STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

August 20, 2019

Steven Laidacker
Lakeside
3921 Oakland Dr
Kalamazoo, MI 49008

RE: License #: CI390201235
Lakeside
3921 Oakland Drive
Kalamazoo, MI 49008

Dear Mr. Laidacker:

Attached is the Renewal Inspection Report for the above referenced facility completed on August 19, 2019. Due to the violations, a written corrective action plan is required. It should be noted that violations of any licensing statutes rules and are also violations of the ISEP and your contract. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each citation will be achieved.
- Who is directly responsible for implementing the corrective action for each licensing statute and rule or section of the contract or ISEP citation.
- Specific time frames for each citation 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.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

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 Claudia Triestram, the area manager at (616) 552-3662.

Sincerely,

Paul Fatato, Licensing Consultant
MDHHS\Division of Child Welfare Licensing
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-2471

enclosure

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #: CI390201235

Licensee Name: Lakeside

Licensee Address: 3921 Oakland Dr
Kalamazoo, MI 49008

Licensee Telephone #:

Administrator/Licensee Designee: Donald Nitz, Designee

Name of Facility: Lakeside

Facility Address: 3921 Oakland Drive
Kalamazoo, MI 49008

Facility Telephone #: (269) 381-4760

Original Issuance Date: 04/01/1990

CMH Funded Facility Yes

Program Type	Setting	Gender	Capacity	From Age	Thru Age	Behavior Mgt. Room	Location
Treatment	Open	MALE	10	12	17	NO	Zeus I
Treatment	Open	MALE	10	11	17	NO	Zeus II
Treatment	Open	MALE	24	12	17	NO	Helios
Treatment	Open	MALE	22	11	17	NO	Apollo
Treatment	Open	MALE	19	12	17	NO	Hercules
Treatment	Open	MALE	24	12	17	NO	Poseidon

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 8/12/19, 8/14/19 & 8/19/19

Date of Fire Inspection: "A" rating on 8/5/19

Date of Environmental/Health Inspection: "A" rating on 7/15/19

	Total No. of Records	No. of Records Reviewed
No. of current residents (***secure-treatment***)	n/a	
No. of current residents (***secure-shortterm***)	n/a	
No. of current residents (***open-treatment***)	123	17
No. of current residents (***open-shortterm***)	n/a	
No. who have left the program since the last inspection (***secure-treatment***)	n/a	
No. who have left the program since the last inspection (***secure-shortterm***)	n/a	
No. who have left the program since the last inspection (***open-treatment***)	81	8
No. who have left the program since the last inspection (***open-shortterm***)	n/a	
No. of Facility Restraints since the last inspection	796	12
No. of Facility Seclusions since the last inspection	n/a	

No. of current employees who have worked at the facility for:		No. of Records Reviewed
More than a year	84	8
Less than a year	47	47

No. Of persons Interviewed:

Direct Care Staff	4
Supervisory Staff	4
Administrators	2
Residents	4

The following required records were on file and available for review:

Program Statement	☒ Yes	☐ No	☐ NA
Program Policies	☒ Yes	☐ No	☐ NA

Item	Yes	No	NA
Staff Training Records	☒	☐	☐
Income/Expenditure for current year, including most recent Financial audit	☒	☐	☐
Staff TB Screening Records	☒	☐	☐
Staff to Resident Ratio	☒	☐	☐
Posted Notice: Criminal History Check for employees and volunteers	☒	☐	☐
Criminal History and Child Protection Registry Checks for employees and volunteers	☒	☐	☐
Volunteer Supervision Policy	☒	☐	☐
Behavior Management Room Log	☐	☐	☒
Meal Menus	☒	☐	☐

III. DESCRIPTION OF FINDINGS

<table>
<tr><td colspan="2">1.) The facility is in compliance with all applicable rules and statutes except for the following:</td></tr>
<tr><td>R 400.4113</td><td>Employee records.</td></tr>
<tr><td></td><td>An institution shall maintain employee records for each employee and
shall include documentation of all of the following information prior to employment or at the time specified in this rule:
(c) Verification of high school diploma or GED when specified by rule.</td></tr>
<tr><td colspan="2">Ten of forty-seven new hire (since the past inspection) employee files reviewed did not have documentation of the education verification in the personnel file prior to hire. This involved four files with no education verification in the file and six files with education verification after the hire date.</td></tr>
<tr><td>R 400.4113</td><td>Employee records.</td></tr>
<tr><td></td><td>An institution shall maintain employee records for each employee and
shall include documentation of all of the following information prior to employment or at the time specified in this rule:
(e) Three dated references which are obtained prior to employment from persons unrelated to the employee and which are less than 12 months old.</td></tr>
<tr><td colspan="2">Thirteen of forty-seven new hire employee files reviewed did not have documentation of three references being completed prior to the date of hire.

