GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 13, 2025

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

RE: License #: AS810409202
Investigation #: 2025A0122008
Kay & Russ House

Dear Ms. Fisher:

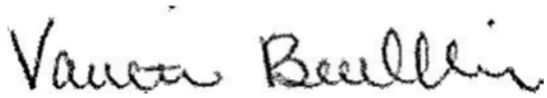
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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 #:	2025A0122008
Complaint Receipt Date:	12/18/2024
Investigation Initiation Date:	12/18/2024
Report Due Date:	01/17/2025
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
Name of Facility:	Kay & Russ House
Facility Address:	1655 Hayes Rd. Chelsea, MI 48118
Facility Telephone #:	(734) 475-8430
Original Issuance Date:	08/11/2021
License Status:	REGULAR
Effective Date:	02/11/2024
Expiration Date:	02/10/2026
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 09/20/2024, staff, Alan Kilchenman, talked about pouring water on Resident A.	Yes

III. METHODOLOGY

12/18/2024	Special Investigation Intake 2025A0122008 APS Referral
12/18/2024	Special Investigation Initiated - Telephone Completed interviews with Guardian A and Adult Protective Services Worker, Renita Young.
12/18/2024	Inspection Completed On-site Completed interview with licensee designee, Deana Fisher, and staff Robin Smith. Received Resident A's Psycho/Social Report and staff, Alan Kilchenman’s telephone number.
12/18/2024	Contact - Face to Face Observed Resident A at High Pointe school. Completed interview with teacher, Shawn Hines.
12/30/2024	Contact – Document sent Recipient Rights referral made.
01/09/2025	Contact – Telephone call made Completed interview with staff, Alan Kilchenman.
01/10/2025	Exit Conference Discussed findings with licensee designee, Lena Fisher.

ALLEGATION: On 09/20/2024, staff, Alan Kilchenman, talked about pouring water on Resident A.

INVESTIGATION: On 12/18/2024, I competed an interview with staff, Robin Smith. Ms. Smith confirmed that she worked with Alan Kilchenman on 09/20/2024 and was a witness to the incident between Mr. Kilchenman and Resident A. Ms. Smith stated that she and Mr. Kilchenman arrived at Hight Point school, to transport Resident A back to his facility, Kay and Russ House, at the end of the day. Per Ms. Smith, as typical, Resident A refused to get in the facility vehicle but instead dropped weight and was sitting on the floor.

Ms. Smith reported as she and Mr. Kilchenman were waiting for Resident A to move/get into a standing position, Mr. Kilchenman repeated a rumor stating that if you got a container of water, positioned it over Resident A's head as if you were going to pour it on him, that would cause Resident A to move and enter the van. Ms. Smith responded by saying to Mr. Kilchenman that type of behavior from staff is not tolerated by the agency and it is something that should never be done to any resident as motivation to get them to comply with a request. Ms. Smith directed Mr. Kilchenman not to repeat that statement.

Ms. Smith stated during the incident, Mr. Kilchenman did not physically touch Resident A, nor did he speak the above statement to Resident A. Ms. Smith did acknowledge that Resident A was in area and overheard Ms. Kilchenman make that statement.

On 12/18/2024, I completed an interview with licensee designee, Deana Fisher. Ms. Fisher reported that she was aware of the incident between Mr. Kilchenman and Resident A. Ms. Fisher stated she addressed the issue by having the program director, Father Franklin, review the incident with Mr. Kilchenman and discuss appropriate ways to address behavior issues with residents.

On 12/18/2024, I completed an interview with Guardian A. Guardian A reported that she was not made aware of the incident between Resident A and Alan Kenchmark on 09/20/2024. However, she did visit with Resident A in September 2024, and he appeared fine. Guardian A stated she has no issues of concerns at this time with the care Resident A is receiving from staff members of the Kay and Russ House.

On 12/18/2024, I completed a face-to-face meeting with Resident A at High Point school, located in Ann Arbor, MI. Resident A was resting after an outing with his class members and staff. He displayed no signs of distress. Per Resident A's Washtenaw County Community Mental Health's Annual Bio/Psycho/Social report dated 06/03/2024, he is diagnosed with autism, severe cognitive impairment, and oppositional defiant disorder. Resident A is non-verbal and therefore unable to participate in an interview.

On 12/18/202, I completed an interview with teacher, Shawn Hines, of Hight Point school. Mr. Hines confirmed that he was present during the incident between Resident A and Alan Kilchenman on 09/20/2024. Mr. Hines confirmed that Mr. Kilchenman made the statement, as reported by Robin Smith, in front of Resident A on 09/20/2024. Mr. Hines described Resident A as being “fearful,” after hearing Mr. Kilchenman make the statement.

On 01/09/2025, I completed an interview with staff, Alan Kilchenman. Mr. Kilchenman confirmed that he spoke with staff, Robin Smith, about a rumor he had heard, that if you positioned a container of water over Resident A’s head as if you were going to pour it on him, that would cause Resident A to move and enter the van. Mr. Kilchenman denied threatening Resident A with this method but did confirm Resident A was in the vicinity of his conversation with Ms. Smith and heard his question to Ms. Smith.

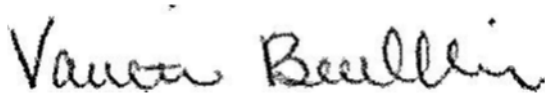
Per Mr. Kilchenman, Ms. Smith gave verbal redirection to not repeat the topic, and they waited until Resident A voluntarily got into the van. Mr. Kilchenman stated Resident A was returned back to his facility without incident. Mr. Kilchenman stated he discussed the issue with his supervisor and was given direction regarding appropriate conversations to have in front of residents.

On 01/10/2025, I completed an exit conference and discussed my findings with licensee designee, Deana Fisher. Ms. Fisher agreed with my findings and stated she would submit a corrective action plan to address rule violation stated in this report.

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:	Based upon my investigation, which consisted of multiple interviews with staff members, Robin Smith and Alan Kilchenman, and teacher, Shawn Hines there is a preponderance of the evidence to substantiate the allegation that on 09/20/2024, staff member Alan Kilchenman talked about pouring water on Resident A in front of Resident A, thereby not treating Resident A with dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon recipient and approval of a corrective action plan I recommend no change in the status of the license.



Vanita C. Bouldin Date: 01/10/2025
Licensing Consultant

Approved By:

Ardra Hunter Date: 01/13/2025
Area Manager