STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

LANSING

ORLENE HAWKS
DIRECTOR

Michelle Helmuth-Charles
LADD, Inc.
300 Whitney Dr.
Dowagiac, MI 49047

January 31, 2023

RE: License #: AS110383298
Investigation #: 2023A1030018
Niles Pointe

Dear Ms. Helmuth-Charles:

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.

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 (616) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

611 W. OTTAWA • P.O. BOX 30664 • LANSING, MICHIGAN 48909 www.michigan.gov/lara
• 517-335-1980

# MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
# BUREAU OF COMMUNITY AND HEALTH SYSTEMS
# SPECIAL INVESTIGATION REPORT

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS110383298 |
| | |
| **Investigation #:** | 2023A1030018 |
| | |
| **Complaint Receipt Date:** | 12/29/2022 |
| | |
| **Investigation Initiation Date:** | 12/29/2022 |
| | |
| **Report Due Date:** | 02/27/2023 |
| | |
| **Licensee Name:** | LADD, Inc. |
| | |
| **Licensee Address:** | 300 Whitney Dr.<br>Dowagiac, MI 49047 |
| | |
| **Licensee Telephone #:** | (269) 240-1473 |
| | |
| **Administrator:** | Michelle Helmuth-Charles |
| | |
| **Licensee Designee:** | Michelle Helmuth-Charles |
| | |
| **Name of Facility:** | Niles Pointe |
| | |
| **Facility Address:** | 2433 Bond Street<br>Niles, MI 49120 |
| | |
| **Facility Telephone #:** | (269) 262-0195 |
| | |
| **Original Issuance Date:** | 02/16/2017 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/04/2021 |

| | |
|---|---|
| | |
| **Expiration Date:** | 08/03/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff physically assaulted Resident A. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 12/29/2022 | Special Investigation Intake<br>2023A1030018 |
| 12/29/2022 | Special Investigation Initiated - Telephone<br>Interview with Tina Tucker |
| 01/06/2023 | Contact - Telephone call made<br>Interview with Lavonda Thomas |
| 01/06/2023 | Contact - Document Received<br>Document received from Lavonda Thomas |
| 01/06/2023 | Contact - Face to Face<br>Interview with Resident A |
| 01/09/2023 | Contact - Telephone call made<br>Interview with Brittany Whitfield |
| 01/09/2023 | Contact - Telephone call made<br>Interview with Mafaro McLaurin |
| 01/09/2023 | Contact - Telephone call made<br>Interview with Guardian A1 |

| | |
|---|---|
| 01/30/2023 | Contact - Telephone call made<br>Interview with Roxie DeJesus |
| 01/30/2023 | Contact - Telephone call made<br>Interview with Christine Clements |
| 01/30/2023 | Exit Conference<br>Exit conference by phone |
| 1/31/2023 | Contact – Telephone call made<br>Interview with Lavonda Thomas |

**ALLEGATION:**

**Staff physically assaulted Resident A.**

**INVESTIGATION:**

On 12/29/22, I received a call from regional director Tina Tucker regarding Resident A being assaulted by direct care staff member (DCSM) Brittany Whitfield. Ms. Tucker reported there were several witnesses and Ms. Whitfield has been suspended. Ms. Tucker reported Resident A was given first aid (ice and anti-biotic ointment) in the home and she made a police report after she was informed of what occurred.

On 1/6/22, I attempted to interviewed DCSM Lavonda Thomas however she indicated she felt traumatized about what occurred and submitted an account of what occurred in writing.

On 1/6/23, I received and reviewed a document submitted by Lavonda Thomas. The document indicated Resident A was prompted to fold laundry and reacted by “frowning and rolling her eyes.” The document then indicated Roxie DeJesus told Resident A “this is one of the reasons you never get to see your boyfriend on a regular basis because you won’t listen and do what your supposed to do.” The document then indicated Resident A threw a towel and Ms. Whitfield “pushed a chair out of the path, pushed Resident A’s toward the closet door, where she slammed her forehead against the door a few times.” Ms. Thomas reported she then yelled “stop it Brittany, this isn’t right.” The documents then indicated Ms. Whitfield began choking Resident A while she was on the ground and Ms. Thomas whispered in Ms. Whitfield’s ear “let her up, let her go.” The document then indicated Ms. Whitfield let Resident A up and told her to go to her bedroom. Ms. Thomas and Ms. Whitfield followed Resident A into her bedroom.

