STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

November 12, 2019

Steven Laidacker
Lakeside
3921 Oakland Dr
Kalamazoo, MI 49008

RE: License #: CI390201235
Investigation #: 2019C0214063
Lakeside

Dear Mr. Laidacker:

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.

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

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
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	CI390201235
Investigation #:	2019C0214063
Complaint Receipt Date:	09/24/2019
Investigation Initiation Date:	09/24/2019
Report Due Date:	11/23/2019
Licensee Name:	Lakeside
Licensee Address:	3921 Oakland Dr Kalamazoo, MI 49008
Licensee Telephone #:	Unknown
Administrator:	Donald Nitz, Designee
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
License Status:	REGULAR
Effective Date:	09/18/2019
Expiration Date:	09/17/2021
Capacity:	126
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

	Violation Established?
Bits Intakes: 167899 Allegation 1: On 9/23/19, it was reported that while Resident A was being restrained, Staff 3 allegedly punched Resident A in the face.	No
Bits Intakes: 167980 Allegation 2: Today (9/24/19) around 2:55 P.M, Staff 7 argued with Resident D and pushed him down.	Yes
Bits Intakes: 167972 Allegation 3: On an unknown date and time, staff member, Supervisor 2 came into Resident F's room at his dorm and pushed him and slammed him up against the bunk bed.	No
Bits Intakes: 167901 Allegation 4: Approximately two weeks ago, Resident K is alleged to have pulled Resident J's pants down while he was sleeping and ejaculated him. Resident J woke up and reported this incident to the unknown staff member.	Yes
Bits Intakes: 168072 Allegation 5: Last week, Resident M reported that Staff 14 punched Resident M in the ribs.	No
Bits Intakes: 168149 Allegation 6: Staff 23 took her hand and backhanded Resident R in the face.	Yes
Bits Intakes: 168390 Allegation 7: Resident S was restrained today, 10-10-19. Resident S has marks, scrapes and bruises from the restraints. Staff 25 told Resident S that if he told anyone in the administration building that he would kill Resident S.	No
Additional Findings	No

III. METHODOLOGY

09/24/2019	Special Investigation Intake 2019C0214063
09/24/2019	Special Investigation Initiated - Telephone
09/25/2019	Contact - Document Received-email from facility of allegations 3 reported
09/27/2019	Contact - Face to Face – Interview with Resident K and Resident G
09/28/2019	Contact - Document Received – email from facility of allegations 5 reported

09/30/2019	Contact - Document Received – Human Resources and policy information from the facility.
10/01/2019	Contact - Face to Face – Interviews with: Administrator B, Resident M, Resident O, Resident P, Resident N and Nurse 2.
10/01/2019	Contact - Document Received - email from facility of allegations 6 reported
10/02/2019	Contact - Face to Face – Interviews with: Staff 14.
10/02/2019	Contact - Document Received – Email of safety plan
10/03/2019	Contact - Document Received – Restraint Policy
10/07/2019	Contact - Face to Face – Interviews with: Administrator A, Administrator B, Administrator C, Resident A, Resident B, Resident G, Resident H, Therapist A, Supervisor 1, Supervisor 2, Supervisor 3, Supervisor 4, Supervisor 6, Staff 1, Staff 5, Staff 6, Staff 8, Teacher A,
10/07/2019	Contact - Document Received – Human Resources, Incident reports, Resident face sheets, Resident written statements, overnight room checks facility investigation and action plan for overnight room checks.
10/08/2019	Contact - Face to Face – Interviews with: Administrator A, Administrator B, Administrator C, Administrator D, Staff 2, Staff 14. Staff 15. Staff 16, Staff 22, Therapist C, Nurse 1, Teacher B, Resident I, Resident N and Resident.
10/08/2019	Contact - Document Received – Resident face sheets, Overnight bed checks log, Resident safety plan and Human Resources information.
10/10/2019	Contact - Face to Face – Interview with: Staff 23.
10/10/2019	Phone interview with Staff 7.
10/11/2019	Contact - Document Received – Email of personnel available for upcoming interviews.
10/14/2019	Contact - Face to Face – Interviews with: Supervisor 2, Supervisor 5, Supervisor 8, Staff 4, Staff 9, Staff 10, Staff 11, Staff 24 and Case Manager A.

10/14/2019	Contact - Document Received – Residents face sheet
10/15/2019	Contact - Document Received – Resident Residential Updated and Initial Service plans.
10/16/2019	Contact - Document Received – Description of device used for overnight room checks.
10/17/2019	Contact - Document Received – Human Resources information.
10/18/2019	Contact - Document Received - Human Resources information.
10/22/2019	Contact - Face to Face – Interviews with: Administrator A, Supervisor 8, Staff 21, Staff 25 and Staff 26.
10/22/2019	Contact - Document Received – Resident medical information, Resident Residential Updated Service Plan and Human Resources information.
10/28/2019	Contact - Face to Face – Interviews with: Supervisor 8, Staff 25, Staff 26, Nurse 3, Resident S and Resident T.
10/28/2019	Contact - Document Received – Human Resource information, Resident Residential Updated Service Plan,
10/29/2019	Contact - Face to Face – Interview with Resident S.
10/29/2019	Inspection Completed On-site
10/29/20129	Exit Conference with Administrator A and Administrator B.
10/31/2019	Contact - Document Received – Human Resources information.
10/31/2019	Inspection Completed-BCAL Sub. Compliance

ALLEGATION 1:

There were three allegations made by Resident A, which each have some differences. The three are as follows:

On 9/23/19, it was reported that while Resident A was being restrained, Staff 3 allegedly punched Resident A in the face. Resident A allegedly suffered either a bloody nose or

mouth in addition to having a bruise on the side of his neck. It is unknown if Resident A is afraid of Staff 3 or if he complains of pain. Resident A was examined by the nurse on staff; however, the details of his examination is unknown. The video footage of the incident shows that Staff 3 restrained Resident A for less than two minutes. There was no assault, bloody nose, or mouth observed.

The following information was also provided by the complainant:

> Additional information: the complainant stated that the Program Executive Director, Administrator A, reviewed the video footage along with staff as she'd would spoke with licensing. Administrator A also spoke with the group living facility director, Administrator B. The complainant stated that she had no information regarding Resident A's DOB or family as she'd have to locate it in a different system and was unaware the information would be required to file a complaint. The complainant stated that Staff 3 is still on shift currently.
>
> On 9/23/19 Supervisor 1 punched Resident A in the face and elbowed him in the lower abdomen. He did have some redness on his cheek, but not likely to bruise. He has no bruising on his abdomen. Supervisor 1 also restrained Resident A, but it is unknown how he was restrained. Prior to being restrained Resident A was "riled up", because another peer was disrespecting a female staff person and that upset Resident A. It is unknown what Resident A was doing during the restraint. Typically, there is more than one staff involved when a restraint occurs, but it is unknown who else other than Supervisor 1 was involved. It is unknown if the restraint was done properly, however staff have been trained to properly restrain. There have been prior issues with Resident A that required him being restrained, but nothing chronic. He did not require any medical attention or treatment. There is a restraint form that was signed by the nurse on staff. It is unknown if the incident was captured on surveillance. It is unknown if Supervisor 1 has a history of restraining or physically abusing the residents.
>
> On 09/23/2019, Resident A was talking to another resident, Resident C, about Resident C being physically retrained for no reason. Staff member, Supervisor 1, stated to Resident A "it is coming to you soon". Resident A replied "no, because I am doing my work". Supervisor 1 then cleared the classroom and Resident A was put into an issue with Supervisor 1. Supervisor 1 stated to Resident A "so you like punching other kids" and Resident A replied "no". Supervisor 1 made the same statement to Resident A and Resident A again replied "no". Supervisor 1 then pushed Resident A from behind and Resident A fell into Supervisor 2. Supervisor 1 then bear hugged Resident A and slammed him to the ground. Supervisor 1, Staff 2, Supervisor 3, and Supervisor 2 then put Resident A into a supine restraint. Supervisor 1 punched Resident A in the face and then Supervisor 1 choked Resident A with his forearm on his throat. Resident A was grasping for air and when Resident A told Supervisor 1 that he could not breathe, Supervisor 1 responded "I know". After a few seconds, Supervisor 1 took his forearm off of Resident A's throat.

While Resident A was still in the supine restraint, Staff 2 took his elbow and began jamming it into Resident A's waist. Staff 2 was twisting his elbow and rotating it as hard and as fast as he could. Staff 2 then lifted Resident A's shirt and jammed his elbow into Resident A's ribcage. Staff 2 did the same motion as hard and as fast as he could, on Resident A's ribcage, skin to skin. Staff 2 then returned to his position in the supine restraint, which was at Resident A's waist.

A short time later, Supervisor 1 gave a verbal command "that is good" and all the staff members released Resident A from the restraint. Staff 1 was also present and stood at the classroom door and made sure that no one else witnessed the incident. There are no cameras in the classroom where the incident occurred. Due to there being no cameras in that part of the facility, that is where the staff members will restrain the residents. After the incident with Resident A, the same staff members attempted to clear the classroom again and create an issue with another student, Resident B.

After the incident, Resident A's face was broke out and the left side of his face was swollen from Supervisor 1 punching Resident A in the face. Resident A also had blood in his mouth and nose after the incident. Resident A's leg is sore and Resident A was limping yesterday. It is unknown why Resident A's leg was sore or why he was limping. It is unknown if Resident A has any injuries on his waist or by his ribcage from Staff 2.

