one-on-one log was completed through 3pm even though it was not yet 3pm and he did not have a one-on-one staff. The house was very chaotic with youth walking in and out of the house.
- 3/16/22 Unannounced: At House 1 Staff 10 indicated they could not find Youth G. None of the staff went to find the youth or notify anyone that the youth was missing. The consultant instructed them to do so. Youth G was found in House 2. In review of the shift expectation log, it was not being completed per the safety plan.

Documents Reviewed:

- E-mail from PD dated 1/30/22 stating Youth A would have one-on-one supervision.
- E-mail from PD dated 2/3/22 stating Youth A would have one-on-one supervision.
- Safety Plan dated 2/25/22. Youth A will have a one-on-one staff during waking hours, Youth J was moved out of the bedroom with Youth A, a one-on-one log would be completed everyday if someone is in a bedroom alone with Youth A staff will supervise the bedroom, staff will complete a shift expectation form for each shift which will indicate what staff will be responsible for which youth, all workers will initial or sign the shift expectation form indicating they had input or reviewed the form.

- Timeline of events on 3/2/22 provided by Program Manager. Youth from House 1, including Youth A were in a van with one Samaritas staff and an interpreter when they began to escalate and eventually left the van. Youth A did not have a one-on-one staff with him in the van.
- Shift Check-in form: These were viewed during unannounced visits on 2/28/22, 3/9/22, 3/10/22, and 3/16/22 The form does not allow for staff to indicate who will be responsible for which youth, it does not have a spot for the date, the shift, and is not initialed or signed by any staff.
- One-on-One logs were viewed during unannounced visits on 2/28/22, 3/9/22, 3/10/22, and 3/16/22 and were being completed by staff.
- Coordinated Response Reporting Neglect and Abuse policy: When an employee has suspected that a youth or someone associated with a youth has been physically or sexually abused or neglected the facility is to take any immediate action necessary to assure the safety of the youth.

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 residents' needs, implementation of treatment plans, and discharge of residents.**
ANALYSIS:	Three safety plans were put in place to keep Youth A safe from his peers however none of those plans were followed as evidenced by the on-site visits and interviews with staff. This goes against the facility's policy indicating they will take any immediate action necessary to assure the safety of the youth.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Staff 2 is not completing her 15-minute interval checks at night.

INVESTIGATION:

Interviews:
Staff 1 was interviewed via telephone on 2/22/22. He reported Staff 2, who works third shift, does not do her checks and then falsifies the 15-minute check logs. He stated Staff 2 told him this, but he did not know when this occurred.

PD was interviewed face to face at the facility on 2/18/22. He reported staff are required to complete 15-minute check logs that indicate where each youth is every 15 minutes at all times during the day and night.

Staff 2 was interviewed via telephone on 3/11/22. She stated she did not work nights and she always completes her 15-minute interval checks.

Youth A, Youth F, Youth G, Youth I, and Youth J were all interviewed face to face at the facility on 2/1/22. Youth B, Youth C, Youth D, Youth E, Youth H, and Youth K were all interviewed face to face at the facility on 2/9/22. All Youth indicated during their interviews that staff do their checks at night. The times varied from every 2 minutes to once every hour.

Video Reviewed:
Program Manager (PM) was asked to supply any video of Staff 2 working at night in which she did not complete her checks. He supplied a video of House 1's great room from the overnight of 2/20/22 from 2am to 3am. For the duration of the video Staff 2 did not complete any 15-minute interval checks. Staff 2 also left the house at 2:56am then the video ended. There were federal employees and interpreters in the house but no other Samaritas staff. Federal Staff 2 appears to do one check during the hour.

Documents Reviewed:

- E-mail from Staff 1 indicating Staff 2 does not complete her 15-minute checks at night.
- The youth handbook states that all youth are to stay where staff can see them. Staff will check the bedrooms at least every 15-minutes.
- 15-minute interval check log from 2/20/22 was viewed and indicated all checks were completed by Staff 2.
- E-mail from PM indicating there were only two Samaritas staff working for both houses during the overnight of 2/20/22 and one of the staff working was Staff 2.
- Staff 2 employee file indicated she did not have any disciplines.

