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GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

December 14, 2022

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

RE: License #: AS810409202 Investigation #: 2023A0122004

Kay & Russ 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,

Vanon Beullen

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 #:	AS810409202
Investigation #:	2023A0122004
investigation ".	2020/10122004
Complaint Receipt Date:	11/18/2022
Investigation Initiation Date:	11/18/2022
investigation initiation bate.	11/10/2022
Report Due Date:	01/17/2023
Licensee Name:	St. Lauis Contar for Eventional Children 9 Adults
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
Election Designee.	Deana Fisher
Name of Facility:	Kay & Russ House
Facility Address:	1655 Hayes Rd.
racinty Address.	Chelsea, MI 48118
Facility Telephone #:	(734) 475-8430
Original Issuance Date:	08/11/2021
License Status:	REGULAR
Effective Date:	02/11/2022
Expiration Date:	02/10/2024
Capacity:	5
oupdoity.	
Program Type:	PHYSICALLY HANDICAPPED
	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

Violation Established?

On 11/16/2022, staff member, Daniel Platte poured water on	Yes
Resident A to get him to comply with leaving a room.	

III. METHODOLOGY

11/18/2022	Special Investigation Intake 2023A0122004
11/18/2022	Contact - Document Received APS Referral made. Email received from APS Department.
11/18/2022	Special Investigation Initiated - Letter Email received from Deana Fisher, Licensee Designee. Informing me of the incident. Email from school personnel forwarded to me.
11/21/2022	Contact - Document Sent Email received from Deana Fisher, Licensee Designee.
11/22/2022	Contact - Document Sent Email sent to Sarah Igonin, School Personnel.
11/22/2022	Inspection Completed On-site Observed Resident A. Reviewed Resident File and received documents. Completed interview with Lindsey Patrick, Social Worker.
11/28/2022	Contact – Document sent Email sent to Sarah Igonin, School Personnel.
11/29/2022	Contact – Face to face Completed interview with Sarah Igonin, School Personnel.
11/29/2022	Contact – Telephone call made Daniel Platte, Staff Member. Unavailable, left voice message requesting return phone call.
12/06/2022	Contact – Telephone call made Daniel Platte, Staff Member. Unavailable, left voice message requesting return phone call.

12/07/2022	Exit Conference Discussed findings with Deana Fisher, Licensee Designee.
12/07/2022	Contact – Telephone call made Recipient Rights Referral made
12/09/2022	Contact – Telephone call received Daniel Platte, staff member.

ALLEGATION: On 11/16/2022, staff member, Daniel Platte poured water on Resident A to get him to comply with leaving a room.

INVESTIGATION: On 11/18/2022, Deana Fisher, Licensee Designee, stated she received information the following information from school personnel of Resident A: on 11/16/2022, staff member, Daniel Platte poured water on Resident A to get him to comply with leaving the classroom.

Ms. Fisher reported that in addition to notifying me an Adult Protective Service referral had been made. Ms. Fisher stated she has removed Mr. Platte from working in the same facility as Resident A until the outcome of this investigation has been received. Ms. Fisher submitted documents from Resident A's file and submitted a copy of an email received from school personnel.

Ms. Fisher also reported that she had Daniel Platte complete a refresher course of non-violent crisis intervention training on 01/16/2022 as she had concerns regarding him handling residents that display aggressive behaviors. On 11/21/2022, I reviewed Mr. Platte's training record. He completed all adult foster care licensing direct staff training requirements prior to being assigned to work with residents.

On 11/18/2022, I reviewed email received from school personnel documenting the following: "I also wanted to address an issue with the SLC (St. Louis Center) staff that picked him up today. The staff was pouring water on [Resident A] to get him to comply (to leave the room) and I honestly have never seen [Resident A] look so frightened. This is also the point where he bit me." "[Resident A] and I have a very solid relationship and I'm usually able to calm him down so this was very out of the ordinary for him."

On 11/21/2022, I completed an onsite inspection. Per Resident A's file he is diagnosed with Unspecified Intellectual Disabilities and Autistic Disorder and is non-verbal. I observed Resident A sitting at the kitchen table drinking a juice box. He was observed to be sitting quietly showing no signs of disorder or distress. Resident A was non-responsive to my greeting.

On 11/21/2022, I completed an interview with Lindsey Patrick, Social Worker. Ms. Patrick reported that Resident A displays aggressive behavior issues that include biting, pinching, and grabbing. Per Ms. Patrick, Resident A can display these issues when he does not want to follow directions and he also will drop weight or sit down when he does not want to comply. Ms. Patrick stated that Resident A has an Individual Plan of Service to address his issues.