On 1/6/23, I interviewed Resident A at the home, Ms. Tucker was also present to act as a support person for Resident A. Resident A reported she was asked by DCSM Lavonda Thomas to fold some of the towels and did not feel it was her job and “rolled her eyes” and threw a towel on the floor. Resident A reported DCSM Brittany Whitfield

intervened and “slammed her head into the activity closet door.” Resident A reported she went to the ground and Ms. Whitfield began choking her and scratched her side. Resident A reported she was told to go into her bedroom which she did, and Ms. Smith entered her room carrying a plastic wiffleball bat and hit her on her abdomen. Resident A reported several DCSM were yelling at Ms. Smith to stop but they did not physically intervene.

Ms. Tucker provided additional context to the interview and indicated this occurred during shift change and Ms. Whitfield has punched out and was on her way home. Ms. Tucker reported Ms. Whitfield has never demonstrated this type of behavior, however she will not be returning to her position at the home. Ms. Tucker reported Resident A has a legal guardian and provided her name and contact information.

On 1/9/23, I interviewed DCSM Brittany Whitfield by phone. Ms. Whitfield reported she was involved in an incident with Resident A. Ms. Whitfield reported she was getting ready to leave for the day and had punched out when another DCSM asked Resident A to help fold towels. Ms. Whitfield reported Resident A gave them “an evil look” and refused to fold any towels. Ms. Whitfield reported Resident A continued to refuse to fold towels despite being encouraged by the staff. Ms. Whitfield reported she then asked Resident A to go to her bedroom to take a five-minute break because she was starting to get upset. Ms. Whitfield reported she was “trying to get other residents out of the way” when Resident A “fell against the closet door” and threw herself onto the ground. Ms. Whitfield reported Resident A then began scratching and hitting herself and she asked Resident A to stop and again asked her to go to her bedroom. Ms. Whitfield reported Resident A did not stop and began calling her names and threatening her. Ms. Thomas reported she then got on top of Resident A while she was on the ground to protect her from hurting herself.

Ms. Whitfield reported there were three other staff members there and they did not do much to help her. Ms. Whitfield reported Roxie DeJesus did grab Resident A’s legs. Ms. Whitfield denied knowing why neither of the other staff members tried to assist her. Ms. Whitfield reported Resident A eventually calmed down enough to go into her bedroom. Ms. Whitfield denied hitting, choking or abusing Resident A in any manner and instead was reacting to her behavior.

On 1/9/22, I interviewed DCSM Maforo McLaurin by phone. Ms. McLaurin reported she was coming into work on 12/28/22 and witnessed the situation between Ms. Whitfield and Resident A. Ms. McLaurin reported Resident A was asked to fold towels as they were “house towels” however she refused and “got an attitude.” Ms. McLaurin reported there was some back and forth between Resident A and the home manager, Ms. DeJesus and Ms. Whitfield “slammed Resident A’s head into the closet door.” Ms. McLaurin reported Resident A then thew herself onto the ground and Ms. Thomas began “choking her” while she was on the ground. Ms. McLaurin reported Resident A began trying to fight Ms. Whitfield and grabbed her glasses off her face. Ms. McLaurin reported she yelled at Ms. Whitfield to stop and that “she cannot do that.” Ms. McLaurin reported Ms. Whitfield stopped choking Resident A and stood up and put her foot on Resident A’s stomach while she was still on the floor.

Ms. McLaurin reported Resident A was then escorted to her bedroom by Ms. DeJesus and Ms. Whitfield. Ms. McLaurin reported she did not see Ms. Whitfield take a wiffle ball bat into the bedroom but did not go to her bedroom with them. Ms. McLaurin reported she heardr noises and Resident A yelling. Ms. McLaurin reported she has never witnessed Ms. Whitfield doing anything like this in the past but has heard that she has assaulted other residents in a similar fashion. Ms. McLaurin reported she and the three other staff members did not physically intervene but did tell Ms. Whitfield to stop what she was doing. Ms. McLaurin reported Resident A "did nothing wrong."

On 1/9/22, I interviewed Resident A's legal guardian, Guardian A1 by phone. Guardian A1 reported she is aware of the situation and does plan to peruse legal action.

On 1/30/23, I interviewed Roxie DeJesus by phone. Ms. DeJesus reported she worked in the home for five years and was working on 12/28/22 when the incident occurred with Resident A. Ms. DeJesus reported she believes Resident A's behavior problems occurred because of the Behavior Specialist, Christine Clements as she discussed reducing Resident A restrictions with Resident A. Ms. DeJesus reported that Resident A was triggered, and she could tell that Resident A was starting to have behavior problems by her body language. Ms. DeJesus reported she asked Resident A if she wanted to talk or take a five-minute break in her room. Ms. DeJesus reported Resident A "ran to the activities closet and threw herself on the floor." Ms. DeJesus reported Resident A then began harming herself while she was on the floor and Ms. Whitfield intervened to protect Resident A from harming herself. Ms. DeJesus reported she also tried to help but Resident A was kicking her legs and kicked her in the port in her stomach and she is a dialysis patient and has a port in her arm and stomach. Ms. DeJesus reported there were two other DCSM working however they did not do anything to assist.

