GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ROBERT GORDON
DIRECTOR

March 19, 2019

Randall Copas
Starr Commonwealth
13725 Starr Commonwealth
Albion, MI 49224-9580

RE: License #: **CI130201440**
Investigation #: **2019C0212001**
Starr Commonwealth

Dear Mr. Copas:

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. As these are repeat violations, please identify what adjustments will be made to previous CAPs to ensure compliance going forward.
- 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 (866) 685-0006.

Please note that violations of any licensing rules are also violations of the ISEP and your contract.

Sincerely,

Heather Reilly, Licensing Consultant
MDHHS\Division of Child Welfare Licensing
22 Center Street
Ypsilanti, MI 48198
(734) 660-8309

enclosure

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	CI130201440
Investigation #:	2019C0212001
Complaint Receipt Date:	10/08/2018
Investigation Initiation Date:	10/10/2018
Report Due Date:	12/07/2018
Licensee Name:	Starr Commonwealth
Licensee Address:	13725 Starr Commonwealth Albion, MI 49224
Licensee Telephone #:	(517) 629-5591
Administrator:	Randall Copas, Chief Administrator
Licensee Designee:	Elizabeth Carey, Designee
Name of Facility:	Starr Commonwealth
Facility Address:	13725 Starr Commonwealth Albion, MI 49224-9580
Facility Telephone #:	(517) 629-5591
Original Issuance Date:	04/01/1991
License Status:	REGULAR
Effective Date:	09/02/2018
Expiration Date:	09/01/2020
Capacity:	240
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATIONS

	Violation Established
It was alleged that a male staff slammed a male youth on the ground and the youth lost consciousness.	Yes
Additional Findings: Staff completed an incident report which did not accurately reflect the restraint or youth injury.	Yes

III. METHODOLOGY

10/08/2018	Special Investigation Intake 2019C0212001
10/10/2018	Special Investigation Initiated - On Site
10/10/2018	Contact - Face to Face Interviews completed on-site
10/10/2018	Contact - Face to Face Preliminary findings reported to Director of Compliance and Quality Assurance
10/11/2018	Contact - Telephone call received Received additional allegations
10/31/2018	Contact - Telephone call made Conference Call with DHHS
11/07/2018	Contact - Document Received Conference Call with LARA Adult Services
11/07/2018	Inspection Completed-BCAL Sub. Compliance
11/29/2018	Contact - Document Received Received additional information
03/18/2019	Exit Conference

ALLEGATION:
It was alleged that a male staff (Staff 1) slammed a male youth (Youth A) on the ground and the youth lost consciousness.

INVESTIGATION:
On 10/8/18 it was reported that Youth A made an allegation regarding Staff 1. Youth A is no longer placed at Starr. Youth A reported that on 2/21/18 he was slammed down on the ground by Staff 1, while being restrained. One peer (Youth C) reported that he saw Youth A get slammed to the ground and lose consciousness. Another peer (Youth B) reported that he did not see Youth A get slammed to the ground. However, Youth B did witness the restraint and felt it was appropriate.

Per the nurse's note on file at Starr, Youth A remembered falling to the ground and losing consciousness briefly. There was no diagnosis of injury at the time and Youth A declined going to the clinic for further evaluation. Later that day, Youth A began to complain of left shoulder pain. Youth A was taken to the clinic to be examined. Per the clinic report, Youth A was alert and oriented. He had no complaints of nausea, vomiting or dizziness. Youth A had full range of motion and was not referred for outside medical care. It was noted that Youth A had injured his wrist on the day prior, from punching a tree. He was seen at the clinic for that incident as well.

Youth A
Youth A was interviewed on 10/8/18. Youth A is no longer placed at Starr; he was placed there from 6/1/16-3/6/18. Youth A stated that he is 17 years old. Youth A reported that while at Starr, he was inappropriately restrained by Staff 1. This occurred on 2/21/18. Youth A verified that on the day before the restraint, he injured his hand when he became upset and punched a tree. After punching the tree, Youth A had an x-ray on his hand, and found there were no injuries. Youth A stated that he has scratches and soreness, but nothing was broken.

Youth A reported that on 2/21/18 a peer (Youth B) started a fight with him. During the fight, Staff 1 attempted to separate the two boys by pushing Youth A up against the wall. Youth A claims that he remembers trying to get away from Staff 1, but could not remember what happened next. Youth A stated he only remembers waking up on the ground with Staff 1 standing over him. Youth A stated that he was taken to the hospital after the incident. The doctor at the hospital said that there was nothing wrong with him. Youth A stated that his shoulder and ribs still hurt to this day. Youth A believes that his ribs were broken in the restraint.

Youth A reported that he once witnessed Staff 1 assault a peer (Youth F) at Starr. Youth A reported that Staff 1 punched Youth F sometime around December 2017. Youth A could not recall any other details about the incident.

Director of Compliance and Quality Assurance
On 10/10/18 the DCQA was notified of the allegations. He reported that Staff 1 has been reassigned pending investigation. The DCQA provided the incident report regarding Youth A and additional requested documents. An incident report could not

be found regarding Youth F in December 2017. Youth F did not have any restraints while at Starr and did not have any injury reports.