INVESTIGATION:

Interview with Administrator A (Executive Director) and Administrator B (Living Services Director) at the facility on 10/7/19. They both report being aware of the allegations and when asked about their knowledge of the allegations they gave the following report,

> We have no cameras in the classroom, but on October 12, 2019, installation of cameras in the classrooms is scheduled to begin. There is a video of Resident A’s restraint by Staff 3 but there was nothing inappropriate and Resident A has indicated that the allegations do not involve Staff 3 but rather Supervisor 1. Resident A told his therapist that it was not Staff 3 but rather Supervisor 1. We have moved Resident A from Helios dorm to Apollo dorm as part of the safety plan. Resident A has presented three different stories about the allegations

Interview with Resident A at the facility on 10/7/19. Resident A reported that he has been moved to the Apollo dorm from the Helios dorm since he made the allegations. He was asked about the three different stories about the allegations and reported, “I believe I was restrained by Staff 3 in the hallway of the Helios dorm on the morning of October 23rd. I got restrained because I hit someone in the face.” Resident A was asked about the second allegation and he reported,

> I was hit in the face by Supervisor 1 and elbowed in the stomach by Staff 2. This happened in the classroom where there are no cameras. I'm not sure why they restrained me because I was not riled up over anything. I had just came back from a trauma assessment. The other residents were standing in the hallway because there was another resistant taking place in the classroom. Five minutes later I spoke with Resident C and he said that he had a dirty restraint because they put him in a seater. I told him I agreed with him because I wanted to make him feel good and not left out. Supervisor 1 then told me that it would soon be me in a restraint. Supervisor 1 has been saying this kind of thing to me for a while. He said that because I got into a fight with someone that I would pay for it. We went into the classroom and Supervisor 1 looked at me for a few seconds and told everyone to clear the classroom. Then he told me to stand up and accept my expectations (this was referred to as taking responsibility for a behavior). I stood up and put my hands to my sides. Supervisor 1 asked if I liked to punch kids just before he bear hugged me and slammed me to the ground. I never resisted the restraint.

Resident A was asked about the actions when the restraint began,

> I was on the ground and Supervisor 1 put his forearm on my neck. I said I can't breathe, and he said, "I know". They put me in a supine and Supervisor 1 hit me in the face. Staff 2 rubbed his elbow in my stomach and rib cage. Supervisor 1 then got up and told them "he's had enough". Then he said that if I didn't get up slowly, they would do it again.

Resident A was asked about possible witnesses to the allegations and he indicated that Resident B saw it through the window. Resident A was also asked about feeling safe and he reported that he does feel safe.

Interview with Resident B at the facility on 10/7/19. Resident B was asked about his knowledge of witnessing the allegations and he provided the following information,

> I looked through the window in the door and saw that they had Resident A in a supine. I didn't see anyone punch or choke him. I think I saw them put a finger or an elbow in his ribs and this is not appropriate.

Resident B was asked about feeling safe at the facility and he indicated that he feels safe with residents and staff.

Interview with Therapist A at the facility on 10/7/19. Therapist A reports working as a Limited Licensed Master Level Therapist as the facility for the past three months. He also reports being the therapist for Resident A. He was asked about his knowledge of the allegations and gave the following report,

> Resident A told me during a therapy session on 9/24/19 at 2:00 pm. He said that he had a conversation with another resident about a dirty restraint earlier in the day. He said that Supervisor 1 overheard their conversation and threatened him by saying that he would be the next issue. Resident A told me that he told Supervisor 1 that he would not be the next issue because he was doing his schoolwork. He said that the staff then called a critical (this action results in other residents being moved from the area) and he didn't know why he was being placed in a verbal issue. He indicated that Supervisor 1, Supervisor 4, Staff 1 and Staff 2 were present at the time. He shared that Supervisor 1 told him to stand up, so he stood up with his hands at his sides. Then it was reported that Supervisor 1 said "so you like punching kids" to which Resident A replied 'no' and Supervisor 1 repeated the statement. He told me that Supervisor 1 walked behind him and nudged him into Supervisor 2 at which point, Supervisor 1 put him into a bear hug and slammed him to the ground. Resident A said that Supervisor 1 then punched him in the face and used his forearm to choke him. He said that he told Supervisor 1 that he couldn't breathe, and Supervisor 1 responded with" I know". He reported that Supervisor 1 then took his forearm off his neck.

Therapist A was asked about how he learned about the restraint with Resident A and what actions he takes when learning about a restraint. He reported that following the restraint, he is notified by email and then he will make time to talk to the resident. His goal is to help the resident (Resident A in this case) process the incident. Therapist A continued his recall of the information Resident A shared with him during a therapy session,

> Resident A said that Staff 2 took his elbow and jammed it into his stomach. He also said that Staff 2 grinded his elbow into his stomach. The Staff 2 lifted up Resident A's shirt and jammed his elbow in his stomach again. After which he made circular motions with his elbow on Resident A's stomach.

Therapist A reported that he took Resident A to Nurse 1's office to be examined but that he was unaware of the conversation between Resident A and Nurse 1. Therapist A was asked about the allegation that Resident A had a bloody nose and mouth but denied seeing this on Resident A. He did suggest that it may have looked like Resident A's face was swollen near the left cheek bone, but Resident A never mentioned this to Therapist A. Therapist A indicated that Resident A told him there were witnesses to the restraint and named three different residents. Therapist A reported that he questioned Resident A about how these residents could have witnessed the restraint since they were not in the room. He indicated that he received no response to this question.

Interview with Supervisor 1 at the facility on 10/7/19. Supervisor 1 reports working as a Program Coordinator at the facility since 2010. He was asked about his knowledge

of the allegations and indicated remembering the incident that is supposed to have taken place in the allegations. He gave the following report,

> I know that he was restrained earlier in the day because he had hit another resident. I had yet to process this incident with Resident A. I try to process with each resident the incident they were involved in to make sure they are doing alright. I received a call to come to the Wellness building (classrooms are located in this building) because the residents were being disruptive. I sat in the classroom and noticed that Resident A was acting funny (this was described as struggling to sit still, pay attention and making loud comments to others). I told Resident A to chill out and do his work. Then I asked him to step into the hallway so we could talk about what is going on with him. He refused to leave so I had the classroom cleared so we could process what emotional struggle he was having. He shared being upset over an earlier restraint and began to calm down. I wanted to get the other residents back into the classroom, so I asked him to follow me out into the hallway. Just as we were walking out of the classroom, Resident A football tackled me from behind. I hooked his shoulders and took him to the ground.

Supervisor 1 was asked about the events that took place after the beginning of the restraint, and reported:

> We went into a supine hold once on the floor and I had his legs. My back was to the other staff involved but I kept talking to Resident A throughout the restraint. I was trying to deescalate him. Staff 2, Supervisor 2 and Supervisor 3 all saw Resident A tackle me. I don't recall where the teacher was at this time and I never observed a resident looking through the door window. I ended up on his legs because another staff rotated in and grabbed his arms. I never tried to choke him and was never near his neck. I had rotated to his legs. No one punched him or put their elbows into his ribs.

Supervisor 1 was able to identify the treatment plan for Resident A and shared how Resident A is working on anger issues. He reported that Resident A had put together six to seven positive weeks but still struggles with his anger. He also reported that the majority of the restraints of Resident A involve him punching other residents. Supervisor 1 ended by indicating that he keeps distance between himself and Resident A at this time. This allows other staff to work at processing issues with Resident A.

Interview with Supervisor 2 at the facility on 10/7/19. He reports working at the facility as a Group Leader for the past year and a half. He also reports working on the Apollo dorm. He was asked about the allegations and provided the following,

> Resident A was in the classroom cursing and the teacher asked him to stop. Supervisor 1 and myself placed him in a verbal (staff verbally

> engage residents in an effort to help them identify and take responsibility for their behavior). Resident A accepted the verbal and I began to walk away. I was going to sit back down. I heard footsteps and turned around to see Resident A grabbing Supervisor 1 by his side. It looked like he was trying to tackle Supervisor 1. They went to the floor and Resident A was placed in a supine hold. I had his arms and Supervisor 1 had his legs.

Supervisor 2 denied seeing anyone elbow or punch Resident A. He also denied that anyone twisted Resident A's elbows. He also reports that the other residents were moved to the hallway because Resident A had become a threat to the group. Supervisor 2 ended by reporting that he heard someone ask Resident A if he wanted to see the nurse, but he was unable to identify who made this statement.

Interview with Supervisor 3 at the facility on 10/7/19. Supervisor 3 reports working at the facility in the role of a Group Leader for the past three years. He also reports working on the Poseidon dorm. Supervisor 3 was asked about his knowledge of the alleged incident and he gave the following information,

> When I came into the classroom, Resident A was already in the supine restraint. I don't remember which staff were where in the restraint. I do recall that Supervisor 1, Supervisor 2 and Staff 2 were involved. I believe the restraint was handled appropriately. I never witnessed anyone punching or using their elbows on Resident A. The other residents were in the hallway and some staff (he was not able to identify who) said that a resident peeked in the door window. I believe I was told it was Resident B who looked in the window, so I addressed this with him. Resident B laughed and said that the restraint was inappropriate. He never specified what was inappropriate about the restraint. I left before the restraint was completed and went into the hall to support the staff there.

Supervisor 3 was asked about his awareness of the restraint being appropriate and he indicated that he is a Safety Crisis Management instructor. This is the behavior management technique used by the facility. He also indicated the restraint was appropriate.