APPLICABLE RULE	
R 400.4127	**Staff-to-resident ratio.**
	(4) When residents are asleep or otherwise outside of the direct supervision of staff, staff shall perform variable interval, eye-on checks of residents. The time between the variable interval checks shall not exceed fifteen minutes.
ANALYSIS:	The facility is found in non-compliance as Staff 2 was not completing her 15-minute interval checks during the overnight shift on 2/20/22 as confirmed by video documentation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

The facility utilizes federal employees to provide supervision of the youth, but they do not have employee files for the federal employees.

INVESTIGATION:

During PD's interview on 2/1/22 he reported the facility utilizes federal employees to supplement their staffing, but the federal employees are not to be alone with youth. They have had many staff resign due to COVID and again when Samaritas accepted a new population in January 2022. He reported the federal employees did not have clearances or training. An additional interview occurred with PD on 3/7/22. He reported he informed the Office of Refugee Resettlement (ORR), Samaritas could not take placement of the 19 youth referred because they did not have enough staff. ORR said they would send federal employees to assist. PD reported he told ORR Samaritas did not want the federal employees, but ORR sent them to the facility anyways.

VC reported in her interview on 2/24/22, federal employees do not receive any training on working with youth. Federal employees watch a video in Washington DC about working with different cultures and working with children. Federal employees did not receive training from the facility when they first started. Samaritas recently provided them with a training that VC and another federal worker attended.

A meeting took place on 2/3/22 with the PD, Chief Administrator (CA), and Chief Operations Officer (COO). They indicated they did not have employee documents or clearances for the federal employees. They were informed they needed the documents. The CA confirmed they told ORR they did not want to take placement of the youth and did not want the federal employees; however, ORR brought the youth to the facility anyways and sent federal employees.

On-site Inspections:
On 3/9/22 the federal employees were observed to be alone in the house with the youth. During on-site visits on 2/1/22, 2/18/22, 2/24/22, 2/25/22, 2/28/22, 3/9/22, 3/10/22, and 3/16/22 the federal employees were watching the hallways and sometimes they were seen providing one-on-one supervision.

Documents Reviewed:

- E-mail from CA on 3/15/22 indicating ORR is not cooperating with Samaritas in order to obtain employee paperwork on the federal employees.
- E-mail from PM on 3/15/22 stating they do not have employment documents for the federal employees.
- Administrative and Regulatory Policies: Volunteers that interact with the youth will have criminal history and child abuse screens completed before any interaction with the youth.

Video's Reviewed:

- A video of an incident that occurred on 2/17/22 shows two interpreters helping to hold a youth back from harming himself and others (This is being addressed in special investigation 2022C0103009).
- A video from the night of 2/21/22 shows the youth trying to break into the basement. Federal Employee 2 was the only person following the youth and engaging with them.
- A video from the night of 2/20/22 shows federal employees and interpreters in the house without a Samaritas staff. It also appeared that Federal Employee 2 was completing room checks.

APPLICABLE RULE	
R 400.4113	**Employee records.**
	An institution shall maintain employee records for each employee and shall include documentation of all of the following information prior to employment or at the time specified in this rule: **(a) Name.** **(b) A true copy of verification of education from an accredited college or university where minimum education requirements are specified by rule.** **(c) Verification of high school diploma or GED when specified by rule.** **(d) Work history.** **(e) Three dated references which are obtained prior to employment from persons unrelated to the employee and which are less than 12 months old.** **(f) A record of any convictions other than minor traffic violations from either of the following entities:** **(i) Directly from the Michigan state police or the equivalent state law enforcement agency, Canadian**