The incident report dated 2/21/18, regarding Youth A, was reviewed and stated: "Youth A was in the classroom and he was flinching at peers. He was addressed by peers and staff members to stop this behavior. He then went and invaded the personal space of another peer. A third peer pushed Youth A off the second peers' personal space. Youth A then tried to fight the peer that pushed him. (Staff 1) tried to de-escalate him for several minutes and he tried to get him into the hallway. He refused to move and kept trying to fight the peer. He was then put into an upper torso." The IR did not mention any restraint to the ground, or potential injury or need for medical attention.

A medical noted, dated 2/21/18, written by RN 1 stated: "Student came to the clinic this evening with complaint of left shoulder and scapular pain, which began after being restrained around 11:00 this morning. Student stated that during the restraint, he remembered falling to the ground and that he had lost consciousness for a few minutes. He stated that he initially felt dizzy and had problems hearing for a few minutes afterward. On assessment, student was alert and oriented. PERRL (pupils equal round reactive), no complaint of nausea or vomiting, no dizziness. He was able to perform ROM (range of motion) by slowly lifting arms up over his shoulders bilaterally. Student advised to alternate cold and heat to the shoulder and scapular area, use ibuprofen per protocol. Staff advised to monitor student for symptoms of dizziness, nausea, vomiting or disorientation. Also, student had taken the splint off his right hand, stating that the edge of the splint was rough and irritating his hand. The nurse padded the edge of the splint, applied triple antibiotic and antibiotics to 3rd, 4th, and 5th knuckles of the same hand (scrapes from hitting tree yesterday), then secured the splint with the elastic bandage. After application, capillary refill was less than 3 seconds. If no improvement or worsening of symptoms, student advised to return to the clinic. Student was laughing and chatting with cottage staff when they left the clinic area." The RN's note did not indicate any allegations made against staff.

Youth B

On 10/10/18 Youth B was interviewed on-site at Starr. Youth B reported that he is 17 years old. Youth B stated that he is currently placed in Oliver cottage and doing well. He is a "Big Cat", which means he is a leader on campus. Youth B stated that he has never been restrained. However, he has observed the restraint of others on campus due to physical aggression or fighting. Youth B reported that has never seen any staff restrain without a reason. He has never seen any staff get too rough or witnessed any kids get hurt, other than rugburn or something from fighting the restraint. Youth B stated that he remembers Youth A. Youth B described Youth A as someone who was always cussing, disrespectful to staff, fighting with peers, attempted to sexually act out with peers, did not take things seriously, and generally caused trouble. Youth B apologized, but used an expletive to describe Youth A, and said that was the best way to describe him.

Youth B stated that he witnessed the restraint of Youth A, by Staff 1. Youth B reported that he had his head down on the table across from Youth G during a video at school. Youth B looked up and saw what seemed to be Youth A hitting Youth G. Youth B pushed Youth A away and told him to keep his hands of off peers. Youth A got mad and escalated very quickly. Youth B moved away from him, and Youth A tried to go after him. Staff 1 was trying to keep Youth A from going after Youth B. Youth A made threats to Youth B, such as, "I'm going to get you and f*** you up", "I'm not the one to be messing with". Youth A continued to try to attack Youth B. Staff 1 put his arms around Youth A from the front to keep him back. Youth B described Staff 1 as being very large compared to Youth A. Youth A kept trying to get through Staff 1 to fight Youth B. Staff 1 placed Youth A in an upper torso hold. Youth A was fighting the restraint. Staff 1, "put (Youth A) on the ground". Youth B had moved away from them at that point, so he did not really see what happened. Youth B stated that he only saw Youth A on the ground, being restrained by Staff 1. Youth C later told Youth B that Staff 1 slammed Youth A to the ground. Youth B reiterated that he did not actually see that though and did not believe Youth C. Youth B stated that Youth A did not appear to be hurt after the restraint, but he laid on the ground looking at the ceiling. Youth A was awake and his eyes were open. Staff 1 walked away from Youth A after he would not get up.

Youth B described Staff 1 as "supportive" and "good staff". Youth B stated that he believes Staff 1 knows his strengths and would not slam anyone to the ground. Youth B called Staff 1 a "phenomenal staff". Youth B stated that he had previously seen Staff 1 restrain other kids without any incident. Youth B was asked what other peers were present at the time of this incident. Youth B identified Youth C and Youth F. Youth B described Youth F as a "Big Cat", a good guy, who played basketball. Youth B reported that he never saw Youth F get restrained while at Starr. Youth F completed the program and was able to return home. Youth B described Youth C as someone who has been restrained several times for fighting. Youth C is reportedly not doing well in the program and has stated several times that he wants to get staff in trouble.

Youth B stated that he is eager for Staff 1 to return, as the cottage runs better with him there. Youth B stated that the cottage is cleaner, runs smooth, and the kids appreciate how helpful and nice Staff 1 is.

Youth C

On 10/10/18, Youth C was interviewed on-site at Starr. Youth C reported that he is 18 years old and has been at Starr for approximately eight months. He was placed here by the State of Washington. Youth C was hopeful that he would be leaving the program in January 2019.