Interview with Supervisor 4 at the facility on 10/7/19. Supervisor 4 reports working at the facility as a Group Leader for the past year. He also reports working primarily on the Kratos dorm. He was asked about his knowledge of the alleged incident and he provided the following,

> I was in the hallway after dealing with a prior resident when they began to clear the classroom. I heard noises coming from the classroom that sounded like some type of struggle. I went into the classroom and it looked like Resident A was trying to grab Supervisor 1 from behind. They transitioned Resident A into a supine at which time I had his right arm. Staff 2 had the left arm with Supervisor 2 on the top (this is described as

> the area of the wrists). Supervisor 1 had his legs and was never near Resident A's head. No one punched or elbowed him, and he never said anything during or right after the restraint about being punched or elbowed. At the end of the restraint, Supervisor 1 asked if he wanted to see the nurse and he said "no". Then the group came back in, he sat down, and everything seemed fine.

Interview with Staff 1 at the facility on 10/7/19. She reports working as a Youth Counselor and School Point for the past five years at the facility. She described the position of School Point as the staff who stays engaged in the school building during school hours to provide additional supervision for residents. Staff 1 was asked about her involvement and knowledge of the allegations and she gave the following report,

> I went into the classroom during the restraint and I first saw the staff transitioning Resident A to a supine hold. I stood near the door so I could watch other residents in the hallway and the restraint. The teachers were also in the hallway for supervision. One kid looked through the window, but this happened quickly. The restraint was appropriate and when it was over, I didn't notice any marks on Resident A. he was crying at the end and just sat in his chair until the other residents came back into the room. He never said that he was hurt, and I remember a staff (unable to identify which one) ask him if he wanted to see the nurse. I don't remember his response.

Interview with Teacher A at the facility on 10/7/19. She reports working as a teacher at the facility for the past two years. She also reports teaching all subjects. She was asked about her knowledge of the allegations and gave the following report,

> Prior to the restraint, Resident A was being disruptive towards other students and he kept moving around the classroom. He was asked to sit down several times but refused and seemed to be escalating. There were twelve students in the classroom and when staff began to address Resident A for his behaviors, he just got angrier. I moved the other students to the hallway. I think a student did look in the window, but I can't remember which student it was.

Teacher A was asked about the verbal addressing of Resident A by staff and if she noticed any marks on him following the restraint. She gave the following response,

> The staff were very appropriate in addressing him and seemed to want him to deescalate. As for marks, I didn't notice any and I was very close to him later. I spoke with him, but he didn't want to talk about anything, so I didn't push the issue.

Interview with Staff 2 at the facility on 10/8/19. He reports working at the facility as a Youth Counselor for the past two years. He also reports working on the Apollo dorm

beginning in August of this year. Staff 2 was asked about his awareness of the allegations and he provided the following information,

> I was part of the restraint after I received a staff call to the Wellness Center (school building on campus). I was in the gym (located in the same building) processing another issue with another resident when I got the call. When I came to the classroom, I observed the other residents in the hallway and when I entered the room, Supervisor 1 had Resident A in an upper torso hold. Resident A was kicking and trying to get out of the hold and Supervisor 1 transitioned him to a supine. I assisted with the restraint and never observed anyone punching or elbowing Resident A. The restraint ended and I believe that someone asked him if he wanted to see the nurse, but I can't remember who it was.

Interview with Nurse 1 at the facility on 10/8/19. She reports working as a Registered Nurse at the facility for the past year and a half. She also reports meeting with Resident A on the day of the restraint involved in this allegation. She provided the following information,

> I saw Resident A at the pm med cart and that's when he told me that Supervisor 1 hit him in the face, and he was elbowed in the lower abdomen. He didn't have any blood on his nose or mouth areas, but there was a redness around his cheeks. This didn't look like it came from an assault but rather like he rubbed his face to make it red. He told me he was badly bruised on his abdomen, so I had another staff witness my observation of his abdomen. There was no marks or bruising on his abdomen or other parts of his body. I had no concerns of his condition but reported what he told me.

Interview with Supervisor 5 at the facility on 10/14/19. He reports working as a Group Leader on the Kratos dorm for the past year and three months. Supervisor 5 was asked about his awareness of the situation in the allegations and he provided the following information,

> As I walked into the room, Supervisor 1 and Resident A were talking. Resident A appeared to get mad and threw some stuff on the ground. Then he ran at Supervisor 1 and bull rushed him (described as a low football type tackle). Supervisor backed up and transitioned Resident A into a supine hold. Supervisor 1 tried an upper torso hold but transitioned because it appeared that they would have fallen to the ground if he went through with the upper torso. Resident A was frustrated and resisting the restraint. He started kicking his legs so the person (unable to recall who) holding his legs changed to a better position. No one ever punched, choked or elbowed Resident A. The restraint was appropriately conducted.

Supervisor 5 ended by reporting that he heard Resident A say that he felt safe at the end of the restraint. He was able to report hearing that Resident A was asked about seeing a nurse but not sure who asked it.

A phone call interview with Staff 4 took place on 10/14/19. Staff 4 reports working as a Youth Counselor in different dorms at the facility for the past three months. He reports remembering assisting Nurse 1 with her inspection of Resident A and he gave the following report,

> I remember Nurse asking me to be a witness at the evening med cart and when I looked at Resident A, I didn't see any marks. He lifted his shirt and there were no marks, bruising or scars of any kind. There was no blood on his face but one of his cheek bones was a little red. He complained of something happening during a restraint.

None of the personnel files reviewed had documentation of a staff using inappropriate restraint techniques. This involved a review of Supervisor 1, Supervisor 2, Supervisor 3, Supervisor 4, Staff 1 and Staff 2's personnel files. Disciplinary action for infractions (late for work, improper supervision and failure to complete paperwork) were documented, corrective action plans appeared appropriate and all corrective action plans were documented as being completed. The facility provided their "progressive discipline policy" which is documented to have taken place in the personnel files.

A review of the Safety Crisis Management (SCM) behavior management techniques provided documentation that the staff did engage in an appropriate restraint with Resident A. An upper torso restraint transitioning to a supine hold is outlined in the technique's manual.

A review of the written documentation (Incident Report #19-09-23-007, Debriefing Report #19-09-23-007 and four Supplemental Incident Reports #19-09-23-007) all describe the restraint in similar terms as the verbal descriptions during the interviews (meetings) with staff.

A review of Resident A's last Residential Updated Service Plan provided documentation of the focus of Resident A's treatment while at the facility. Each goal presents as measurable and appropriate. Each goal addresses the issues that Resident A was experiencing when he entered care at the facility. Further documentation indicates that Resident A is receiving individual and group therapy sessions as required.

ALLEGATION 7:

Resident S was restrained today, 10-10-19. Resident S has marks, scrapes and bruises from the restraints. The marks are on his arms and hands. It is unknown what happened that Resident S needed to be restrained. Staff 25, Supervisor 8, and Staff 26 (workers) were involved in the restraint. Staff 25 told Resident S that if he told anyone in the

administration building that he would kill Resident S. The workers are still on campus, but Resident S is in another dorm. It is unknown if there was any video of the incident because of the limited amount of disclosure.

Resident S did not feel safe at the facility, so he went AWOL and was gone for about 18 hours.

The following allegations were made after Resident S spoke to the police: The staff at the facility have been physically assaulting residents, taking them into areas where it is known that there is no camera coverage. Staff 25, Supervisor 8, Staff 26, and Supervisor 1 specifically have been involved in assaults where Resident S was the victim. Resident S has been assaulted on four different occasions in multiple areas where there is no camera coverage. One staff member will restrain Resident S while another punches him in the ribs, face, and other areas. During one of the assaults a sweatshirt was placed over Resident S face making it difficult for him to breath. One staff admitted that a sweatshirt was used to prevent Resident S from spitting while the other staff denied that a shirt was involved at all.

INVESTIGATION:

Interview with Administrator A (Executive Director) at the facility on 10/22/19. She reports being aware of the allegations and indicated that Resident S has been having significant problem behaviors since being placed in the facility on 4/18/19. She also reports that he has been very disruptive and aggressive with both residents and staff. She stated, “Staff 25 is almost the only staff that can deescalate him and help him calm down. We are scheduling a Family Team Meeting (FTM) with a focus of moving him to a dorm with residents more able to keep from being bullied by him. This other dorm has residents his own size, but the issue is that it’s not an abuse and neglect dorm, so we need permission from his worker to have him moved.”

Interview with Staff 25 at the facility on 10/22/19. He reports working at the facility for the past five years and is currently working as a Group Leader on the Helios Dorm. Staff 25 was asked about the allegations and he reports remembering the incident. He gave the following report.

> I never told him that I would kill him. This started when he threw a punch at me and knocked my glasses off my face. Just before that happened, I had to separate him from the rest of the group because he was antagonizing his peers. He was very aggressive with them and keep trying to get his peers not to follow staff’s directions. I started to move the group on, and he only got more escalated. He started cursing and making threats at me. He said that he was going to come after me. After he took the swing at me Staff 26 went hands on. He was strongly resisting Staff 26 and dropped his weight. This caused them to go to the ground where I engaged, and Supervisor 8 became involved. He was very angry at me and kept his focus on me.

Staff 25 was asked if he was upset when Resident S hit his glasses off his face. He suggested that he doesn't get upset and indicated that he has experienced much worse with residents' aggression. He was asked of the position of staff during the restraint and he recalled that it ended as a supine restraint with Staff 26 holding the arms and hand. He also recalled that he was holding his midsection or legs (struggled to recall) with Supervisor 8 also holding him. Staff 25 was asked to recall what occurred at the end of the restraint,

> I let the other staff take over because I was his focus. When we are a focus we need to avoid contact as much as possible, so they are able to deescalate without the trigger in front of them. He was upset and crying but I didn't see any marks on him.