	province, or other country where the person usually resides or has resided in the previous 5 years. **(ii) From an entity accessing either Michigan state police records or equivalent state, Canadian provincial, or other country law enforcement agency where the person usually resides or has resided in the previous 5 years.** **(g) If the employee has criminal convictions, the institution shall complete a written evaluation of the convictions that addresses the nature of the conviction, the length of time since the conviction, and the relationship of the conviction to regulated activity for the purpose of determining suitability for employment in the institution.** **(h) A statement from the employee regarding any convictions.** **(i) Documentation from the Michigan department of human services, the equivalent state or Canadian provincial agency, or equivalent agency in the country where the person usually resides, that the person has not been determined to be a perpetrator of child abuse or child neglect. The documentation shall be completed not more than 30 days prior to the start of employment and every 12 months thereafter.** **(j) A written evaluation of the employee's performance within 30 days of the completion of the probationary period or within 180 days, whichever is less, and a written evaluation of the employee's performance annually thereafter.** **(k) Verification of health where specified by institution policy.**
ANALYSIS:	The facility is found in noncompliance as they have allowed federal employees onto their campus who have been performing specific services covered under the rules without creating an employee file and obtaining the required information prior to them working.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

The federal employees utilized by the facility do not have the required training.

INVESTIGATION:

Interviews:
On 2/1/22 PD stated they utilize federal employees to supplement their staffing due to a staffing shortage. Federal employees do not receive any training from Samaritas, and he was unsure what training they receive prior to arriving at the Samaritas. They are not to be left alone with the youth. On 3/7/22 PD stated he provided an 8.5-hour training for the federal employees. Only two federal employees participated because there was to be a turnover in federal employees. He planned to train the new federal employees when the transition occurred. He stated he has regular conversations with VC but didn't elaborate on what is discussed.

Federal Employee 3 was interviewed on 2/11/22, He reported he received training from his employer prior to working at Samaritas. He reported he is a mental health worker.

The VC was interviewed on 2/24/22 and reported the federal employees receive minimal training prior to going into the field. Samaritas did provide federal employees with a training but only two federal employees participated. There have been no other trainings since, and they have had a large turnover in federal employees. She reported the federal employees are only to provide line of sight supervision of the youth.

Federal Employee 1 indicated in his interview on 3/9/22 that he had to hold a youth in order to keep the youth safe (This is being investigated in special investigation 2022C0103009).

Interpreter 1 and Interpreter 2 were interviewed on 3/10/22 and Interpreter 3 was interviewed on 2/28/22. They all indicated they had to help de-escalate youth and two of them even held a youth to prevent the youth from harming himself and others (This is being investigated in special investigation 2022C0103009).

Staff 5 reported during her interview on 3/4/22 the turnover for the federal employees is high and they are not trained. Everyone is confused regarding the role of the federal employees.

On-site Visits:
During on-site visits various unknown federal employees were observed alone with youth, Interpreter 1 and Interpreter 3 were trying to de-escalate youth, and providing one-on-one supervision.

Videos Reviewed:
- Video from 2/21/22 was reviewed that showed Federal Employee 2 trying to de-escalate youth during a crisis when no other staff would engage the youth.
- Video from 2/17/22 showed Interpreter 1, Interpreter 2, and Interpreter 3 holding a youth to keep him from hurting himself and others.
- Video from 2/20/22 showed Federal employee 2 conducting room checks.

Documents Reviewed:

- Administrative and Regulatory Policies: Volunteers that have unsupervised contact with the youth will receive the same orientation as hired staff.

APPLICABLE RULE	
R 400.4128	**Initial staff orientation and ongoing staff training.**
	(1) The licensee shall provide an orientation program for new employees. Job shadowing shall not be the only form of orientation. The orientation shall include the following: **(a) The institution's purpose, policies, and procedures, including discipline, crisis intervention techniques, and emergency and safety procedures.** **(b) The role of the staff members as related to service delivery and protection of the children.** **(3) The licensee shall document that each staff person whose function is covered by these rules has participated in a minimum of 50 clock hours of planned training within the first year of employment and a minimum of 25 clock hours of training annually thereafter related to the employee's job function. At least 16 of the 50 hours provided in the first year shall be orientation provided prior to the assumption of duties.** **(4) Training opportunities for direct care staff shall include, but are not limited to, all of the following:** **(a) Developmental needs of children.** **(b) Child management techniques.** **(c) Basic group dynamics.** **(d) Appropriate discipline, crisis intervention, and child handling techniques.** **(e) The direct care worker's and the social service worker's roles in the institution.** **(f) Interpersonal communication.** **(g) Proper and safe methods and techniques of restraint and seclusion if the agency has an approved seclusion room.** **(h) First aid.**
ANALYSIS:	The facility is found in non-compliance as the federal employees and interpreters are not provided with training as required by the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

The Chief Administrator (CA) did not ensure compliance with the rules.