Youth C stated that he lives in Oliver cottage, where everything is "pretty good". He stated that he is trying to stay out of trouble. Youth C was asked to describe the staff that work in his cottage. Youth C identified a specific staff as the strongest, most

experienced staff. However, Youth C stated that he gets along well with all staff. Youth C reported that he has been restrained approximately ten times for fighting or being aggressive. He felt that staff overreacted and unnecessarily restrained him to the ground once, but he was not hurt. Youth C did not wish to elaborate on this. Youth C reported that he has never seen any staff restrain when it was not necessary. Youth C stated that staff try really hard not to restrain; they use it as a last resort and want to keep hands off of kids.

Youth C reported that he remembered Youth A. Youth A "tried really hard to get into it with everyone". Youth C described Youth A as being aggressive with staff and kids, always messing up the cottage. On the day of the restraint in question, they were at school. Youth A was swinging his fists at Youth G. Youth B thought Youth A was hitting Youth G, so Youth B shoved Youth A and told him to stop. Staff 1 stepped in between the two to separate them. Youth A kept trying to get around Staff 1. Staff 1 said, "I don't want to restraint you. I don't want to have to put you on the ground". Youth A kept trying to get to Youth B. Staff 1 picked Youth A up and dropped him head first on the ground. Staff 1 went down to the ground too and was on top of Youth A for a moment. Then Staff 1 got up and walked away. No other staff were present to come over to check on Youth A to see if he was ok.

Youth C reported that he was new at the time and did not know what to do. Youth C was asked if it was possible Staff 1 ended up on the ground accidentally with Youth A, while attempting to restrain him. Youth C said it was possible, but they went to the ground hard.

Prior to the restraint on the ground, Youth C did not observe any type of standing hold with Youth A. Staff 1 was blocking Youth A to keep him away from Youth B. Youth A had his back to the wall and Staff 1 was in front of him. Staff 1 was not holding or pushing Youth A against the wall. Youth C was able to accurately describe what a standing hold should look like, and stated that this did not take place.

Youth C could not recall if there was a teacher or any other staff in the classroom at the time. The DCQA later confirmed that Staff 1 was the only adult present that morning, which was within ratio.

Youth C stated that he was restrained by Staff 1 once before. Staff 1 is a "big guy". When Staff 1 got up from the restraint, he put his knee down on Youth C, which really hurt. However, he believes it was accidental. Youth C stated that Staff 1 is one of the favorite staff at the cottage and gets along with everyone. Staff 1 tries very hard not to restrain kids, and is generally good about talking with kids to deescalate them.

Youth C did not recall any time that Youth F was restrained by Staff 1. Youth C then recalled a time he witnessed an improper restraint that occurred with Youth D. However, he did not provide additional details.

Youth D

On 10/10/18 Youth D was interviewed on-site at Starr. Youth D is 16 years old. He has been placed at Starr for about one year and currently lives in the Oliver cottage. Youth D reported that he was previously placed in Allen cottage. Youth D stated that things are going "pretty good" at Starr.

Youth D reported that he has only been restrained once while placed in Oliver cottage. This occurred approximately three weeks ago, on a Monday. The restraint was with Staff 1. Staff 1 stated that he tripped over Youth D's foot and they went down. However, Youth D recalled it differently. Youth D stated that Staff 1 grabbed him and "dropped" him on his head. Youth D reported that he had blood all over his face and his ankle was injured. Staff 1 put cream and band-aids on his face where he had cuts. Youth D saw a Nurse and Doctor. He was found to have a hematoma on his side from the restraint. He was taken to the ER for his ankle.

Youth D stated that he was restrained for fighting with a peer. Staff 1 had him in a standing hold; Youth D was not fighting the restraint. Staff 1 then picked Youth D up and dropped him on his head. Staff 1 also told Youth D that he tripped on Youth D's foot and fell, that's why they were in a floor restraint.

Youth D described Staff 1 as "really cool staff, who helps me out". Youth D does not believe Staff 1 was trying to hurt him and does not feel he would ever hurt kids on purpose. Youth D did not recall Staff 1 ever having an altercation or restraint with Youth F.

After this interview, the DCQA was consulted and confirmed that Starr staff are not supposed to do a single person take down in a restraint, as they are not trained on it. For any restraints to move from standing to a floor restraint, two staff are required. The DCQA was also asked to provide medical documentation for Youth D's restraint involving Staff 1. The DCQA reported that the hematoma Youth D experienced was actually due to an elective surgery that Youth D had the Friday after this incident. The hematoma occurred a week later and was at his incision site which sometimes happens post-surgery. This was verified via medical documentation. However, it was true that Youth D went to the hospital after the restraint.

The medical documentation from the 9/24/18 restraint was provided and stated: "Received call that student was restrained in cottage. Arrived and student was sitting in front door area with a piece of paper towel on head from a rug burn. He has a bruise on left, top, eye lid. No swelling noted, denies any vision changes at this time. PERRLA (pupils equal round react to light accommodation). Denies any other injuries at this time. No nausea, vomiting noted. Student advised to ice as needed and use PRN medication for pain. Sat and talked with student for 30 minutes about issues he was having and to make sure he did not have any other injuries. He was

up and walking and laughing when I left. Advised to come to clinic tomorrow if he has any issues. Staff 3 is aware." Authored by LPN 1.