This is a repeat violation from the 2018 Annual Licensing Study Report with an approved CAP on 10/24/2018.</td></tr>
<tr><td>R 400.4113</td><td>Employee records.</td></tr>
<tr><td></td><td>An institution shall maintain employee records for each employee and
shall include documentation of all of the following information prior to employment or at the time specified in this rule:
(f) A record of any convictions other than minor traffic violations from either of the following entities:
(i) Directly from the Michigan state police or the equivalent state law enforcement agency, Canadian province, or other country where the person usually resides or has resided in the previous 5 years.</td></tr>
</table>

	(ii) From an entity accessing either Michigan state police records or equivalent state, Canadian provincial, or other country law enforcement agency where the person usually resides or has resided in the previous 5 years.
One of forty-seven new hire employee files reviewed did not have documentation that the criminal background check was done prior to hire. The employee was hired on 10/8/18 and the background check was completed on 11/28/18.	
R 400.4113	**Employee records.**
	An institution shall maintain employee records for each employee and shall include documentation of all of the following information prior to employment or at the time specified in this rule: (g) If the employee has criminal convictions, the institution shall complete a written evaluation of the convictions that addresses the nature of the conviction, the length of time since the conviction, and the relationship of the conviction to regulated activity for the purpose of determining suitability for employment in the institution.
Twelve of forty-seven new hire employee files reviewed that had documentation of a criminal conviction, did not have the required written evaluation to address the criminal conviction.	
R 400.4113	**Employee records.**
	An institution shall maintain employee records for each employee and shall include documentation of all of the following information prior to employment or at the time specified in this rule: (i) Documentation from the Michigan department of human services, the equivalent state or Canadian provincial agency, or equivalent agency in the country where the person usually resides, that the person has not been determined to be a perpetrator of child abuse or child neglect. The documentation shall be completed not more than 30 days prior to the start of employment and every 12 months thereafter.
Two of forty-seven new hire employee files reviewed did not have documentation that the Central Registry Check was completed prior to the date of hire.	
R 400.4113	**Employee records.**
	An institution shall maintain employee records for each employee and

	shall include documentation of all of the following information prior to employment or at the time specified in this rule: (j) A written evaluation of the employee's performance within 30 days of the completion of the probationary period or within 180 days, whichever is less, and a written evaluation of the employees' performance annually thereafter.
Six of thirty-one new hire employee files reviewed that required the 90-day evaluation did not have documentation in the file that the evaluation was completed. **This is a repeat violation from the 2018 Annual Licensing Study Report with an approved CAP on 10/24/2018.**	
R 400.4114	**Tuberculosis screening for employees and volunteers.**
	The licensee shall document, prior to employment, that each employee and volunteer who has contact with residents 4 or more hours per week for more than 2 consecutive weeks is free from communicable tuberculosis. Freedom from communicable tuberculosis shall be verified within the 1-year period before employment and shall be verified every 1 year after the last verification or prior to the expiration of the current verification.
Three of forty-seven new hire employee files reviewed did not have documentation that the Tuberculosis screening was completed prior to the date of hire.	

R 400.4155	**Institutions not detention institutions or shelter care institutions; initial treatment plan.**
	(1) The social service worker shall complete, sign, and date an initial treatment plan for each resident within 30 calendar days of admission.

1 of 6 contracted open Abuse and Neglect resident files with an Initial Service Plan required during this Period Under Review (PUR) did not have the ISP completed on the correct form. This single report was completed on an Updated Service Plan form.

Four of eight Initial Treatment Plans of contracted Juvenile Justice files reviewed during this Period Under Review (PUR) did not have the dates for the report period documented on the report.

This is a repeat violation from the 2018 Annual Licensing Study Report with an approved CAP on 10/24/2018, 2017 Renewal Licensing Study Report with an approved CAP on 9/15/2017 and from the 2016 Annual Licensing Study Report with an approved CAP on 10/10/2016.