INVESTIGATION:

On 1/30/22 an e-mail was received from PD indicating Samaritas will be providing one-on-one supervision for Youth A due to the allegations of sexual assault. The CA was not included on the e-mail.

During the unannounced visit to the facility on 2/1/22, PD was informed a safety plan needed to be in writing and provided by the end of the day. On 2/2/22 an e-mail was sent to PD asking for the safety plan. An e-mail was received on 2/3/22 from PD. The e-mail included the CA. The safety plan would be for Youth A to have one-on-one supervision.

On 2/3/22 a virtual meeting was conducted with the CA, PD, Chief Operations Officer (COO), and a quality director. They indicated they did not have a choice on utilizing the federal employees. They were informed by this consultant that they needed to have employment paperwork and clearances for all the federal employees. It was also recommended PD be provided with more support as he seemed overwhelmed with his duties.

On 2/10/22 an e-mail was sent to PD asking for documentation for the investigation. Another e-mail was sent on 2/15/22 asking again for the documentation. CA was copied on this e-mail.

After not receiving a response from PD or CA on the documents requested an unannounced visit to the facility was conducted on 2/18/22. PD stated they were no longer able to staff one-on-one supervision for Youth A because they did not have enough staff. PD showed a list of eight staff who were resigning. It was observed that Youth J was again sleeping in Youth A's bedroom. Their beds were observed to be positioned a few feet away from the other and had blankets tied to their bedposts making it difficult for staff to see the youth when in their beds. PD was asked if staff were sitting outside the youth bedroom door when they were in the room together and he stated they leave the bedroom door open and check on the youth during 15 minute checks.

On 2/18/2022 a phone call was placed to CA informing her that the safety plan was not being followed as Youth A did not have a one-on-one staff and Youth J was sharing a bedroom with Youth A without staff supervising them while they were in the bedroom together. She was also informed the youth had blankets tied to their bedposts. She was informed a new safety plan needed to be received from her by 6pm on 2/18/22. An e-mail was received from CA on 2/18/22 indicating that they will continue to provide one-on-one supervision as much as possible during the day. PD will work to create a one-on-one log for staff to document behaviors of Youth A

throughout the day. At night, if Youth A is in a bedroom with another minor the door will remain open, and staff will be seated immediately outside of the doorway. There may be times that the youth will sleep on the couches if there is limited staff. Samaritas staff or federal employees will be the responsible to sit outside of the doorway. Staff must always have eyes on the youth when the youth are in the room together. Also, an effort will be made to move one of the youth out of the bedroom. An e-mail was received from CA on 2/21/22 stating that the two youth are in separate rooms.

During an unannounced visit on 2/24/22 staff were not supervising Youth A when another resident went into his bedroom unnoticed by staff. This was addressed with Supervisor and Staff 5 who were on-site at the time. Later in the day it was again observed that staff were not watching the hallway where Youth A and other youth were in their rooms. During this visit there were multiple federal employees and interpreters in each house. A phone call was made to CA to inform her that the safety plan was not being followed. Prior to leaving the facility a federal employee was watching the hallways.

During a virtual meeting on 2/25/22, the COO and CA indicated they did not want the federal employees at their facility. They informed ORR, but ORR still sent the federal employees.

During PD's interview on 3/7/22 he stated he had communicated his concerns about the program to CA. She was very aware that he was doing his job, the supervisor's job, and the job of a youth specialist. He was not offered any support even after this consultant talked to CA about PD needing extra support. CA was involved in one e-mail to ORR prior to the youth being admitted to the program. He has been the one to communicate their concerns with ORR. CA has never been to the shelter.

During an unannounced visit on 3/9/22 Staff 7 and Staff 8 left the house leaving federal employees to supervise the youth and complete Youth A's one-on-one. After the consultant told the staff to come back in, they left again a few minutes later and a youth left the house without staff knowing. There were several federal employees and interpreters in each house at the time of the visit. A phone call was placed to CA to let her know of the safety issue.

