GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 25, 2023

Karen LaFave
Adult Learning Systems - UP, Inc
Suite-4
228 West Washington
Marquette, MI 49855

RE: License #: AS520326257
Investigation #: 2023A0873014
Superior Home

Dear Ms. LaFave:

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 (517) 643-7960.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 250-9318

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520326257
Investigation #:	2023A0873014
Complaint Receipt Date:	06/05/2023
Investigation Initiation Date:	06/07/2023
Report Due Date:	08/04/2023
Licensee Name:	Adult Learning Systems - UP, Inc
Licensee Address:	Suite-4 228 West Washington Marquette, MI 49855
Licensee Telephone #:	(906) 228-7370
Administrator:	Kelsey Williams
Licensee Designee:	Karen LaFave
Name of Facility:	Superior Home
Facility Address:	651 West Spring Street Marquette, MI 49855
Facility Telephone #:	(906) 273-1601
Original Issuance Date:	02/20/2013
License Status:	REGULAR
Effective Date:	08/20/2021
Expiration Date:	08/19/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff member Diana Truscott's behavioral interventions were excessive and forceful toward Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

06/05/2023	Special Investigation Intake 2023A0873014
06/07/2023	Special Investigation Initiated - On Site
06/08/2023	APS Referral Referred to APS
06/22/2023	Inspection Completed On-site Interviews with staff
06/22/2023	Contact - Document Received Received copies of assessment plan and behavior plan for Resident A
07/25/2023	Inspection Completed-BCAL Sub. Compliance
07/25/2023	Exit Conference with Kelsey Williams - administrator

ALLEGATION: Staff member Diana Truscott's behavioral interventions were excessive and forceful toward Resident A

INVESTIGATION: I received an incident report dated 5/19/23 that detailed an incident that occurred between two staff members and Resident A on that same date. The incident report was authored by staff member Grace Souza and detailed

allegations against Diana Truscott, staff member at Superior Home. The incident report explains that on the afternoon of 5/19/23, Resident A went into the downstairs bathroom before his scheduled doctor's appointment at 2pm. After some time, he was prompted to come out of the bathroom but argued with staff through the door about not wanting to come out. Resident A continued to occupy the bathroom for another 30 minutes with the water running before Staff Souza knocked on the door to report to him that they had to leave for his appointment in 20 minutes. At this time Staff Truscott came to the downstairs bathroom and started yelling, seeming to be very angry and aggressive and raising her voice through the door for Resident A to come out. Resident A said that he was coming out but continued to stay in the bathroom. Staff Truscott then grabbed the bathroom keys and used these to open the bathroom door without Resident A's consent. Staff Truscott continued yelling and Resident A tried to shut the door on her, but Staff Truscott kept pushing on the door to keep it open while raising her voice and yelling. Staff Truscott eventually went upstairs and complained to staff about how "this job is bullshit" and how "[Resident A] does the same thing every day, I'm sick of his bullshit." The incident report goes on to explain that after the incident occurred staff follow up with Resident A asking him if he was okay and then detailing the incident.

On 6/7/2,3 I conducted an unannounced, onsite inspection of the facility. While there I briefly interviewed several other residents, all of whom seemed well-cared for. The home was in good repair and comfortable. The home manager, Nikki Gibson, was not there at the time, nor was Truscott. However, I was able to interview both Souza as well as Resident A. Souza confirmed what was in the report and told me that she did not know why Truscott involved herself in the situation. I was told that Resident A will often remain in the bathroom for long periods of time. This behavior often causes frustration among staff members of the home but Truscott's behavior that day during the incident was unusual.

Also, on 6/7/23, I interviewed Resident A. Resident A told me that he has been living at the home for approximately 5 years. Once I confirmed with Resident A the incident I was investigating, I asked him to give me his side of events and to tell me what he remembered from that day. He told me that he often spends a lot of time in the bathroom and that staff will let him know when it is time to come out. He told me that on 5/19/23 he was in the bathroom when Staff Truscott came to get him out. Resident A told me that Staff Truscott was yelling at him to get out of the bathroom, and this escalated to her forcing her way into the bathroom. Resident A told me him and Staff Truscott were going back and forth pushing on the door. He was trying to keep it closed and Staff Truscott was trying to force it open. I was told that during his time living at the home staff have never yelled at him or other residents and he had never experienced any other staff member trying to force their way into a room he was in. Although Resident A told me that it scared him, he also reported that he likes living there and generally gets along well with other residents and staff members.

On 6/22/23 I conducted a second unannounced inspection of the facility. During this visit I was able to interview Diana Truscott as well as Nikki Gibson, the home manager. Staff Truscott disputed the allegations as written in the incident report. She told me that Resident A was in the bathroom for three hours that day and that, although she may have been frustrated, she did not raise her voice, nor did she try to open the bathroom door. She told me that Resident A engages in this behavior often and that he will stand in the bathroom for hours with the lights off. Staff Truscott told me that she intervened in the situation because she was concerned for Resident A's safety.

On 6/22/23, I interviewed home manager, Nikki Gibson. Manager Gibson told me that she was not there the day the incident occurred but that she had heard about it from staff. Manager Gibson confirmed to me that Resident A goes into the bathroom often and will stay there for an extended period of time. Manager Gibson told me that Resident A mentioned to her that he felt like Staff Souza and Staff Truscott were "ganging-up" on him that day and also mentioned that she has never heard Staff Truscott swear at staff or residents.

On 6/22/23, I was able to review Resident A's assessment plan which confirms he needs regular prompting for dressing, grooming, bathing, and toileting and that he requires prompting to exit the bathroom after excessive usage. I was also able to review Resident A's behavior plan with Pathways CMH which concerns itself, in large part, to Resident A's showering. The behavior plan explains the history of this issue, including attempting to incentivize Resident A to shower, as well as developing strategies for effectively prompting Resident A to leave the shower when done. The most current behavior plan explains that Resident A's guardian has agreed to come to the home once per week and assist Resident A with showers.

On 7/25/23, I conducted an exit conference with Kelsey Williams, Superior Home's administrator. I explained to Williams that I believe there is evidence to substantiate a rule violation as a result of this situation between Staff Truscott and Resident A. Williams informed me that after reviewing this report, she will begin working on a corrective action plan.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(1) A licensee shall ensure that methods of behavior intervention are positive and relevant to the needs of the resident.

ANALYSIS:	After interviewing several staff members as well as Resident A, I believe there is enough evidence to substantiate this rule violation. Even though Truscott denied the allegations as laid out in the incident report, Resident A himself confirmed what was in the incident report, including Truscott attempting to force open the bathroom door without Resident A's consent.
CONCLUSION:	**VIOLATION ESTABLISHED**

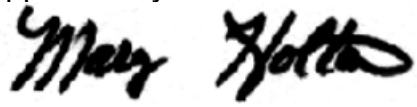
IV. RECOMMENDATION

Contingent upon implementation of an appropriate corrective action plan, I recommend no changes to the status of this license.

7/25/2023

Garrett Peters Date
Licensing Consultant

Approved By:



7/24/2023

Mary E. Holton Date
Area Manager