GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 21, 2025

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

RE: License #: AL810007467
Investigation #: 2026A0122009
Fr Guanella Hall

Dear Ms. Fisher:

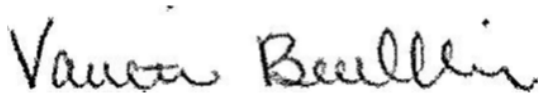
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL810007467
Investigation #:	2026A0122009
Complaint Receipt Date:	12/18/2025
Investigation Initiation Date:	12/19/2025
Report Due Date:	01/17/2026
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:	Fr Guanella Hall
Facility Address:	16195 Old US-12 Chelsea, MI 48118
Facility Telephone #:	(734) 475-8430
Original Issuance Date:	02/01/1991
License **Status:**	REGULAR
Effective Date:	10/21/2024
Expiration Date:	10/20/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 12/17/2025, Resident A was dragged down a hallway by staff members, Tina Cloud and Hayley Jula and locked out of her bedroom.	Yes

III. METHODOLOGY

12/18/2025	Special Investigation Intake 2026A0122009
12/18/2025	APS Referral
12/19/2025	Special Investigation Initiated - On Site Discussed allegations with Relative A1.
12/22/2025	Telephone call made Conducted interview with housekeeper, Melissa Parrish.
01/02/2026	Contact – Telephone calls made Completed interviews with staff members, Tina Cloud and Hayley Jula.
01/13/2026	Exit Conference Discussed findings with licensee designee, Deana Fisher.

ALLEGATION: On 12/17/2025, Resident A was dragged down a hallway by staff members, Tina Cloud and Hayley Jula and locked out of her bedroom.

INVESTIGATION: On 12/19/2025, I conducted an interview with Relative A1 who informed me that she had been notified of the incident regarding Resident A. Both Relative A1 and I were present at the facility at the same time, waiting for Resident A to return to the facility from school. Relative A1 gave permission for me to interview Resident A, however, I was unable to interview Resident A as she began having a behavior at school, Relative A1 left to pick Resident A up from school at another location and transport Resident A back to her family home for the weekend.

On the evening of 12/19/2025, Relative A1 sent a text stating Resident A “doesn’t appear to have any injury or bruising.” I tried to see Resident A face to face on 12/22/2025, however, she was not present at the facility and was with another

relative. Resident A's schedule for the week of December 22, 2025, is uncertain due to the holidays.

On 12/22/2025, I conducted an interview with housekeeper, Melissa Parrish. Ms. Parrish reported that she witnessed the following on 12/17/2025, Resident A ran into her bedroom and laid on the floor as she was upset for missing her school bus. Ms. Parrish stated she followed Resident A and observed staff member, Hayley Jula, grabbed Resident A by her knees and staff member, Tina Cloud, grabbed Resident A by her arms and then picked her up and laid her on the floor in the hallway. Ms. Parrish stated they directed her to lock Resident A's bedroom door to which she complied.

Per Ms. Parrish, she observed both staff members, Ms. Jula and Ms. Cloud, dragging Resident A down the hallway towards the front door. They both placed Resident A in the foyer and after a few minutes, Resident A got up and walked out of the building with both Ms. Jula and Cloud following her towards the administrative building on the property.

On 12/29/2025, I reviewed Resident A's Behavior Treatment Plan dated 09/09/2025. It documents that Resident A is diagnosed with cognitive impairment and is non-verbal. She requires full support for all self-care tasks including bathing, toileting, and showering. Per the report, Resident A displays aggressive and self-injurious behaviors, and the plan is needed to ensure her safety and support skill development. The plan lists strategies for staff to use to address her behaviors, but physical force and/or restraint is not listed as a strategy to address Resident A's behaviors.

On 01/02/2026, I conducted interviews with staff members, Tina Cloud and Hayley Jula. Both confirmed that they were on duty on 12/17/2025, providing care to Resident A. Both reported that Resident A was displaying behaviors in her room on this day as they were trying to get her prepared for school and ready to catch the bus. Ms. Could reported that she and another co-worker, Hayley Jula, observed Resident A on the floor refusing to get up, so each of them placed their arms under her arm, lifted/helped Resident A up onto her feet and then Resident A walked into hallway. Per Ms. Cloud, after Resident A was in the hallway, her bedroom door was closed and locked.

Ms. Jula confirmed that she observed Resident A displaying behaviors while she was in her bedroom on 12/7/2025, she observed that Resident A was on the floor. Ms. Jula stated she and co-worker, Tina Cloud, responded by picking Resident A up off the floor in her bedroom, and walking her into the hallway. They then placed Resident A on the floor in the hallway. Per Ms. Jula, she placed her hands under Resident A's shoulders and Ms. Cloud picked up Resident A by her legs/feet and both removed Resident A from her bedroom and shut the door.

Both Ms. Cloud and Ms. Jula stated once Resident A was in the hallway, she got up independently and ran to the front door of the facility and they followed behind her. Both denied dragging Resident A down the facility hallway.

On 01/13/2026, I conducted an exit conference licensee designee, Deana Fisher, and discussed my findings with her. Ms. Fisher agreed with my findings and stated she would submit a corrective action plan to address rule violations found during this investigation.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(b) Use any form of restraint without an order from an appropriately licensed heath care professional or physical force, other than physical restraint for crisis intervention.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, Tina Cloud, Hayley Jula and Relative A1, and a review of pertinent documentation relevant to this investigation, there is a preponderance of evidence to substantiate the allegations that staff members, Tina Cloud and Hayley Jula picked Resident A up off her bedroom floor, walked her out of the room, and placed her on the hallway floor on 12/17/2025. Therefore, Ms. Cloud and Ms. Jula used physical force to remove Resident A from her bedroom on 12/17/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(q) Access their bedroom at their own discretion.**

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, Tina Cloud, Hayley Jula and Relative A1, and a review of pertinent documentation relevant to this investigation, there is a preponderance of evidence to substantiate the allegations that staff members, Tina Cloud and Hayley Jula locked Resident A out of her bedroom on 12/17/2025. Therefore, Resident A was denied access to her bedroom at her discretion on 12/17/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Vanita C. Bouldin Date: 01/16/2026
Licensing Consultant

Approved By:

Ardra Hunter Date: 01/21/2026
Area Manager