The 9/24/18 incident report was also reviewed and stated: "Youth D and another peer were engaged in an argument. It should be noted that Youth D has surgery (scheduled) this week and his anxiety has been very high due to this operation. Youth D was upset with this other peer and his behaviors continued to escalate. Staff 1 tried to intervene to have Youth D move to the back with him to diffuse the situation However, Youth D started to get aggressive towards this other peer. Youth D tried to go after this peer and Staff 1 put him in a standing upper torso. During this restraint, Staff 1 tripped over Youth D's foot and they fell to the ground. Neither was injured."

A follow-up 9/25/18 incident report was reviewed and stated: "Youth D complained about his ankle hurting. Staff 4 took him to the clinic. The clinic staff members looked at his ankle and sent him to the hospital for an x-ray. The hospital communicated that it was just a bruise and that it was not broken." The nurse's section of the IR stated, " Student comes to clinic to be seen for right ankle, right wrist pain after a restraint last night. He was not sure how it happened and doesn't remember hitting either extremity on an object. Right wrist has full ROM, no swelling or bruising noted. Right ankle he has swelling and pain over medial side of ankle with palpitation. Walking with slight limp and ROM limited in ankle. He says he was icing but has not taken any medications for pain. He was given Tylenol in the clinic. He was instructed per Doctor to go for x-ray, of right ankle, ice and use Tylenol for pain since Motrin is being held due to surgery on Friday. Staff 4 aware and given x-ray order." Authored by LPN 1.

Youth F

An interview was not completed with Youth F as he is no longer at the facility. An attempt was made to contact his home phone number, but no response was received. As Youth B, C and D, and Staff 1 do not recall any restraints or incidents with Youth F, nor are there any incident reports on file, no further attempts were made.

HR Manager & SCM Trainer

On 10/10/18 the HR Manager/SCM trainer demonstrated an upper torso restraint. He explained that the restraint should be initiated by staff approaching youth from behind, at a 45 degree angle. This restraint should not be initiated face to face, or when the youth is against a wall.

Staff 1

Staff 1 reported that he has been with Starr for over a year. In February 2018 he began working the morning shift, in which he is the single staff present to get the kids up and ready for school. Regarding the restraint with Youth A, Staff 1 stated that he was the only staff present in the classroom. A teacher was in and out of the room, but was not present when the restraint occurred. Staff 1 stated that he

observed Youth A bothering Youth G. Youth G pushed Youth A away. Then Youth B got involved and told youth A to stop picking on other kids. Youth A quickly became angry and Staff 1 tried to verbally redirect him. However, Youth A would not calm down. Staff 1 had been blocking Youth A from getting to Youth B, but Youth A continued to try to attack Youth B. Staff 1 then placed Youth A in a standing upper torso hold. Staff 1 reported that he approached Youth A from the front to initiate the standing hold. Youth A had his back to the wall, but was not being held or pushed against the wall. Staff 1 was trying to talk to Youth A to get him to calm down. Youth A pushed off the wall and pushed them both into a file cabinet, then down to the ground. Once on the ground he was still talking and mouthing off about messing up Youth B. Staff 1 recalled they were on the ground for approximately 30 seconds. One youth (Youth C) was walking around telling everyone that Youth A was knocked out. Staff 1 stated that Youth A was not knocked out. Youth A's eyes were open and he was talking. Youth A appeared to be fine; he had calmed down, but decided to lay on the floor for a few minutes. After the restraint, Youth A did not complain about being hurt. He declined an offer to see the nurse and said that he was fine.

When asked if his intent was to restrain Youth A on the floor, Staff 1 stated that he felt it was necessary as Youth A was fighting the standing hold. However, he did not have a second staff there to assist with a floor restraint.

Staff 1 stated that he does not like restraining or getting "hands on" with kids. Staff 1 was then asked about other kids that he has worked with. Regarding Youth F, Staff 1 stated that he was never any trouble. He was a really good kid and was never restrained. Regarding Youth D, Staff 1 recalled restraining him once in the rec room. Youth D was having a disagreement with a peer (Youth E). Both escalated very quickly. Staff 1 was going to assist Youth D out of the room, to separate them. Youth D ran at Youth E. Staff 1 then placed Youth D in an upper torso hold. Youth D was fighting and stepping on Staff 1's ankle, trying to swing at Youth E. Staff 1 and Youth D both fell to the ground. Youth D reported that his ankle was hurt, so he was taken to the nurse. Youth D also had a rugburn on his face, for which he was provided a band-aid and antibiotic cream. The marks cleared up within two days. Staff 1 reported that Staff 2 was also present for this incident.

Staff 3

On 10/29/18 Staff 3 was interviewed on site. Staff 3 reported that he remembers Youth A. However, he was not present for the restraint in question. Youth A was "trouble in a lot of ways". Staff 3 stated that Youth A had potential, but did not use it. Youth A was given help from a lot of people, but did not accept it. He was aggressive, agitated easily, and was a catalyst for other students.