Staff 25 was asked about the events leading up to the incident,

> He was engaged in horseplay and this always ends up in a fight. The newer staff wasn't aware that we are not to take balls to the Atlas center and when I started to take the balls away, I think this started him going. He kept saying that I didn't want him to have any fun. I kept talking to him trying to deescalate him as much as possible, but he escalated.

Staff 25 was asked about Resident S's performance in the program and he replied that Resident S tends to make a lot of threats to his peers and engages in aggressions towards his peers. He also reported that Resident S attempted to attack a female staff earlier this morning and he was able to deescalate him.

Interview with Supervisor 8 at the facility on 10/22/19. He reports working at the facility as a Campus Coordinator for the past six years on second shift. He was asked about his understanding of the allegations,

> When I got to the Atlas Center, Resident S was running around and starting stuff with the other kids. He was trying to fight kids and we were trying to transition the group to the cafeteria. Me and another staff took the group to the cafeteria and when we got there a resident pointed out to me that Resident S was in a verbal outside of the Atlas Center. I made sure we had coverage for the group and started moving towards the Atlas Center. I noted that he appeared to be showing aggression towards Staff 25. By the time I got there they were in the process of a restraint on the ground. Resident S was fighting by kicking and hitting the staff involved. I grabbed his arms with Staff 26 and Staff 25 had his legs. I may have had his midsection, but I can't recall. We held him down until he calmed down and at this time Supervisor 1 came up. As we released him, Staff 25 walked away to avoid triggering him again. We asked if he wanted to see the nurse and he said, "fuck no and fuck you". I looked him over and didn't see any marks.

Supervisor 8 ended the interview by stating that he never heard Staff 25 make any negative remarks or threaten to kill Resident S.

Interview with Staff 26 at the facility on 10/22/19. Staff 26 reports working at the facility for the past two years and is currently working as a Group Leader on the Helios Dorm. He was asked about the allegations and provided the following report,

> Prior to the restraint, Resident S kept arguing and picking fights with everyone. I asked another staff to help transition the group to the cafeteria. Resident S kept arguing with Staff 25 and he started swearing at and threatening staff. He had started walking towards the cafeteria when he escalated and saying that he was going to beat Staff 25's ass. We closed proximity and worked at trying to deescalate him. Then he swung on Staff 25 and I grabbed him. I had him in an upper torso when he dropped his weight. We went to the ground and he kept fighting. He was trying to kick Staff 25 and he was fighting to get his arms loose. On the ground, he was still fighting when Supervisor 8 came and helped. I had his arms; Supervisor 8 had his mid-section and Staff 25 had his legs.

Staff 26 recalled that when the restraint was over, he took Resident S to see the nurse. He also recalled observing an old scratch on his arm that was scabbed over. Staff 26 reports asking Resident S about the scratch and being told by Resident S that he received the scratch when he was jumping fences while AWOL. Staff 26 was asked about the allegation of Staff 25 saying he would kill Resident S and he denied hearing that from Staff 25. Staff 26 was asked about Resident S's behavior prior to the incident and he recalled that he was AWOL the day before and upon his return he said, "I'm going to catch another charge so I can go to prison with my brother". Staff 26 indicated that Resident S was supposed to be on "staff shadow". Staff shadow requires a youth to be within arm's length of a staff for 24 hours upon return from AWOL to ensure that the resident has support if he should become emotionally dysregulated again. He ended the interview by reporting that the restraint was appropriate.

Interview with Administrator A (Executive Director) and Administrator B (Living Services Director) at the facility on 10/28/19. Both report that the local police had spoken to Resident S late last week about the allegations and that Resident S had added to his reported allegations. The additions to his initial allegations are the information contained in the second paragraph of the allegations above. This additional information was not initially reported. They also report that they are following the safety plan that was developed when they first learned about these allegations.

Interview with Resident S at the facility on 10/28/19. He reports being placed at the facility about eight months ago and that he is lodged on the Apollo Dorm. He was asked about the allegations and gave the following information,

> It happened a couple of hours after I returned from going AWOL. We were going to dinner and they (staff Supervisor 1, Supervisor 8, Staff 25 and Staff 26) told me to stay back. We were the Atlas Center. They restrained me and put a shirt in my face. They said that they were restraining me because I ran truant. Supervisor 8 said that he would kill me, it wasn't Staff 25 who said it. Staff 25 put the sweater over my face. I don't' know why, maybe it was to keep me from screaming. They put me in a seater position and pushed my head between my legs.

Resident S was asked about possible witnesses to the restraint and he indicated that the other residents were not present but may have seen it occur. He denied that he swung at Staff 25 or that he resisted the restraint. Resident S was asked about feeling safe at the facility and he reported that he doesn't feel safe because staff engage in "dirty restraints". He shared a belief that staff are "trying to hurt me when they restrain me". He also suggested that Supervisor 1 and Supervisor 8 try to hurt him. He was asked about his progress in the program and gave the following response,

> I don't need to work on anything here. I just need to find a place to go. I don't want anything here and I wish I could just get out of here. I'm not willing to work on any changes while I am here.

Interview with Resident S on 10/10/2019. The following are the notes from the DHHS investigator's interview:

> Face to face contact made with Resident S. Forensic interview occurred. Resident S appeared tired but was appropriately dressed. There were no bruises observed on Resident S but there were several large scratches on his arms and smaller ones on his hands. Resident S allowed this worker to take photographs of his injuries. Resident S reported that all of the marks are from the staff at the facility. Resident S was asked to tell this worker about being restrained today. Resident S asked "which time?" Resident S stated that he was restrained 3 different times today. Resident S was asked why he was being restrained and he stated that he was "playing around too much." Resident S stated that the staff pulled his shirt over his face so he could not breathe, and a worker threatened to kill him if he told anyone. Resident S was asked which staff member did this to him and he refused to name any names for fear of retaliation against him. This worker tried repeatedly to try and get Resident S to disclose who threatened him and he refused every time. This worker wrote down the names of the three staff members that were listed in the complaint and asked if Resident S could point to the name that threatened him and he refused. Resident S was asked how he is restrained, and he asked what this worker meant by that. This worker asked him how the staff members are restraining him, and he said that he does not really know but most of the time it is with their hands. Resident S stated that it has been a couple of staff members who regularly harm him while restraining him and the same staff member

continues to threaten him. Resident S stated that he is very fearful for his safety if he stays at the facility. Resident S stated that he has been at the facility for 6-7 months and does not have a good relationship with a single staff member. Resident S stated there is no staff member that he trusts because they are all connected, and he will be retaliated against for anything that he says. Resident S stated, "if I say something it will not be pleasant." Resident S was asked how often he is being restrained and he stated that the staff is physical with him every day. Resident S was asked how often they leave marks and bruises and he stated that they "pretty much always leave marks and bruises." Resident S stated that him and his peer, Resident T, tried to make a run the other day because they kept getting restrained by staff and they caught them and brought them back. Resident S stated that after they were brought back, they were restrained in the Titans lounge. Resident S stated that on his way down to see this worker this evening he was told by a staff member to tell this worker that he does not know what happened. This worker tried to engage Resident S again to disclose who is threatening him and he refused again stating that they would be back in the morning. This worker asked if Resident S was fearful of the two staff members who were outside of the room and he said yes. Resident S was informed that another worker will be out soon to speak to him, and it is very important that the department is informed who is threatening his life so we can address it right away. It should be noted that throughout this whole interview Resident S was speaking very softly so the staff outside of the door could not hear. He had a glazed over appearance and seemed very frightened to be returned to the staff. This worker asked if Resident S has any way of making telephone calls during the day and he said no. This worker still provided Resident S with a business card in case anything happens, and he needs to speak to someone. Resident S was informed that this worker will advise the staff that he is not to be harmed, threatened, or retaliated against in any way. Resident S was thanked for his time.

Interview with Resident T at the facility on 10/28/19. He reports being at the facility for the past two and a half months and resides on the Poseidon Dorm. He was identified by Resident S as the individual who went truant with him. Resident T was asked about going truant and he indicated “if you go truant you get to change dorms, but it does cost you extra time here”. Resident T was unable to identify if Resident S was hurt while truant. He did suggest that they went truant because “staff keep threatening” them. He was unable to provide any first hand knowledge of a restraint of Resident S.

Interview with Staff 25 at the facility on 10/28/19. This is the second interview with Staff 25 and was conducted because of a second allegation involving Resident S. Staff 25 was asked about the allegations of a sweater or sweatshirt being put in Resident S’s face during the restraint in the original allegation. He provided the following recall,

> I used a sweatshirt I found on the ground, but it was never near his face. I kept it about three feet away from him and only held it up when it looked like he was going to spit on me. The sweatshirt was left behind by a resident. This occurred on 10/10/19 outside of the Atlas Center and this is the only resistant involving Resident S that I have been involved with. No one put anything near his face, and I would stop any staff that might do that. I have never seen that happen.

Interview with Supervisor 1 at the facility on 10/28/19. Supervisor 1 reports working as a Program Coordinator at the facility since 2010. Supervisor 1 was asked about his knowledge of the allegations involving Resident S and he provided the following,

> I was in my office when I heard a staff call. When I got there, Resident S was in a supine restraint. I became involved and held his legs. I don't know about him spitting but never observed anyone put anything near his face. Generally, we will use our hands to block spit if the resident is trying to spit on us. If I saw or heard about a staff putting something in a resident's face, I would report it and send them off campus. The restraint was appropriate.