On 11/28/2022, I reviewed documents from Resident A's file. Resident A has an Individual Service Plan that addresses the following: Responding appropriately to directions, Communication, Reduction to high stimulation behaviors, 1:1 Supervision, Proper Table Etiquette, and Elimination of unsafe transportation behaviors. When attempting to have Resident A respond appropriately to directions direct care staff are to allow him time to process the request, help him stay focused, give praise when he completes a task, etc. Direct care staff are to use methods of verbal redirection or directing Resident A away from a group to process the request given.

On 11/29/2022, I completed an interview with Sarah Igonin, School Personnel. Ms. Igonin stated she observed the incident on 11/16/2022 between Resident A and Daniel Platte. Ms. Igonin reported the following: Resident A was having difficulty and refused to leave the bathroom which is inside of his classroom. Ms. Igonin requested assistance from Daniel Platte with getting to Resident A leave the classroom. Ms. Igonin stated Mr. Platte gave verbal redirection to Resident A to which he did not comply. Ms. Igonin then observed Mr. Platte raise his water bottle over Resident A's head, sprinkle water on Resident A's head, and follow him around the classroom trying to get Resident A to exit the classroom.

Per Ms. Igonin, Resident A has difficulty with transitioning at the end of the day with leaving the classroom and going to the facility van to leave school for the day. After she observed the incident, she went over to Resident A as he appeared scared, attempted to give him a hug, and he bit her. Ms. Igonin stated after an hour Resident A eventually left the classroom and got on the facility van. Ms. Igonin stated she was only person that observed this incident between Resident A and Daniel Platte. Ms. Igonin stated she reported the incident to Deana Fisher and Adult Protective Services.

On 12/07/2022, I completed an exit conference with Deana Fisher, Licensee Designee. Mr. Fisher stated she understood my findings and would submit a corrective action plan to address rule violations found.

On 12/09/2022, I completed an interview with Daniel Platte, staff member. Mr. Platte confirmed he was a part of the incident on 11/16/2022 with Resident A. Per Mr. Platte, he was trying to get Resident A to leave the classroom and get him on the facility van to be transported back to his home at the end of the school day. Mr. Platte stated he "tilted the water bottle as if he was going to pour on Resident A's head," but he had no intention of doing it. He wanted to motivate Resident A to

leave the classroom by using this behavior intervention as it had worked in the past. Mr. Platte reported that Resident A bumped into his arm as he was holding the water bottle up and that is how the water got spilled on Resident A.

Danie Platte confirmed that he had reviewed Resident A's behavior plan but could not recall if using a water bottle to motivate him to follow direction was part of the plan.

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:	On 11/16/2022, Sarah Igonin, School Personnel, observed direct care staff, Daniel Platte, raise his water bottle over Resident A's head, sprinkle water on Resident A's head, and follow him around the classroom trying to get Resident A to exit the classroom.	
	On 11/29/2022, Sarah Igonin, confirmed she observed what she reported on 11/16/2022.	
	On 12/09/2022, Daniel Platte confirmed that he raised a water bottle over Resident A's head as a behavior intervention to get him to comply with the verbal direction to exit the classroom. During this behavior intervention water was spilled on Resident A.	
	Based upon my investigation I find there is sufficient evidence to support the allegation that direct care staff member, Daniel Platte, poured water on Resident A to get him to comply with a request. Therefore, Resident A was not treated with dignity nor was his safety attended to on 11/16/2022.	
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: (a) Use any form of punishment.	
ANALYSIS:	On 11/16/2022, Sarah Igonin, School Personnel, observed direct care staff, Daniel Platte, raise his water bottle over Resident A's head, sprinkle water on Resident A's head, and follow him around the classroom trying to get Resident A to exit the classroom.	
	On 11/29/2022, Sarah Igonin, confirmed she observed what she reported on 11/16/2022.	
	On 12/09/2022, Daniel Platte confirmed that he raised a water bottle over Resident A's head as a behavior intervention to get him to comply with the verbal direction to exit the classroom. During this behavior intervention water was spilled on Resident A.	
	Based upon my investigation I find there is enough evidence to support the allegation that direct care staff, Daniel Platte, poured water on Resident A to get him to comply with a request. Therefore, direct care staff, Daniel Platte, used water as a form of punishment on Resident A during the incident on 11/16/2022.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

IV. RECOMMENDATION

Area Manager

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

Vanen Beellin	
Vanita C. Bouldin Licensing Consultant	Date: 12/13/2022
Approved By:	
Ardra Hunter	Date: 12/14/2022