Ms. DeJesus reported Resident A calmed down a little bit and got up and went into the bathroom. Ms. DeJesus reported she and Ms. Whitfield got Resident A into her bedroom to continue to calm down. Ms. DeJesus reported she asked Resident A to talk with her as she is usually able to redirect and get her calmed down. Ms. DeJesus reported Resident A yelled at her that she did not want to talk. Ms. DeJesus reported she and Ms. Whitfield were the only staff in Resident A's bedroom and despite what has been reported Ms. Whitfield did not hit Resident A with a "wiffleball bat." Ms. DeJesus reported there is a wiffleball bat in the home that is kept in the activities closet. I informed Ms. DeJesus that several others indicated Ms. Whitfield was the aggressor and that Resident A was hot with a wiffleball bat. Ms. DeJesus continued to blame Ms. Clements and denied Ms. Whitfield doing anything improper. Ms. DeJesus also denied knowing why Ms. Thomas or Ms. McLaurin did anything to intervene or assist.

On 1/30/23 I interviewed behavior specialist Christina Clements by phone. Ms. Clements reported she was in the home on 12/28/22 as she was conducting "behavior monitoring" for Resident A and two other residents that day. Ms. Clements reported she was in the from about 11:00am to 1:00pm. Ms. Clements reported she was trying to determine if Resident A's behavior plan could be altered to include less restriction. Ms. Clements reported Resident A has been having positive behaviors for over a year and the general plan would be to allow Resident A more community access however she would still require supervision. Ms. Clements reported she spoke with the staff on duty

that day but at no time did she ever discuss the plan with Resident A and never promised anything to er. Ms. Clements reported Resident A was in a good mood when she left the home at 1:00pm.

On 1/31/23, I interviewed Lavonda Thomas by phone. Ms. Thomas was asked if she witnessed Ms. Whitfield take a wiffleball bat into Resident A's bedroom. Ms. Thomas reported she was in another part of the home when Ms. Whitfield and Resident A went into her bedroom but was informed by Resident A that Ms. Whitfield hit her with a wiffleball bat. Ms. Thomas reported she believes Resident A was being truthful about being hit with a wiffleball bat and the bat was taken out of the home by management.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | **(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.** |
| **ANALYSIS:** | It was alleged that Resident A was physically assaulted by Brittany Whitfield, which was witnessed by three other staff members. Based on interviews with Resident A, Tina Tucker, Mafaro McLaurin, Christina Clements and review of a written statement by Lavonda Thomas, this violation will be established. According to these accounts of the incident Ms. Whitfield assaulted Resident A due to frustration over Resident A refusing to fold towels. Specifically, Ms. Whitfield slammed Resident A's head against a closet door, choked her and hit her with a wiffleball bat.<br><br>Brittany Whitfield and Roxie DeJesus were also interviewed and provided similar accounts of the incident, however their statements conflict with the statements made by the other witnesses and Resident A and appear to be self-serving and deflected blame away from themselves. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 12/28/22, Resident A was assaulted by Ms. Whitfield in the presence of three staff members who did not attempt to intervene or protect Resident A.

| **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:** | During an investigation into the assault of Resident A by Brittany Whitfield it was discovered that the assault occurred in the home during shift change and there were three other staff members present. Roxie DeJesus, Lavonda Thomas and Mafaro McLaurin all had the opportunity to intervene and protect Resident A as the assault occurred in a common area of the home and later in Resident A's bedroom. Ms. Thomas and Ms. McLaurin indicated they asked Ms. Whitfield to stop but did not do enough as they could have physically intervened or called law enforcement. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 1/30/23, I shared the findings of my investigation with licensee, Michele Charles by phone. Ms. Charles acknowledged and agreed with the findings. Ms. Charles will submit a corrective action plan upon receipt of the investigation report.

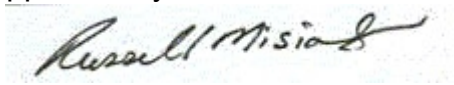
## IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

1/31/23

Nile Khabeiry Date
Licensing Consultant

Approved By:



2/9/23

Russell B. Misiak Date
Area Manager