Supervisor 1 indicated that he has observed some of the restraints that Resident S has had and suggested that Resident S will fight many of the restraints, especially when the restraint goes to a supine hold.

Interview with Supervisor 8 at the facility on 10/28/19. This is the second interview with Supervisor 8 and was conducted because of a second allegation involving Resident S. Supervisor 8 was asked about his awareness of the second allegation and he reported the following,

> When I got there, they were already on the ground and I helped by taking the middle, upper legs. I don't remember seeing a sweatshirt being used. We are not allowed to put anything in the resident's face and if they are going to spit, we will hold something up, but it must be away from their face. The whole restraint happened quickly.

Interview with Staff 26 at the facility on 10/28/19. This is the second interview with Staff 26 and was conducted because of a second allegation involving Resident S. He was asked about his knowledge of the second allegation and provided the following information,

> I don't remember seeing a sweatshirt. I was holding his arms and I don't remember where Staff 25 was. No one put anything in his face and I never heard him trying to spit. If a kid is spiting, we will use our forearms or hands to block it. If a staff is not being appropriate in a restraint, I will remove that staff immediately.

Interview with Nurse 3 at the facility on 10/28/19. She reports working as a Registered Nurse at the facility for the past ten years. She was asked about her observations of Resident S after his return from being truant and after the restraint on 10/10/19. She gave the following report,

> I saw him right after he returned to campus after being AWOL. I asked him if I needed to see anything and he said no. He said that he had no injuries and he didn't show me anything. I saw him again at the morning med cart after the restraint and he didn't say anything about injuries or pain. He has never come to nursing sharing that he had bruising or injuries for any of his restraints.

Nurse 3 was asked about marks or bruising on residents following restraints and she indicated "if the kid fights the restraints there is a good chance they will have some type of mark. It depends on how aggressive they are being."

Interview with Resident S at the facility on 10/29/19. This interview took place in the classroom of Resident S. He again reported that he was unwilling to work on any goals while at the facility. He indicated having a negative attitude and that he didn't care what the program would provide for him. He began to engage with others in the room and their focus was on being negative in the program.

A review of the written incident report (#19-10-10-007) supported the verbal statements provided by the staff interviewed. This written document also has evidence that Nurse 3 was able to observe Resident S but that he did not require or ask for medical attention.

A review of the camera video provided documentation of Resident S running around the Atlas Center throwing a ball. Staff can be seen attempting to speak to him, but he quickly runs away. He appeared to be engaging other residents to also avoid staff. Currently, the area outside of the Atlas Center where the restraint took place is not within the view of a camera. Administration indicated that cameras are being installed and this area will be covered by a camera within a couple of weeks.

A review of the resident's service plans provided the following description of his overall progress in the program:

> Resident S is struggling to adhere to the rules and expectations of Lakeside Academy. Resident S was slowly turning his behaviors around after having a few bad weeks. That progress came to a halt when Resident S was involved in an incident that required the use of Emergency Safety Physical Intervention (ESPI) on 5/19/19. The following week Resident S was involved in two additional incidents that required the use of ESPI). After those incidents, Resident S did well for five weeks' despite the restraint on 6/20/19. Resident S was able to bounce back that week and received a positive rating. However, Resident S has since struggled to do "bounce back" from his negative and become a positive peer. Resident

S has been mostly neutral with some negative weeks due to escalating in his negative behaviors, walking away from the group or staff without permission, disrespecting staff and peers, as well as not following directions. When staff “follow-up” or debrief after the restraints, Resident S can usually identify where he went wrong, but cannot associate that is what caused him to be restrained. Overall, despite the negative weeks, Resident S is doing well at Lakeside and he is expected to continue doing well and improving his aggression.

The treatment goals for Resident S are identified within the Residential Updated Service Plan:

Resident S will express his anger through appropriate verbalization’s and healthy physical outlets on a consistent basis.

Progress: Resident S is working towards managing his anger on a daily basis but is struggling to do so. In individual therapy, Resident S works with his therapist to identify triggers and various coping skills that Resident S could try to utilize when he is feeling pressured or upset. Resident S is very aware of most of his triggers and what he could do or could have done in situations where he’s been triggered however, Resident S has expressed that it is difficult to incorporate any coping skills in the moment.

Resident S will learn to better process his thoughts and feelings as well as learning how they affect his behaviors.

Progress: Resident S actively participates in individual therapy and is making much progress towards this goal. Resident S is able to identify when he is wrong and how the outcome could have been different, had he used the “STAR” method (Stop, Think, Analyze and Respond) or informed staff of what current situation is at hand.

Resident S will be assessed for Trauma Focused Cognitive Behavioral Therapy.

Progress: Resident S has recently switched therapist and the new therapist will assess him for the Trauma Focused Cognitive Behavioral Therapy. Once Resident S and his therapist have built rapport, the therapist will then assess him. With the assumption that Resident S meets the criteria, he will then begin Trauma Focused Cognitive Behavioral Therapy and identify trauma triggers, what PTSD is and how impactful it can be.

Resident S will work towards increasing his grades while decreasing negative behaviors in school.

Progress: Resident S does well in school behaviorally and has not been in many issues in school with pers or staff. Resident S is struggling with breaking down large tasks into smaller tasks, which will he will work on in individual therapy. Resident S is able to identify what stressor he has in school, at times, he says it's nothing, it is just difficult for him to focus.

Resident S will gain independent living skills in order for him to be successful in the community.

Progress: Resident S participates in Boys Council, life skills and skills to pay the bills on a weekly basis and actively participates. He also cleans his room, completes chores and successfully does his own laundry daily. Resident S will continue participating in this goal and objectives until Resident S is discharged from Lakeside Academy.

Overall, the Residential Updated Service Plan identifies the specific staff techniques that are being used to assist Resident S to be successful. There is also documentation of the twice weekly individual therapy sessions and weekly group therapy. All services appear to target the presenting problems of Resident S.

A review of the personnel files of Staff 25, Staff 26, Supervisor 1 and Supervisor 8 provided the following information. There was a written disciplinary action taken with all four staff. Supervisor 1 had disciplinary action resulting from inadequate supervision on 8/2/14 and 4/17/14, and failure to complete written task on 4/25/18. Supervisor 8 had disciplinary action resulting from inadequate supervision on 4/20/16 and failure to complete written tasks on 10/11/17 and 4/23/18. Staff 25 had disciplinary action taken on 7/2/16 for sleeping on shift and a lack of supervision. Staff 26 had disciplinary action taken on 4/27/18, 4/18/18, 8/13/18 and 4/13/19 for being late reporting to work. He also had disciplinary action taken on 4/21/19 for failing to complete a written task. These disciplinary actions ranged from a written warning to suspensions of work without pay. The facility appears to have taken an increasing level of disciplinary action with each new infraction if there was a prior infraction.

APPLICABLE RULE	
R 400.159	**Resident restraint.**
	(2) Resident restraint shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of trauma, and done in a manner consistent with the resident's treatment plan.

ANALYSIS:	**Allegation 1:** Through face-to-face interviews and written documentation there is insufficient evidence to support the allegation that staff used inappropriate behavior management techniques during the restraint of Resident A in the classroom on 9/23/19. Resident A's report is not supported through any other means and the verbal evidence provided through interviews with staff support that staff were appropriate during the restraint. There is no physical evidence that Resident A was struck or elbowed during the restraint and this was evidenced by the nursing and witness reports. **Allegation 7:** Through face-to-face interviews and written documentation there is insufficient evidence to support the allegation that staff used inappropriate behavior management techniques during the restraint of Resident S. Evidence suggests that staff had the appropriate training and understanding of the facility's behavior management and acted as required. Although it was reported that Resident S had bruising, this is not uncommon in the event of a restraint, especially if the resident is resisting the restraint. There is also no evidence that staff placed an object over the face of Resident S as he claims. It is reported that a staff held up a sweatshirt to block spit, but it was not held on Resident S's face, rather a couple feet away. **Technical Assistance:** Nurse 3 indicated that Resident S was not inspected for possible bruising and marking after his return from going AWOL. It was suggested that to ensure the wellbeing of a resident that they are provided a complete examination by medical staff upon a return from an AWOL episode.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION 2:

Today (9/24/19) around 2:55 P.M, Resident D argued with a peer and his behavior was addressed by Staff 7 and another staff member, Staff 5. Resident D said, "fuck you bitch" to Staff 7, and Staff 7 started to argue back with Resident D. Staff 7 called Resident D," a pussy ass bitch," and she told him, "fuck your mama." Resident D pushed Staff 7 and Staff 5, and Staff 7 pushed Resident D back. When Staff 7 pushed Resident D, he had fallen into a table and chairs. Resident D landed on his back and side. It is unknown if he was hurt or injured. It is unknown if he has marks or bruises. When Resident D got up, he pushed Staff 7 again, and Staff 5 restrained him by using the single person, upper torso assist. The incident happened in the classroom and there

were no cameras present. Staff member, Staff 6, removed the other children from the room while the incident was happening. Occasionally, he peeked into the classroom to check on the staff members. It is unknown if he observed the physical contact. Resident E did observe the incident. It is unknown if there have been past concerns with Staff 7's behavior with other residents. It is unknown if a supervisor has spoken to Staff 7 at this time.