Staff 3 described Staff 1 as supportive and good to communicate with. Staff 1 is generally on the same page as other staff. Staff 3 has no concerns with how Staff 1 restrains youth, or how he works with kids.

Secondary allegation

On 10/11/18 a second allegation was reported. The Director of Compliance and Quality Assurance reported that Youth E made an allegation regarding Staff 3. This is the same incident in which Staff 1 restrained Youth D. However, the allegation is that Staff 3 improperly restrained Youth E. Staff 3 has been assigned to another unit pending investigation. It was reported that Staff 2 was also present for this incident, and reported that he did not witness any inappropriate actions.

On 10/15/18 and intake was received from Adult Services. The intake stated, “on 9/25/18 Youth E was involved in an incident with another youth. Staff 3 stepped in to stop the incident and used excessive force to restrain Youth E. Staff 3 slammed Youth E’s face against the wall at which time his nose started bleeding. Staff 3 then took Youth E from against the wall and slammed him on the ground. Staff 3 put his knee on the middle part of Youth E’s back and was grinding his knee while continuing to shove Youth E’s face into the ground. After the excessive restraint, Youth E was taken in for a concussion test. Youth E’s nose was bleeding for 24 hours after the incident. On 10/10/18 Youth E was observed with blood in the white of his eyes. Youth E had hit his face hard enough on something that the blood vessel in his eye hemorrhaged. During the excessive restraint, Staff 3 made threats against Youth E. The specifics of the threats are unknown. This is not the first time Staff 3 has been verbally aggressive to Youth E. Youth E has named Staff 3 as someone he does not trust and is more or less afraid of.” It was noted in the intake that the incident report did not reflect the information provided by Youth E. It was also alleged that Starr did not provide a copy of the incident report to Youth E’s DHHS worker.

The incident report dated 9/25/18, was reviewed and stated: “While in the living room preparing for group therapy, Youth E and another student got into an argument about a previous issue. Youth E and this peer continued to go back and forth in an aggressive manner. The Oliver staff members tried to diffuse the situation and stepped in between the other student. The other student got up in a threatening manner towards Youth E. At that time, Youth E got up and tried to go after the other student. Staff 2 and Staff 3 intervened and placed Youth E into a supine restraint. Youth E was asked if he needed medical attention and he was seen by a nurse.” A fax confirmation sheet was attached, verifying that this was sent to Youth E’s worker on 9/26/18 via fax and email.

Staff 1

On 10/29/18 Staff 1 was interviewed on-site. He reported that he was present for the alleged incident with Youth E and Staff 3. Staff 3 was trying to take Youth E down to a floor restraint. Staff 2 was helping guide him to the ground. Staff 2 then went into the hall because the other kids were getting rowdy. Youth E was biting, fighting, and pushing at Staff 3. Staff 3 had his arm in Youth E’s face to block him from spitting or biting. Youth E did not complain about Staff 3 or the restraint, but he did complain about rug burn on the back of his head. Youth E’s eye was observed to be red, maybe from the fight he was in prior to the restraint. Staff 1 denied Youth E having a bloody nose or having any other injuries. Staff 1 stated he has no issues

with Youth E and gets along well with him. Youth E has been having ongoing problems fighting with peers.

Staff 2

On 10/29/18 Staff 2 was interviewed. Staff 2 reported that he was present for the restraint with Staff 3 and Youth E, and Staff 1 and Youth D. Staff 2 reported that Youth D and Youth E were getting into a physical altercation. Staff 3 placed Youth E into a standing restraint, in which he held Youth E's hands behind his back to prevent him from swinging at staff or anyone else. Staff 2 observed that Youth E and Staff 3 were struggling and fell to the floor. Staff 2 observed Staff 3's knee on Youth E's shoulder, but not on his head or back. Staff 2 stated that he stepped in and took Youth E to another room to cool off. Staff 2 reported that he did see blood on the carpet and a scrape/rugburn on the back of Youth E's head. He gave Youth E ice and a towel.

A few days later, Staff 2 did see Youth E with a black eye. Staff 2 reported that he does not believe it was from the restraint, but that it was from the peer punching Youth E before staff could restrain them.

Staff 2 stated that he never saw Staff 3 throw, elbow, or smack Youth E. He did not hear Staff 3 make any threats or inappropriate comments to Youth E.

Regarding that same incident, Staff 2 stated that he was aware Staff 1 was restraining Youth D. Staff 2 stated that he was busy trying to get the other kids out of the class room, to limit spectators, so he did not see all of the restraint. Staff 2 stated that he observed Staff 1 attempting a standing restraint with Youth D. He then observed Staff 1 and Youth D to be in a restraint on the floor. Staff 2 stated that he did not know how they ended up there. Staff 2 denied assisting with either floor restraint. No other staff were present.