On 3/10/22 during the unannounced visit Youth A did not have one-on-one staffing and staff had falsified the documentation saying he did have one. There were multiple federal employees and interpreters in each house. A phone call was placed to CA to let her know the safety plan was not being followed. She reported it appeared to be an issue with Staff 7 who was also working on 3/9/22 during that visit. She would have PM talk to her.

On 3/16/22 during an unannounced visit both houses were chaotic with youth walking in and out of the house without staff being aware. In House 1, Staff 10 indicated they could not find a youth. They were instructed by this consultant to go

look for him. He was found in the other house. A phone call was placed to CA to report the safety issues. She indicated they were pulling staff from all other programs in order to staff the houses. There were multiple federal employees and interpreters in each house.

During our telephone conversation on 3/16/22, CA reported they have not asked the federal employees to leave. CA also stated there was a medical reason why she could not be at the shelter, but she communicated with PD every day. She stated she was unaware of the first safety plan.

Documents Viewed:

- E-mail from PD on 2/3/22 in which CA is copied indicating they will have a one-on-one staffing for Youth A as a response to the incident.
- Safety plan e-mail dated 2/18/22 from CA and a follow-up e-mail indicating Youth J had moved out of the bedroom he shared with Youth A.
- Safety plan dated 2/25/22 signed by CA.
- E-mail from PM on 3/15/22 indicating they did not have employment documents and clearances for the federal employees.

APPLICABLE RULE	
R 400.4116	**Chief administrator; responsibilities.**
	(1) An agency shall assign the chief administrator responsibility for the on-site day-to-day operation of the institution and for ensuring compliance with these rules.
ANALYSIS:	Based on interviews and visits to the facility, CA was not ensuring compliance with the rules and ensuring safety plans were being followed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Staff falsified documentation.

INVESTIGATION:

Interviews:
Staff 1 indicated in his interview that Staff 2 falsified documentation. He reported she did not do her 15-minute checks when she worked the overnight.

During Staff 2's interview she stated that she did not work overnights and that she always did her 15-minute checks.

On-site visit:
During an on-site visit on 3/10/22, consultant observed Staff 7 leave House 1 at 2:45pm, the one-on-one log was reviewed at that time and Staff 7 had filled in that she provided Youth A one-on-one supervision until 3pm.

Video:
Video of Staff 2 on the night of 2/20/22 showed her not completing any 15-minute checks.

Documents Viewed:

- Youth A's on-on-one log for 3/10/22 was signed by Staff 7 stating she provided his one-on-one staffing until 3pm.
- 15-minute check logs for 2/20/22 indicated all checks were completed.
- Staff 2 employee file indicates she has been working at the facility since 3/22/21 and she did not have any disciplinary action in her file.
- Staff 7 employee file indicated she had been working at the facility since 7/22/21 and she did not have any disciplinary action in her file.

APPLICABLE RULE	
MCL 722.120	**Investigation, inspection, and examination of conditions, books, records, and reports; access by department, bureau of fire services, or local authorities; records; report; forms; confidentiality; disclosure of information; availability of confidential records; child information cards to be provided to department; failure of licensee to cooperate with investigation, inspection, or examination.**
	(1) The department may investigate, inspect, and examine conditions of a child care organization and may investigate and examine the books and records of the licensee. The licensee shall cooperate with the department's investigation, inspection, and examination by doing all of the following: **(c) Providing accurate and truthful information to the department, and encouraging witnesses, such as staff and household members, to provide accurate and truthful information to the department.**
ANALYSIS:	Based on the video, on-site visits, and documents, Staff 2 and Staff 7 did not provide accurate information by falsifying their supervision logs. Additionally, Staff 7 reported she did not work the night shift, but was observed on video footage to be working the night of 2/20/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

It is recommended, upon receipt of an acceptable corrective action plan the license status be modified to a First Provisional license.

4/1/22

Rorie Dodge-Pifer — Date
Licensing Consultant

Approved By:

April 5, 2022

Jessica VandenHeuvel — Date
Area Manager