INVESTIGATION:

Interview with Resident A at the facility on 9/26/19. He reports remembering the allegations and gave the following report,

> I was down by the courthouse and asked to talk to my therapist, Therapist B. Staff 7 said I could. Then she got mad because I was trying to come in the classroom and she came in and she grabbed me. Staff 7 said that I was being disruptive and that I was not to come in. She pushed me out of the door and pushed me with two hands. Then she said "you ain't gonna do shit" and I went to lunch. Everything was fine at lunch. I was mad and waiting for Supervisor 6 to get there so I could talk to him about it. I asked if I could take five minutes and they wouldn't let me, so I stayed in the hallway. Staff 7 kept flicking me off through the door and saying stuff about my mom. I told her I was staying in the hallway and I started cussing at that point. She still wouldn’t let me take five minutes and I really needed it, but I went to class.

Resident D continued his recall of the incident.

> I went to homeroom and then tried to get up and out of class to go to the hallway where there were cameras. Staff 7 slammed my arm on the table, and I told her to stop touching me. Then she put me in a verbal, and I argued back to her. Then she cleared the classroom of all the other residents. Staff 5 was there too. I was trying to stay calm, but she said, "your mom ain’t going to do anything to me." She knows that I doesn't like anybody talking about my mom. Then she called my mama a bitch. She told me she was ready to wrap me up. I asked what she said, and she said, "jump up and you'll see." She pulled the chair out from under me and she was smiling in my face. Then I hit the table. Staff 5 was trying to calm me down and she was not saying anything inappropriate to me. I told them to get out of my space. Staff 5 backed up, but Staff 7 stayed in space. I put my foot out and Staff 5 tried to restrain me and told me to calm down. Staff 7 said let him go so I can do something else. Staff 7 called me a "pussy bitch." I told her to stop and she kept cursing at me. Supervisor 3 came in and she stopped. Supervisor 3 told me to accept his expectations, so I took a verbal. Then I went to the bathroom but when I came back Staff 7 was still saying stuff to me. The other residents started saying stuff to me and Staff 7 was smiling about it. She didn't say

> anything to them about talking crap to me. She kept mouthing stuff off to me. Supervisor 2 came in the room and I was cussing back at her at that point, so Supervisor 2 put me in a verbal. After, she kept talking to me so I started saying blah blah blah so I couldn't hear her. She finally stopped and flipped me off through the door again.

Resident D was asked about the events that occurred next and reported that Staff 5 followed up with him after the incident. He also reported that Staff 5, Supervisor 2, Staff 6 and Staff 7 were all present in the room. Resident D shared a belief that Staff 7 was singling him out because “she had never talked to other kids like that”. He said he talked to Supervisor 3 in the que right after the incident and they told him to write a grievance.

Interview with Administrator C at the facility on 10/7/19. She reports being employed as the Director of Human Resources at the facility for the past seventeen years. She indicated that Resident D is currently in Borgess Hospital after presenting with psychotic features. She also indicated that this began on Wednesday, October 2, 2019. She presented the personnel file for Staff 7 and indicated that there was an issue with Staff 7 in the past and that she was suspended. She indicated that this was a result of Staff 7 using an inappropriate tone of voice with a resident. She provided documentation of this incident and it was documented that she was suspended for this behavior.

Interview with Supervisor 6 at the facility on 10/7/19. He reports working as a Program Director on the Apollo dorm for the past seven years. He was asked about his awareness of the allegations and provided the following:

> I was told by Staff 5 that Staff 7 was being verbally aggressive towards Resident D in the classroom. I’m not sure but I think she told me this the same day it occurred. I was also told that Staff 7 called Resident D a bitch and told him that he will not do anything about it. She also told me that she would be reporting this behavior to DHHS. I talked with Supervisor 2 and he said that he went to the classroom and told Staff 7 to remove herself from campus. I contacted both Supervisor 2 and Supervisor 7 and told them to make sure it is communicated to Staff 7 that she is not to return to work (be on campus) until she receives a call from me.

Supervisor 6 was asked about past issues with Staff 7 and he reported the following:

> She has been verbally aggressive towards fellow staff in the past and not many of her peers care for her. I have had students come to me about issues with her and I have written her up at least three times. Two of the write ups were for being late to work and the third was for being verbally aggressive to a resident. I have worked with her in an effort to get her to perform better with the residents. I know that she was suspended for her aggressive behavior towards a resident in the past.

Supervisor 6 reported that Staff 7 has had to complete corrective action plans in the past for the lateness and aggressive behaviors and provided those coaching notes.

Interview with Supervisor 2 at the facility on 10/7/19. He reports working at the facility as a Group Leader for the past year and a half. He also reports working on the Apollo dorm. He was asked about the allegations and provided the following:

> I walked into the classroom and Resident D kept saying to Staff 7 "keep saying what you have been saying". I heard her say "I don't hold my tongue for anyone". Resident D started cursing at her, so I put him in a verbal to address his cursing. I asked him if he need to process what was going on and he told me that Staff 7 was talking about his family and pushed him. After he told me this, I sent her home and had him stay with me the rest of my shift. I wanted him to spend time with me to process how he was feeling. I passed the information to the next Group Leader on the next shift. I talked to Supervisor 6 and was told to inform her that she is not to return to campus until he contacts her. I was told she was aggressively swearing at him and I didn't know of the prior suspension for being aggressive.

Supervisor 2 was asked about the mandated reporting process at the facility and he indicated that he followed the new procedure on this incident.

Interview with Staff 5 at the facility on 10/7/19. She reports working as a Youth Counselor at the facility for the past five and a half years. she also reports working on the Apollo dorm. Staff 5 reported being present during the allegations and provided the following recall:

> We were in the classroom during a group discussion when two residents began yelling and cursing at each other. Staff 7 addressed Resident D and I addressed Resident E. Resident E began to calm down and I heard Staff 7 and Resident D yelling at each other. This caused Resident E to escalate and being yelling again. The rest of the group went into the hallway and Staff 7 and Resident D continued to yell at each other. The only ones in the room were Resident D, Staff 7, Staff 6 and me. The other staff were in the hallway supervising the other residents. I heard Resident D say, "I don't give a fuck" and Staff 7 responded with "you pussy ass bitch". When I looked over, she had stood up and had her fists clinched. At this time, we were both addressing him when he tried to kick us before trying to knock over a table. I tried to grab his arm to escort him away from her, but she pushed him and knocked him into some chairs and a table.

Staff 5 continued her recall of the incident following the first physical contact between Staff 7 and Resident D.

> Resident D got up and started moving towards Staff 7. I put him in an upper torso hold and Staff 7 said, “fuck your mama”. They were both cursing at each other. About this time Supervisor 2 came into the room and sent her out. I told Supervisor 2 at the end of my shift what had happened and then I told Supervisor 6. I made a report to DHHS.

Staff 5 reported a belief that Supervisor 2 didn’t know the full story of what had occurred at the time he sent Staff 7 out of the room. This is why she indicated informing him later.

Interview with Staff 6 at the facility on 10/7/19. He reports working as a Youth Counselor at the facility for the past seven months. he also reports working on the Apollo dorm. He was asked about his awareness of the allegations and he provided the following information:

> I never heard anything between Resident D and Staff 7. I was told to clear the classroom by Staff 5 and Staff 7. I offered to stay and support, but Staff 7 told me three times that she had it covered. I was standing near the door supervising the other residents, but I thought I observed Resident D and Staff 7 arguing. Resident D was standing in Staff 7’s face and Staff 7 was trying to create distance between them. She put her hands out in front of her. I never heard swearing or saw Resident D on the floor.

Staff 6 was asked about his interactions with Staff 7 and provided the following,

> I have worked with her before and she holds the kids accountable. The kids don’t like this, and they say she is mean to them. I have never seen or heard anything inappropriate from her.

Interview with Supervisor 3 at the facility on 10/7/19. He reports working as a Group Leader at the Poseidon dorm for the past three years. Supervisor 3 was asked about having knowledge of the allegations and he provided the following report,

> I got a staff call to the classroom and when I came into the room, I observed Resident D and Staff 7 arguing. Both of them were cursing and her proximity was very aggressive. I heard her threaten a restraint if he were to keep doing what he was doing. She also said that he ‘wasn’t going to do shit’. She was very close to him and I told her to back up. I talked with Resident D to help him.

Supervisor 3 was asked about his knowledge of Staff 7 and he indicated hearing that she has been aggressive with “those type of kids in the past”, defining that as residents that are emotionally struggling.

Phone interview with Staff 7 on 10/10/19. She reports working as a Youth Counselor at the facility for approximately eight months. Staff 7 was asked about the allegations and provided the following:

I remember the incident. It happened on the morning shift in the school. We were in a DCG (Direct Communication Group) group at the time in the classroom. Resident D was becoming an issue by calling others and threatening to fight them. He was cursing at staff and residents. He was verbally abusive to others and I told him several times to calm down. I tried to put him in a staff issue (verbal), but he kept acting out. Staff 6 and Staff 5 were in the room. He called another resident a pussy and bitch and was trying to fight him when I called to have the classroom cleared. During the staff issue, I asked him how would he feel if someone called him a pussy and bitch and then he called me a bitch. I also asked him if he thought it was all right for him to say things to trigger others. I told him I would not allow him to trigger others. He tried to move away, and Staff 5 was going to put him into a restraint, and I told her she didn't need to do that. Supervisor 3 came into the room and stood in front of him with me. He tried to stand up but because I was close to him, he couldn't stand. I again told him he would not be calling others pussy or bitch. Then he accepted the staff issue and the class came back into the room. That was it.

Staff 7 was asked about the specifics of the allegations of her cursing and pushing him down. She replied:

I never once called him a pussy bitch; when I said that it was in reference to how would you like it. I never once called him that directly. I did not call him names and never said anything about his mother. I never put my hands on him and never pushed him down. Policy does not allow us to use those words on residents. The only time he was down when he was sitting, and he did try to get up but couldn't.