Staff 3

Regarding Youth D and Youth E, Staff 3 recalled that incident. Youth D and Youth E were fighting. Staff 1 placed Youth D in a standing hold. Staff 3 observed and saw no issues with the restraint. Youth D was then placed in a restraint on the floor and no issues were observed. When asked for further detail, Staff 3 reported that he recalled they were at school. The kids were supposed to be using light tones in their conversations. Youth D was being very loud and verbal toward Youth E. The two went back and forth for a while, even though staff tried to redirect them. Staff 3 recalled hearing Staff 1 say, "You're going down a bad path". Youth E then challenged Youth D, and both got up from their seats. Youth D may have hit Youth E in the face before staff reached them. Staff 3 and Staff 1 separated them. Staff 3 and Staff 2 got Youth E away and placed him in a restraint on the ground. They tried talking to Youth E to keep him calm, and talk the situation through. Youth E had some rug burn on the back of his head from rubbing his head on the carpet while fighting the restraint. Staff 3 got kicked in the lip by Youth E's foot. After the restraint, Youth E was checked over by the nurse.

Staff 3 stated that prior to the restraint, they tried to verbally deescalate Youth E. However, Youth E continued to escalate along with Youth D. Youth D threw a punch at Youth E. Youth E spit at Youth D. Staff 3 stated that he does not like to restrain kids as it affects their trust and relationship going forward. Staff 3 stated that he was at Starr Inkster as a youth and knows what a lot of these kids have been going through.

Staff 3 stated that Youth E can be socially awkward and talks loud in general. Youth E enjoys comic books and super heroes and Staff 3 tries to engage with him by talking about those things. However, when Youth E starts getting feedback on how to improve, he does not handle it well. Youth E has a lot of potential, but needs to keep his anger and aggression in check.

Staff 3 clarified that he was kneeling, with his right knee next to Youth E's left shoulder. Staff 3 was holding Youth E's hands over his head, against the floor. No one was holding Youth E's feet or torso. During the restraint, Youth E was verbally aggressive and rubbing his head on the floor. After the restraint Youth E did not have a bloody nose and did not complain about any injuries. Staff 3 was not aware of Youth E having any other nose issues that would cause it to bleed.

Youth E

Youth E was interviewed on-site on 10/29/18. Youth E recalled that the incident was about a month ago. Youth E stated that he was fighting with a peer (Youth D) that day, when Staff 3 approached him. Youth E swung his fist at Staff 3. Staff 3 picked him up, threw him at the TV, while shaking him, smacked him in the back of his head. Youth E stated that "blood was all over the wall and carpet" and Staff 3 "kept dropping his knee" on Youth E's face. Youth E stated he had popped blood vessels in his eyes from Staff 3. Staff 1 pulled Staff 3 off of Youth E. Then Staff 3 smacked Youth E in the face, stating "f***ing b****". Staff 3 then got off of Youth E and walked out. Youth E reported that he was spitting up blood and had a black eye from Staff 3's knee. Youth E stated that all of his peers saw this happen. When asked which peers, Youth E stated that none of them are here anymore. Youth E was informed I could get in touch with them even if they are placed somewhere else. Youth E stated that he could not remember which peers were there. Youth E then became quiet for some time before reengaging.

Youth E stated that he does not get along with Staff 3. Youth E will be joking with Staff 3, and Staff 3 mocks and makes fun of him. when talking about marvel (comic book) things, Staff 3 makes fun of him. Youth E was asked for an example and could not give one. He then said that they get along sometimes, but not always.
Youth E was asked if he felt comfortable returning to the cottage. He said he did not know. Youth E was asked if he was scared; he said no. Youth E was asked if he was concerned about his safety; he said he did not know. Youth E was asked if there was anyone he could talk to if he was concerned or felt unsafe; said no, he does not trust anyone.

During the interview Youth E told the story very quickly, with no eye contact, and appeared to be embellishing as he went along. When asked for more detail, Youth E could not provide any, or answered “I don’t know”. Part way through the interview Youth E shut down, had a blank stare, and would not talk. Attempts were made to reengage him, but he would not make eye contact, and stared off. As he was leaving, he asked if what he said would be confidential. He was told that it would be. Youth E laughed and said, “good, they’d be so mad if they knew what I said”. The way he said it gave an impression that “they” would be mad about the version of events he told, not that they would be mad that he told on them.

Youth E was also interviewed separately by Adult Services on 10/12/18. The worker provided her notes from the interview which stated: *“Youth E was arguing with another peer in the cottage and it escalated when the peer stood up and swung on him. Staff 3 then grabbed him around the waist and threw him to the wall by the TV and he was bleeding from the head and he started to go back after the peer and Staff 3 pushed him to the ground with his knee on his left side of his head and he started to fight Staff 3 when Staff 3 told him to shut the f*** up. Youth E admits to swinging to get Staff 3 off of him. Staff 1 pulled Staff 3 off of Youth E and reported that his nose was bleeding and Staff 2 saw blood. Youth E reported has had a headache on the left side but no pain today during the interview. Youth E reports that the incident happened on the rug in the living room. Youth E wants to do good so he can leave in two months. Youth E had nothing else to say.”*

The medical notes for following the 9/25/18 restraint were reviewed and found the following:

