GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 6, 2024
Michelle Helmuth-Charles
LADD, Inc.
300 Whitney Dr.
Dowagiac, MI 49047

RE: License #: AS140316693
Investigation #: 2024A1030044
Cass Home

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.

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

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
Warning Report Contains Profanity

I. IDENTIFYING INFORMATION

License #:	AS140316693
Investigation #:	2024A1030044
Complaint Receipt Date:	07/23/2024
Investigation Initiation Date:	07/23/2024
Report Due Date:	09/21/2024
Licensee Name:	LADD, Inc.
Licensee Address:	300 Whitney Dr. Dowagiac, MI 49047
Licensee Telephone #:	(269) 240-1473
Administrator:	Michelle Helmuth-Charles
Licensee Designee:	Michelle Helmuth-Charles
Name of Facility:	Cass Home
Facility Address:	224 Avenue J Cass, MI 49031
Facility Telephone #:	(269) 445-8467
Original Issuance Date:	03/05/2012
License Status:	REGULAR
Effective Date:	08/12/2022
Expiration Date:	08/11/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II ALLEGATION(S)

	Violation Established?
Resident A and Resident B were physically mistreated by a staff member.	Yes
Additional Findings	No

III. METHODOLOGY

07/23/2024	Special Investigation Intake 2024A1030044
07/23/2024	Special Investigation Initiated - Telephone Interview with Holly Jackson
07/23/2024	Contact - Document Received Received and reviewed two Incident Reports
07/23/2024	APS Referral APS referral made by home manager
07/25/2024	Contact - Telephone call made Interview with Mya Scholten
07/29/2024	Contact - Telephone call made Interview with Gail Seivert
07/31/2024	Contact - Telephone call made Interview with Tia Olsen
08/06/2024	Contact - Face to Face On-site inspection
08/06/2024	Exit Conference Exit conference on-site

ALLEGATION:

Resident A and Resident B were physically mistreated by a staff member.

INVESTIGATION:

On 7/23/24, I received and reviewed two Incident Reports (IR) dated 7/20/24. The IR's indicted direct care staff member Gail Sievert mistreated two Residents. According to the IR's Ms. Sievert pushed Resident A into the wall after he tried to hit her and aggressively shook Resident B's head when she was asked a question.

On 7/23/24, I interviewed home manager Holly Jackson by phone. Ms. Jackson reported the home suspended Ms. Sievert pending the investigation and that Ms. Sievert denied mistreating Resident A and Resident B. Ms. Jackson reported Ms. Seivert is known as someone with a strong personality and can be very loud when interacting with the residents who can be difficult. Ms. Jackson reported Ms. Seivert can also be difficult during supervision. Ms. Jackson reported she reviewed the IR completed by Ms. Scholten and does not have any reason to question the validity of what was documented.

On 7/25/24, I interviewed direct care staff member (DCSM) Mya Scholten by phone. Ms. Scholten reported she has worked at the home for two months. Ms. Scholten reported she was working with DCSM Gail Sievert on 7/20/24 and expressed some concerns about the way she treated two residents during the shift. Ms. Scholten reported Ms. Sievert was helping Resident A was his hands and he became upset with her and then she was walking him out of the kitchen. Ms. Scholten reported Resident A then turned around and tried to hit Ms. Sievert, which is not uncommon for Resident A, and Ms. Sievert became more upset and said " you are not going to hit me." Ms. Scholten reported Ms. Sievert then put her hands on Resident A and pushed him into a door which was closed. Ms. Scholten reported Ms. Sievert did not push him very hard but did push him and he then slide down the door and sat on the floor. Ms. Scholten reported Ms. Sievert left him on the floor for an hour and a half. Ms. Scholten reported she tried to help Resident A to his feet but he was too heavy for her to do it all by herself and asked Ms. Sievert for help but she refused to help. Ms. Scholten reported Ms. Sievert indicated that he knows how to get up on his own. Ms. Scholten reported Resident A then scooted himself into the living room and was able to get himself up onto the couch. Ms. Scholten indicated that this interaction could have been avoided if Ms. Seivert walked away from Resident A when he tried to hit her and he would have just walked into the living room and sat down.

Ms. Scholten reported another incident that day between Ms. Sievert was helping Resident B put deodorant and called Resident B a "bitch." Ms. Scholten reported Ms. Seivert reacted to Resident B not helping when she was putting deodorant on her and generally talks to the residents in an aggressive manner. Ms. Scholten reported Ms. Seivert then assisted Resident B into the living room and put in her chair. Ms. Scholten reported she asked Resident B if she wanted her doll and Resident B did not respond.

Ms. Scholten reported Ms. Seivert went over the Resident B and put her hands on Resident B's head and aggressively nodded her head up and down for yes and back and forth for no. Ms. Scholten reported she checked Resident B and did not notice any red marks or injuries.

On 7/29/24, I interviewed Gail Sievert by phone. Ms. Seivert reported she has worked for the agency for almost eleven years. Ms. Seivert reported she was trying to help Resident A wipe his beard when he tried to hit her. Ms. Seivert reported she crossed her arms and directed Resident A backward toward the door but did not push him. Ms. Seivert reported Resident A slide down the door and sat on the floor under his own power. Ms. Seivert reported she offered to help him up several times but he would not take her help. Ms. Seivert reported Resident A eventually scooted over the couch and got himself off the floor.

Regarding Resident B, Ms. Seivert reported she was accused of being too rough with her but denied doing anything improper. Ms. Seivert reported Resident B never responds to her when asked a question. Ms. Seivert reported she asked Resident B if she wanted anything to eat or drink. Ms. Seivert reported she could not remember if she asked Resident B about wanting her doll. Ms. Seivert reported she gently placed her hands on Resident B to teach her how to answer yes or no to a question. Ms. Seivert denied calling Resident B a "bitch."

On 7/31/24, I interviewed DCSM Tia Olsen by phone. Ms. Olsen reported she has worked at the home for seventeen years and usually works first shift with Ms. Seivert. Ms. Olsen reported she was not working on 7/20/24 but is aware of the investigation. Ms. Olsen reported she has never witnessed Ms. Seivert physically or verbally abusing a resident. Ms. Olsen reported Ms. Seivert has a loud voice and gets frustrated at times while working with the residents. Ms. Olsen reported she is unsure if Ms. Seivert recognizes that her voice can be so loud.

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 and Resident B were physically mistreated by a staff member. Based on interviews and review of the incident reports, this violation will be established. On 7/20/24 staff member Gail Seivert pushed Resident A against a door and aggressively shook Resident B's head up and down and back and forth. Both incidents occurred as a result of Ms. Seivert becoming frustrated while proving personal care for each resident. Neither resident suffered any physical injuries and did not receive any medical care as a result of the incidents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/6/24, I shared the findings of my investigation with licensee designee Michelle Charles. Ms. Charles acknowledged the findings and agreed to submit a corrective action plan.

IV. RECOMMENDATION

Contingent upon the submission of an acceptable corrective action plan, I recommend no changes in the current license status.

Nile Khabeiry, LMSW

8/6/24

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

8/8/24

Russell B. Misiak Date
Area Manager