R 400.4156	**Institutions not detention institutions or shelter care institutions; updated treatment plan.**
	(1) The social service worker shall complete, sign, and date an updated treatment plan for each resident at least once every 90-calendar days following the initial treatment plan.

Five of five contracted open Abuse and Neglect resident files with Updated Service Plans reviewed during this PUR did not have the USP completed as required. This involved the following issues with the Updated Service Plans reviewed:

- Eight of nine Updated Service Plans with report period dates reviewed had overlapping dates between the reports.
- One of nine Updated Service Plans did not have report period dates present. (The facility is beginning to use a new completed system for reports and this system does not allow for documentation of the report period dates within the reports. This is addressed in the Technical Assistance Section)
- Two of the nine Updated Service Plans reviewed did not document a narrative for the scoring of the Mental Health and Well-being section of the report.
- One of the nine Updated Service Plans reviewed had the Independent Living score as a need, but this was not recorded in the summary section as a need.

- One of the nine Updated Service Plans reviewed was completed three days late. The report period ended on 1/11/19 and the report was completed on 1/14/19.

Six of ten Updated Treatment Plans of contracted Juvenile Justice files reviewed during this PUR did not have all of the requirements for an Updated Treatment Plan documented. This involved the following:

- Two of ten UTPs did not have the narrative in all domains explaining the scoring on the CANS documented in the report,
- Four of ten UTPs did not have the report dates documented in the report.

This is a repeat violation from the 2018 Annual Licensing Study Report with an approved CAP on 10/24/2018, 2017 Renewal Licensing Study Report with an approved CAP on 9/15/2017 and from the 2016 Annual Licensing Study Report with an approved CAP on 10/10/2016.

R 400.4156	**Institutions not detention institutions or shelter care institutions; updated treatment plan.**
	(3) The updated treatment plan shall include all of the following information: (b) Progress made toward achieving the goals established in the previous treatment plan.

Three of five contracted open Abuse and Neglect resident files with Updated Service Plans reviewed during this PUR did not have the goal progress appropriately documented in the USP. This involved the following issues:

- One of the nine Updated Service Plans reviewed did not have the goal progress documented within the report.
- Six of the nine Updated Service Plans reviewed did not have updated information documented in the goal progress section of the report. The information presented in the report read exactly the same as the previous report for several of the goals.

Two of ten Updated Treatment Plans of contracted Juvenile Justice files reviewed during this PUR did not have progress on each goal documented in the report.

This is a repeat violation from the 2018 Annual Licensing Study Report with an approved CAP on 10/24/2018 and 2017 Renewal Licensing Study Report with an approved CAP on 9/15/2017.

R 400.4156	**Institutions not detention institutions or shelter care institutions; updated treatment plan.**
	(3) The updated treatment plan shall include all of the following information: (c) Changes in the treatment plan, including new problems and new goals to remedy the problems. Indicators of goal achievement and time frames for achievement shall be specified along with a specific behavior management plan designed to minimize seclusion and restraint and that includes a continuum of responses to problem behaviors.
One of five contracted open Abuse and Neglect resident files with Updated Service Plans reviewed during this PUR did not document new objectives for identified goals in the plan. The documentation indicated the goal was completed but the narrative indicated additional issues continued and no new objective was identified. This involved four Updated Service Plans for one resident. One of ten Updated Treatment Plans of contracted Juvenile Justice files reviewed during this PUR did not have changes in the treatment plan documented. The report had no objectives for issues that continued after it was documented the resident accomplished the objectives.	
R 400.4156	**Institutions not detention institutions or shelter care institutions; updated treatment plan.**
	(5) The social service supervisor shall approve, countersign, and date the updated treatment plan.
One of ten Updated Treatment Plans of contracted Juvenile Justice files reviewed during this PUR did not have all of the required signatures on the report. The report was missing all of the signatures.	
R 400.4166	**Discharge plan.**
	(1) When a resident is discharged from institutional care, all of the following information shall be documented in the case record within 14 days after discharge: (a) The date of and reason for discharge, and the new location of the child.