> 10/3/18 Medical Note- authored by RN 1. “Call received from Staff 4 stating student complained of spitting up blood since being restrained on 9/24/18. I went to Oliver Cottage and assessed student. Student stated that during a restraint on 9/24/18 someone’s knee was against the side of his head, pinning it against the floor. Student stated that the next morning, he began spitting up blood and since then, when he sniffs, he spits up black, old looking blood and has been feeling pressure in his facial/sinus area. During the assessment, at the nurse’s request, student was able to snuff and spit up what appeared to be old, black blood. Staff stated that the cottage heating system is being used on cooler nights. Breathing was unlabored, no wheezing noted. Student also has what appears to be a small ruptured conjunctival capillaries, which he stated appeared after he was restrained. Staff advised to have student apply a thin layer of petroleum jelly in his nose at night to help with dryness.”
>
> 10/4/18 medical Note authored by RN 3. “This staff re-assess the student complaint about spitting up blood since being restrained on 9/24/18. One of the nurses at the clinic saw him yesterday. He still felt snuffs, spits up black old looking blood and has been feeling pressure in his facial/sinus area. During the assessment, student was able to snuff and spit up what appeared to be old,

black blood. Breathing was unlabored, no wheezing noted. Exam: Ear, throat, normal. Nose: edematous and erythema. Tenderness at frontal and maxillary sinus area. Put the student on Physician's schedule for 10/5/18."

10/5/18 Medical Note by Physician 1. The physician note indicated that old, black, blood was present in Youth E's nose. Youth E stated that he was restrained and had a knee next to his head. He did not indicate that the knee injured him. However, a small hemorrhage in his left eye was noted. His examination showed that he had no other injury. However, there was evidence of sinusitis, for which he was given amoxicillin for the next ten days.

DHHS

On 10/31/18 a case conference was held with DHHS regarding the allegations pertaining to Youth A. DHHS reported no findings. DHHS reported being aware of a previous investigation with Staff 1, in which he allegedly fell with a youth while attempting a restraint. The DCWL SIR 2018C0103021 associated with this information was reviewed and found: *(Staff 1) was interviewed in person at Starr Commonwealth on April 11, 2018. Staff 1 stated he took over the upper torso restraint being conducted by (another staff) and, being concerned that she was a female resident, he leaned away from her. (The resident) kicked her feet on the wall and they fell. (Staff 1) stated he let go of Resident A as they fell. (The resident) never said anything to (Staff 1) about being injured. He stated if (the resident) did get hurt it was because she was struggling and fighting the hold. He stated (the resident) did go to the clinic afterwards.*

Adult Services

On 11/7/18 contact occurred with Adult Services (AS). AS reported that they considered the incident with Youth E to be an "improper use of restraint technique causing injury to the client, but not maliciously done by the staff person".

Documents reviewed

Case files for Youth A, D, and E were reviewed for additional information. However, no other information relevant to the allegations was found.

The Human resources files for Staff 1 and Staff 3 were reviewed and the following information found:

Staff 1

- Hired on 5/14/17
- Clearances ok at the time of hire.
- Signed policy & procedures and job description.
- Current on SCM training.
- No disciplinary action on file.

Staff 3

- Hired 8/8/16
- Clearances were ok at the time of hire.
- Orientation/training 8/9/16
- 11/17/16 Performance review- Satisfactory
- 3/19/18 Performance Improvement Plan- sleeping during shift (plan effective until 6/20/18) review Disciplinary action if he does not follow plan.
- 5/30/18 Positive coaching for improvement in effort to complete daily tasks & communication
- 8/1/18 Coaching- he became frustrated with student inappropriate comments
- 8/8/18 Performance Review- Satisfactory
- 9/26/18 coaching- improper incident report documentation
- Terminated employment in March 2019.

Director of Compliance and Quality Assurance

A preliminary exit conference was held on 10/10/18 with the DCQA, prior to the secondary allegations being reported. At that time, the agency was informed that there was an issue with incident reports not being filled out completely. For example, the IR from 2/21/18 did not mention that Youth A had gone to the ground in the restraint. With an allegation later being made about this incident, it would appear that Staff 1 was attempting to hide information at the time he wrote the IR. In addition, it was discussed that the investigation would likely find a violation regarding restraints. Staff 1 appeared to attempt to move a youth from a standing restraint to a floor restraint without assistance of another staff, which is not allowed. In addition, Staff 1 stated that he lost his balance and fell, which is how they ended up on the ground. As this excuse was stated in a prior investigation, and stated again later in regard to Youth D, it appears suspicious. The DCQA agreed staff "falling" would not be an acceptable excuse to youth being injured in a restraint. The DCQA stated that they have implemented weekly refresher SCM training, and will have monthly SCM training at staff meetings. They will also review IR requirements with staff.

A final exit conference occurred on 3/18/18. The DCQA reported that Staff 3 is no longer employed at Starr. Staff 1 received additional training and has been doing very well since this complaint was initiated. There have been no further concerns.

APPLICABLE RULE	
R 400.4159	**Resident restraint.**
	(1) An institution shall establish and follow written policies and procedures regarding restraint. These policies and procedures shall be available to all residents, their families, and referring agencies.