Staff 7 was asked about prior disciplinary action and she stated:

I had some past issues with my work. I was suspended once after an altercation with my Group Leader. He found a feminine product and made a joke about finding it. I guess I didn't confront him in a professional way, and I had a corrective action plan that included being more professional. The only other issues I have had were for being late to work. All of this happened months ago in June. Now I don't curse on the dorm anymore.

Interview with Resident E at the facility on 10/14/19. He reports being present during the incident described in the allegations. He gave the following recall of the incident:

I don't remember all that was said to Resident D, but I do know that he said, "why did you threaten me?" Staff 7 told him to stop before he gets wrapped up. I never saw staff push him and I never heard staff swear at

> him. Staff 5 was appropriate, and I don't remember what Staff 7 was doing all the time.

Resident E ended by stating that he felt safe and the facility.

The facility provided Staff 7's personnel file and a review of the file was conducted. It was discovered that there were several areas of issue in her daily performance as a Youth Counselor. This ranged from yelling at a resident, being late, and using her cell phone when she was supposed to be supervising residents. Each of these issues had a corrective action plan

A review of her Probationary Period Performance Review (6/10/19) indicated the following:

> The employee has had several days of coming in late and has missed mandatory team meetings. The employee is meeting most requirements for her position. The employee will work on DEA (Distance, Eyesight and Assessment) which is a reference to supervision. Overall, the Performance Review rated Staff 7 as "Satisfactory (with some concerns). The final comments: Staff 7 will continue to work on appropriate tones and more effective de-escalation techniques with youth.

A review of the Safety Crisis Management (SCM) behavior management techniques provided documentation that Staff 7 did not engage in an appropriate intervention with Resident D. She did not follow the policy and procedure for a positive intervention with Resident D.

The local police interviewed Staff 7 and the following is the interview that was conducted on 9/26/19:

> Staff 7 was suspended from Lakeside Academy during this investigation. After multiple failed contacts I was able to contact Staff 7 via a phone call on 9-26-19 at approximately 1850hrs. I was able to confirm it was Staff 7 by having her confirm her last name and DOB. Staff 7 stated that Resident D was cussing and yelling in the classroom. She stated Resident D refused to listen to staff orders. She stated she had the classroom cleared because Resident D continued to not listen and not take directions from them. She stated she never called Resident D names but only made comments stated, "How would you like it if I called you a bitch." She stated she never once put her hands-on Resident D. I asked Staff 7 how Resident D fell back into the chairs. She stated he must have fell when he stood up because she was so close to him. Staff 7 again stated she never touched Resident D and that this "makes no sense" to her as to why anyone said she did. She stated the only thing she did wrong was cuss at Resident D.

WEAPON / EVIDENCE:
Staff 7 used her hands to push Resident D into the chairs and table.

A review of the written documentation (Incident Report #19-09-24-015 and Debriefing Report #19-09-24-015) provided support for the verbal statements by the staff involved with the exception of Staff 7. It was documented that Staff 7 should have used a different approach when dealing with Resident D.

A review of Resident D's last Residential Updated Service Plan provided documentation of the focus of Resident D's treatment while at the facility. Resident D entered the care of the facility with a history of significant trauma and emotional dysregulation. The facility developed goals with a strong focus on trauma issues. The facility has also identified that a smaller group unit (current group is 24) might work better for Resident D since he is easily triggered into the trauma cycle. The facility reports that they have requested a Family Team Meeting to discuss having Resident D replaced to a smaller living unit with a strong focus on Trauma issues.

ALLEGATION 6:

Today October 1, Resident R was disrespectful towards Staff 23. Staff 23 confronted and addressed this with Resident R. Resident R sat down. Resident R's arms were not moving, and his hand was underneath his chin. Staff 23 said something to Resident R. Resident R said something in return under his breath. Staff 23 took her hand and backhanded Resident R in the face. Staff 23 immediately left the room. Initially, Resident R was stunned but then got very upset. Resident R did not appear to have any red marks; however, he will be seen by a nurse. Staff 23 has since been placed on administrative leave pending an investigation.

On 10/01/19 between 2-2:30 PM, Resident R was seated at his desk in class and he was saying rude comments and swearing, which is not allowed. Staff 23 approached Resident R and told him that he cannot say those things. Resident R started yelling and Staff 23 and Resident R yelled back and forth at one another. Staff 23 intentionally struck Resident R with an open hand striking him with the backside of her hand. Staff 23 struck Resident R on the right side of his face and also struck part of his hand that he was resting on his face at that time.

Resident R has no visible mark or injury, however at approximately 7 PM, Resident R still "felt tingling" to the right side of his face that began after Staff 23 struck him there.

INVESTIGATION:

Interview with Administrator A (Executive Director), Administrator B (Living Services Director), Administrator C (Director of Human Resources) and Administrator D (Director of Student Services) at the facility on 10/8/19. They were asked about the allegations and indicated that the local police have conducted

interviews with the resident and some staff. They also provided the following information:

> Staff 22 was witness to the incident. Therapist C was in the room and only heard the sound of Staff 23 striking Resident R. She reported that she did not see the hit but did hear the exchange between Staff 23 and Resident R. She also reported that both were cursing. Teacher B was also in the room, but she told us she didn't witness any hit or hear anything that sounded like a hit. She said that she did overhear Resident R and Staff 23 "bickering". Staff 24 was also in the room, but we are unsure what he witnessed.

They indicated that there were no cameras in the classroom where this incident took place. They report that the facility is in the process of installing cameras in the classrooms.

Interview with Resident R at the facility on 10/8/19. He reports that he has been at the facility for the past four months. He was asked about the allegations and provided the following report:

> It started in my anger management group during a role-playing exercise. My job was to roll play external triggers and one of my cards called for a verbal trigger. I used the word nigger and Staff 23 overreacted to my use of that word. She said that she was going to write me up for using that word because I was talking to a guy who is black. I was sitting at my desk and she put me in a verbal. I didn't stand up because they would have put hands on me. There was two other staff with one on the side of me and one behind me. I don't remember who they were. Staff 23 was yelling and cursing at me and said, "you need to shut the fuck up". Well, I guess I don't remember if she really said that but I know she was yelling at me. I told her to shut up bitch and she said "I told you to shut up" just before she backhanded me. I'm not sure which hand she hit me with, but she hit the right side of my face. My hands were at my side.

Resident R indicated that Therapist C was in the room and asked Staff 23 if she had slapped Resident R and Staff 23 told her "yes I did". Resident R also indicated that Therapist C told Staff 23 to "leave now". Resident R was asked about his relationship with Staff 23 and he indicated having no issues prior to the incident with her. He also reported "she is a loudmouth and I don't like her". He ended the interview by asking if Staff 23 was going back to work his dorm.

Interview with Teacher B at the facility on 10/8/19. She reports working as a teacher at the facility for the past five years. She indicated being present in the classroom at the time of the alleged incident and provided the following information:

> The group was coming back into the classroom after they had been in their anger management group. A student met me at the door and said the Resident R is calling Staff 23 a nigger. I didn't see the incident because there were several people between me and them. I do know that Staff 23 was holding Resident R accountable (verbal) and standing in front of him. she seems to be distressed with her voice. I heard her say she was leaving after Therapist C told her to leave the room. Therapist C was standing close to me when it was supposed to have happened.

Teacher B was asked about her impression of Resident R and Staff 23 and she provided the following:

> Resident R provides consistent issues. He crosses others' boundaries and personal space all the time. He horses around and has said racial things to upset others. Half of the time he is not following directions and you need to stay on top of him. Staff 23 holds the kids accountable and keeps order in the group. She is consistently providing feedback to the kids and will bend over backwards to help them. She seems to be a very compassionate person. I heard that she will spend her own money on the kids if they need things. I also know that she was upset the day this happened and there is a rumor that she did hit Resident R.

Interview with Staff 22 at the facility on 10/8/19. He reports working at the facility as a Youth Counselor for the past three years. He also reports being aware of the allegations and was witness to the incident in the classroom. He provide the following report:

> I had just started my shift and the group was coming back into the classroom from their anger management group. When I walked into the room Staff 23 told me that Resident R had called her a nigger in the anger management group. She appeared upset and irritated. Like she was nervous and stressed. I began to talk to a resident near to Resident R's position when Staff 23 began to address him. She was addressing him for inappropriate behavior and placed him in a verbal. He was sitting at his desk and she was standing in front of him. I was standing to his left side. She was specifically addressing him for cursing. He was sitting with his elbows on the desk and his hands near his face. His hands appeared to be covering his mouth. I heard him say something and Staff 23 backhanded him. There was a loud smacking sound when she hit him. Therapist C who was across the room, asked her if she hit Resident R and she said "yes". Resident R never seemed to be upset during the whole incident.

Staff 22 indicated that he called the program director to inform him of the incident and kept Resident R near him. He also reports being concerned about Resident R. He indicated processing the situation with Resident R in an effort to help him deal with any emotional issues. Staff 22 indicated that Staff 23 used her right hand and hit Resident R

on the left side of his face leaving a mark that he noticed later in the day. He was asked about his impression of Resident R and Staff 23.

> I have worked with Staff 23 before and she gets emotional. I've told her in the past to not get emotional when working with the kids. I told her that the kids will pick up on it and use it against her. I have seen her crying after someone does something like this to her. She tends to get into power struggles with the kids, but I've never seen her get aggressive with a kid. Resident R likes to push others' buttons and will personalize things to get at others.