	(b) A brief summary or other documentation of the services provided while in residence, including medical and dental services. (c) An assessment of the resident's needs that remain to be met. (d) Any services that will be provided by the facility after discharge. (e) A statement that the discharge plan recommendations, including medical and dental follow up that is needed, have been reviewed with the resident and with the parent and with the responsible case manager. (f) The name and official title of the person to whom the resident was discharged.
One of four contracted Juvenile Justice resident files reviewed did not have the behaviors regarding the reasons for the discharge documented in the Discharge Summary. **This is a repeat violation from the 2018 Annual Licensing Study Report with an approved CAP on 10/24/2018 and the 2017 Renewal Licensing Study Report with an approved CAP on 9/15/2017.**	

2.) Any violation listed in section 1 is also an ISEP violation. Please note that there are additional ISEP requirements that may not be included in section 1. The facility is in compliance will all additional ISEP requirements.

3.) Any violation listed in section 1 is also a DHS Contract/Policy violation. Please note that there are additional DHS Contract/Policy requirements that may not be included in section 1. The facility is in compliance will all additional DHS Contract/Policy requirements except for the following:

RFCJJ Contract Oct 17: 2.10.f.1-2 Page 13-14	**Supervisor signature**
	The signature page of the treatment plan shall be uploaded to MISACWIS when the supervisor signs the plan within 14 days of the Report Date.
One of eight Initial Treatment Plans of contracted Juvenile Justice files reviewed during this Period Under Review (PUR) not have the Supervisor's Signature uploaded in the MiSACWIS system.	

This is a repeat violation from the 2018 Annual Licensing Study Report with an approved CAP on 10/24/2018 and 2017 Renewal Licensing Study Report with an approved CAP on 9/15/2017.	
RFCAN Contract Oct 17: 2.10.r. – Page 24	**Contractor Responsibilities-Services to be Provided-Wardrobe/Personal Possessions**
	The Contractor shall assure that children have an adequate wardrobe as defined by and documented on the Clothing Inventory Checklist (DHHS-3377) while in placement and upon leaving placement. When the child is absent or at the conclusion of the placement, the Contractor shall have a process in place to keep the child's wardrobe and possessions safe until claimed by the child or DHHS. If the possessions are not claimed within 90 calendar days, the Contractor may dispose of the items at its discretion.
Two of four contracted closed Abuse and Neglect resident files reviewed did not have the required Wardrobe documentation completed at the time of the resident leaving the facility.	

IV. TECHNICAL ASSISTANCE

The facility was offered technical assistance in the following areas

- The facility was providing a supervisor for the case managers. The case managers were completing the Service plans and Treatment plans. It was suggested that the facility employ a master's level individual with a background in therapy to supervise the case managers. This would ensure that the service plans and treatment plans had a strong therapeutic focus. They agreed that this was needed and indicated that they will begin to look into changing their current process. We also discussed having the residents master's level therapist write most of the plans and again they will look into making this change.
- We discussed the changes in the number of violations involved in the employee files and it was suggested that they develop a system of oversite to ensure that the requirements are being met. They will look into this change and make it part of the corrective action plan that will be required.

- We discussed the new computer system for resident files and the lack of report period dates. They understand that they need to make adjustments to the program, so the dates are included on the quarterly reports.

V. CONSULTATION

The facility was offered consultation in the following areas:

- The process of hiring an individual with a strong therapy base and knowledge of the compliance issues was discussed with the facility. It was suggested that they could fill this need with a part-time person as long as they had the necessary background.

VI. EVALUATION OF RENEWAL PERIOD

The facility has submitted five acceptable corrective action plans not related to maltreatment during this licensing period.

The first corrective action plan submitted and approved involved SI 2018C0214029. The original allegations of a staff not using appropriate restraint techniques were found to be supported during the investigation. The employee involved in the inappropriate action had suffered a head injury during the restraint and appeared to be emotionally dysregulated. The facility's corrective action plan involved the retraining of all direct care staff on the specific aspect of dealing with a resident when the staff has some form of injury or is dysregulated. This training took place during team meetings (September 27, 2018 and October 4, 2018) and involved one hour of course training and one hour of role-playing different scenarios. The facility also indicated expanding the training curriculum for all staff with a focus on more in depth information into the different types of situations they may face.