ANALYSIS:	The agency is found to be in violation of this rule, as staff did not follow the agency's approved restraint procedures. In addition there is concern about Staff 1's reoccurrences of falling while attempting to restrain youth. Regarding the restraint of Youth A by Staff 1- Youth A reported that Staff 1 held him up against a wall, and the next thing he knew, he was waking up on the floor. Two peers were present. One peer stated that Youth A was not held against that wall, but he did witness Staff 1 pick Youth A up and slam him to the ground. The other peer stated that Youth A was not held against the wall, and he did not see Staff 1 improperly restraint Youth A to the ground. That peer also did not believe Staff 1 would do what was alleged. When interviewed Staff 1 reported that he was blocking Youth A and attempted to initiate a standing restraint, which he was then going to move to a floor restraint. At that time, Staff 1 fell, taking Youth A to the ground. Youth A and Youth C report that Youth A was unconscious on the ground. Staff 1 and Youth B report that Youth A did not pass out, and that he was awake and talking on the ground. A medical examination after the restraint found no indication of concussion, head, neck or other injury to support the allegations. It should be noted that Staff 1 admitted to approach Youth A from the front, while the youth's back was to the wall, to initiate the standing restraint. This is against SCM protocol. Lastly, the incident report was vague and did not indicate anything about Staff 1 and Youth A going to the ground. As Staff 1 admitted that he and Youth A ended up on the ground, it appears suspicious that there was no mention of this in the IR. Therefore, while it is unclear exactly how the restraint moved from standing to the ground, it is evident that the restraint was not carried out according to SCM guidelines. Regarding the restraint of Youth D by Staff 2- Youth D reported that Staff 2 picked him up and dropped him on his head, then restrained him on the floor. Youth D also stated that he did not believe Staff 2 was intending to hurt him. Staff 2 reported that he was attempting a standing restraint with Youth D, when he tripped on the youth's ankle and fell, taking them both to the ground. A medical note indicated that Youth D was seen for an injured ankle. During the medical exam Youth D stated that he was unsure of how the injury occurred. Again, while the accounts of this restraint vary, the fact that Youth D was injured due to Staff 1 falling, is concerning. This is an indication that the restraint process was not carried out as trained in SCM.

	Regarding the restraint of Youth E by Staff 3- Youth E reported that Staff 3 was physically violent towards him when attempting the restraint. No peer witnesses were identified to have observed this incident. Staff 3 denied these allegations. Staff 1 and Staff 2 indicated that they witnessed the restraint and found that Staff 3 was appropriate and did not act in the manner described by Youth E. However, both staff reported that Staff 3 moved the restraint from standing, to a floor restraint without any additional staff assistance, which is not an approved technique. Youth E was seen by the nurse and a physician due to reports of a broken blood vessel in his eye, and a bloody nose. It was determined that the eye injury was likely due to the fight that Youth E was in prior to the restraint, and the dried blood in his nose was due to sinusitis.
CONCLUSION:	**VIOLATION ESTABLISHED** **This is a repeat violation from the 1/24/18 SIR 2018C0103021, CAP approved 7/30/18, and 3/17/19 SIR 2018C0212024, CAP pending.**

ADDITIONAL FINDINGS:
Staff completed incident reports which did not accurately reflect the restraint or potential youth injury.

INVESTIGATION:
During the course of this investigation two incident reports were found to be lacking information.

The incident report dated 2/21/18, regarding Youth A, was reviewed and stated: "Youth A was in the classroom and he was flinching at peers. He was addressed by peers and staff members to stop this behavior. He then went and invaded the personal space of another peer. A third peer pushed Youth A off the second peers' personal space. Youth A then tried to fight the peer that pushed him. (Staff 1) tried to de-escalate him for several minutes and he tried to get him into the hallway. He refused to move and kept trying to fight the peer. He was then put into an upper torso." The IR failed to note that staff attempted to move the youth to a floor restraint. The IR did not mention any potential injury or need for medical attention.

The incident report dated 9/25/18, was reviewed and stated: "While in the living room preparing for group therapy, Youth E and another student got into an argument about a previous issue. Youth E and this peer continued to go back and forth in an aggressive manner. The Oliver staff members tried to diffuse the situation and stepped in between the other student. The other student got up in a threatening

manner towards Youth E. At that time, Youth E got up and tried to go after the other student. Staff 2 and Staff 1 intervened and placed Youth E into a supine restraint. Youth E was asked if he needed medical attention and he was seen by a nurse." A fax confirmation sheet was attached, verifying that this was sent to Youth E's worker on 9/26/18 via fax and email. The incident report stated that Staff 2 & 3 placed Youth E into a supine restraint. This is incorrect as Staff 2 reported he was not part of this restraint.

APPLICABLE RULE	
R 400.4159	**Resident restraint.**
	(3) The written policy shall include all of the following: **(c) Procedures for recording restraints as an incident report.**
ANALYSIS:	The agency is found to be in violation of this rule. The incident reports were lacking detailed information about the full course of events in the restraint, or potential injury after the fact.
CONCLUSION:	**VIOLATION ESTABLISHED** **This is a repeat violation from the 3/30/18 SIR 2018C0112023, CAP approved 7/11/18, and 3/17/19 SIR 2018C0212024, CAP pending.**

IV. RECOMMENDATION

Upon approval of an acceptable corrective action plan, the recommendation is to continue the regular status license.

Heather Reilly
Licensing Consultant

March 18, 2019
Date

Approved By:

Claudia Triestram
Area Manager

March 19, 2019
Date