The second corrective action plan submitted and approved involved SI 2018C0214030. The original allegations of a staff not providing appropriate supervision and physically abusing residents were found to not be supported during the investigation. Additional finding involving staff allowing residents to "practice wresting techniques" without this activity being approved by the administration. The facility administration agreed that this staff was not following the appropriate procedure for engagement with residents. The facility's corrective action plan involved the staff involved in the incident receiving a disciplinary waring and the assignment of additional training on resident to staff boundaries. The additional training included, "Boundaries, Therapeutic Boundaries and Ethical Decision Making". The staff was given until November 30, 2018 to complete the required additional training. All direct care staff are also required to complete the "Boundaries" training by the end of January 2019. The facility also added additional cameras to the area the incidents took place and additional weekly camera reviews were scheduled by the management team.

The third corrective action plan submitted and approved involved SI 2019C0214001. The original allegation involved a resident being assaulted by a staff. This allegation and additional finding were discovered during this investigation. Evidence supported that the staff was overly aggressive and did not follow the facility's procedures for behavior management of a resident. The additional findings involved staff noting following the licensing rule and the facility's procedure to assure compliance with the child protection law. The incident occurred on a Saturday and no report was made

until the following Tuesday. The facility's corrective action plan involved refresher training with all staff covering the staff being mandated reports and training for all staff on self-regulation when working with difficult youth. The facility reported that they are adding training with a specific focus on Trauma to help staff understand that their behavior may trigger youth with trauma. Finally, the facility reports that they have changed their policy for compliance with the child protection law to include the "mandated reporter resource guide and the MDHHS child protection law".

The fourth corrective action plan submitted and approved involved SI 2019C0214008. The original allegations of a staff not using appropriate restraint techniques were found to not be supported during the investigation. However, additional finding were uncovered through the course of the investigation. Evidence discovered supported the finding that staff did not follow the facility's procedure for providing space (proximity) when confronting a youth who was acting out. The staff involved presented as escalating the situation rather than providing a deescalating presence. The facility's corrective action plan involved a change to their de-escalation policy to reflect a clear primary and secondary strategy when dealing with escalated youth. All staff are scheduled to completed orientation training (new staff) and quarterly refresher training on the facility's new de-escalation policy. The facility reports that they will continue to monitor each incident during camera reviews at the "Incident Review Committee Meeting".

The fifth corrective action plan submitted and approved involved SI 2019C0214025. The original allegations of a staff not using appropriate restraint techniques were found to not be supported during the investigation. However, additional finding were uncovered through the course of the investigation. These additional finding involved a staff not following the behavior management techniques of encouraging residents to resolve their issues in a positive manner. The staff made negative remarks to the resident involved. The facility's corrective action plan involved the training of all staff on professional and therapeutic boundaries on March 27 and March 238, 2019. They reported that the staff involved attended this required training. The facility also reported that trainings will continue to occur during team meeting, quarterly and annually.

The facility submitted a corrective action plan in response to their 2018 Annual Inspection. The following were identified as violations with an approved corrective action plan and in compliance unless otherwise noted:

R 400.4113 e Employee records - **Continued non-compliance**
R 400.4113 j Employee records - **Continued non-compliance**
R 400.4155 1 Initial treatment plan - **Continued non-compliance**
R 400.4155 3a Initial treatment plan
R 400.4155 3b Initial treatment plan
R 400.4155 3c Initial treatment plan
R 400.4156 1 Updated treatment plan - **Continued non-compliance**
R 400.4156 3b Updated treatment plan - **Continued non-compliance**
R 400.4166 Discharge plan - **Continued non-compliance**

RFCJJ Contract Up to Date MiSACWIS
RFCJJ Contract Supervisor Signature - **Continued non-compliance**
RFCAN Contract Planned Discharge Contact

Interviews were conducted with different levels of staff and residents. The staff present with a strong desire to provide best practice and many had a working knowledge of the trauma-based approach. The staff interviewed were able to identify the different interventions they were using with different residents. Residents present with a feeling of being safe and that staff has their well-being in mind.

VII. RECOMMENDATION

Based on inspection findings the facility is not in compliance with all applicable licensing statutes and rules and/or ISEP requirements and/or contract/policy. Upon receipt of an acceptable corrective action plan, it is recommended that the facility will be issued a renewal of their regular license.

_______________________________ 8/19/2019_
Paul Fatato Date
Licensing Consultant

Approved By:

August 20, 2019
____
Claudia Triestram Date
Area Manager