Staff 22 indicated a belief that none of the other residents observed the incident because they were engaged in different school activities. Staff 22 indicated being aware of the facility's policy for mandated reporting and that he followed the policy.

Interview with Therapist C at the facility on 10/8/19. She reports working as a therapist at the facility for the past ten months. She reported remembering the incident in the allegation and provided the following information:

> I had just completed an anger management group and followed the residents into their classroom. As I was sitting talking with a resident, Staff 23 was standing over Resident R while he sat at his desk. Resident R was chattering and fidgety while he was sitting. I believe he kept saying "ok and alright". Staff 23 continued to talk to him and he was beginning to escalate and become frustrated. I had my back to them when I heard her raise her voice. Then I heard him say, "I said shut up". The next thing I heard was a loud slapping sound to which I turned and asked her if she hit him. She said, "yea I hit him". I told her to leave the room right now because you have lost your job. Staff 2 checked on Resident R and escorted him out of the room. Staff 2 was standing right next to Resident R when it happened. Staff 24 was also a witness because he was sitting on a countertop directly behind Resident R.

Therapist C was asked about her impression of Staff 23 and she reported:

> I don't work much with her but sometimes she seems to become easily frustrated. She will argue with residents and gets into power struggles with them. Because of her tendency to get into power struggles, I'm not surprised that she hit him. I believe this was a carryover from the anger management group.

Therapist C reported being aware of the facility's policy for mandated reporting and that she followed the procedure.

Interview with Staff 23 at her home on 10/10/18. She reports being employed at the facility as a Youth Counselor for the past year and five months. She indicated that she

has worked most of the dorms. She was asked if she had knowledge of the incident and she replied that she does. She gave the following report:

> He was in an issue (verbal) for calling me a bitch. The purpose of the verbal was to help him understand what he did wrong. I explained to him that his behaviors were disrespectful. He was not paying attention to me and he put his hands in front of his face. I went to move his hands and it made a sound. I only moved his hands out of the way and the therapist said that I hit him. I didn't hit him, and the therapist started yelling at me. I don't know why she was acting like this in front of the other kids. Teacher B didn't know what was going on and asked what just happened. All I tried to do was move his hands out of the way and he called me a bitch again.

Staff 23 was asked about other staff in the room at the time and she indicated not being aware of the other staff. She shared a belief that she was the only staff present. She was asked about any issues with Resident R prior to the classroom and she indicated that earlier in the day, Resident R stole another resident's personal card. She reports searching his room which caused Resident R to become upset with her for the "rest of the time". She was asked to describe her relationship with the residents, and she replied:

> I left my past job at the juvenile home because my supervisor told me that I let kids manipulate me. I have fun and am very playful with the kids. I am very hyper, and I don't want to make mistakes with the kids. I can get frustrated with the kids but not easily frustrated. I don't take things to heart when they are being negative or cursing at me. I have heard racial remarks, but I don't get upset over them. Resident R never said nigger to me. He called me a bitch. I have no ongoing conflicts with residents and I only try to hold them accountable. Some of the residents don't like this about me.

Staff 23 was asked about the reason she was unaware of other staff in the room and she indicated that it must have been when she had her back to the others addressing Resident R. She again stated that she had heard Resident R was being inappropriate in the anger management group, using "the n word", and she wanted to process his "struggle" with him. Staff 23 was asked about prior employment issues she has had that involved similar situations. She reported that in the past she received disciplinary action because of an issue she had with a female resident that hit her. She shared that she was suspended for a couple of days and had to complete extra training. She said that "I had to find more positive ways of dealing with residents". Staff 23 ended the interview by stating that she is currently "suspended until further notice".

Interview with Staff 24 at the facility on 10/14/19. He reports working as a Youth Counselor at the facility for the past ten months. He also reports remembering the incident in the allegations and indicated that he was a witness. He provided the following information:

> I reported to the room and residents were yelling out that Resident R called Staff 23 a bitch. I confronted Resident R and told him not to disrespect Staff 23. I was in the back of the classroom sitting on a counter. I was to the back left of Resident R; Staff 23 was standing in front of him and Staff 22 was standing to his right. I could see half of Resident R's face. Staff 23 was giving him expectations and Resident R was being an ass. They were getting into a power struggle when she smacked him. In the middle of what she was saying she just popped him in the face. I saw an open hand slap to his face. I heard the smack and it sounded like a punch. Resident R just sat there and never even jerked or moved backwards. Therapist C asked her if she hit him and she said, 'yea I just slapped him'. Therapist C told her to leave and Staff 23 started to argue with her.

Staff 24 was asked about his impression of Staff 23 and he stated that the kids don't like her because she holds them accountable. He also stated that "she takes stuff to heart and gets too personal with the kids". I have seen her struggle like this in the past.

A review of Staff 23's personnel file provided the following documentation. On 10/23/18 she was found in violation of supervision of residents and following a supervisor's instructions. Disciplinary action was taken but not documented.

A review of past Special Investigations provided documentation that Staff 23 was involved in and cited for a violation of Behavior Management when she became aggressive with a resident.

A review of Resident D's last Residential Updated Service Plan provided the following information:

> During this reporting period, Resident R has struggled to adjust to the expectations that are placed at Lakeside Academy. Resident R has displayed a variety of negative behaviors since his admission to Lakeside on 05/16/19. Resident R has received consistent negative ratings due to behaviors such as stealing food from the cafeteria, not following staff directives, cursing and general disrespect towards staff. Towards the end of this reporting period, Resident R has since then been placed on daily ratings rather than weekly ratings to help individualize his negative behaviors which has helped Resident R to identify areas of negative behavior that need to be changed, as well as hold himself accountable on a daily basis, opposed to a weekly basis. Resident R is currently an Orientation Level on campus and will have to receive positive daily/weekly ratings to receive his Future Status, Pledge and Titan status to progress in his program.

All of the treatment goals identified in the report are appropriate to the presenting problems that Resident D entered care with.

APPLICABLE RULE	
R 400.4112	**Staff qualifications.**
	(1) A person with ongoing duties shall have both of the following: (a) Ability to perform duties of the position assigned. (b) Experience to perform the duties of the position assigned.

ANALYSIS:	**Allegation 2:** Through face-to-face interviews and written documentation there is sufficient evidence to support the allegation that Staff 7 used inappropriate behavior management techniques when dealing with Resident D. This inappropriate behavior also resulted in her physically pushing Resident D causing him to fall. Her use of verbal cursing is also inappropriate and would only trigger the trauma cycle for Resident D. Two of the other three staff present agree that Staff 7 used inappropriate techniques in dealing with Resident D and also agree that she was verbally aggressive. **Technical Assistance:** It appears that her supervisor, Supervisor 6 did not always pass along his coaching notes so they could be placed in her personnel file. It was suggested that even if a staff does not sign off on the notes, all information needs to be passed to the Human Resources department. This will allow the Human Resources department to have full knowledge of a staff's progress, lack of progress or issues that could lead to situation similar to the current allegations. **Allegations 6:** Through face-to-face interviews and written documentation there is sufficient evidence to support the allegation that Staff 23 used inappropriate behavior management techniques when dealing with Resident R. Two present witness stated that Staff 23 did strike Resident R in the face area and a mark was noticed by Staff 22 later in the day. Three staff witnesses stated that Staff 23 made the statement "yea I hit him" after being asked if she had hit Resident R. Although, Staff 23 denies striking Resident R the overwhelming evidence suggests otherwise. **Technical Assistance:** The personnel file did not have documentation of disciplinary action taken when Staff 23 was involved in a situation resulting in a licensing violation. This issue was discussed with Administrator A. She indicated that they are in the process of making significant changes in the Human Resources department. She shared that in the past the Program Managers would keep disciplinary files on staff and not always pass this information along to the Human Resources Department. She noted that that process has since changed, and the Human Resources Department is now keeping all records. We discussed the importance of having central oversite for all Human Resource involvement.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION 4:

Resident J and Resident K were roommates at Lakeside Academy. Approximately two weeks ago, Resident K is alleged to have pulled Resident J's pants down while he was sleeping and ejaculated him. Resident J woke up and reported this incident to the unknown staff member.

The following day Resident K woke Resident J up by ejaculating on him and performing oral sex on him. This incident again was reported to the third shift staff. Resident J is alleged to have been informed by the staff that the incident wasn't observed therefore nothing could be done. Resident J and Resident K are no longer roommates, they were separated approximately a week ago. There is a concern with the improper supervision.

At least a few months ago. Resident J made comments about liking boys. Resident G woke up to Resident J rushing back to his bunk. Resident G Looked down and realized that there was saliva on his penis.

At some other unknown point, an unknown male anally raped Resident G. It is unknown who was supervising any of the boys when prior incidents occurred.

INVESTIGATION:

Interview with Resident J at the facility on 9/27/19. He reports being at the facility for almost a year and is currently on the Apollo dorm after moving from the Helios dorm. He also indicated not knowing why he was moved from the Helios dorm where he was for one week. Resident J was asked about the allegations and gave the following information:

> I didn’t want to be in a room with Resident K anymore because he kept being a butthead. Both times Resident K was playing with my body parts. I grabbed his head and slammed it against the wall. I told midnight staff, Staff 8 right after it happened the first time and then it happened again the next night. He was sucking my penis; I slammed his head against the wall."

Resident J was asked if Resident K was hurt or if he said anything. Resident J said that “Resident J responded by saying, ‘I thought you liked that’ and then went back up to his own bed”. Resident J reports that Resident K has switched dorms. Resident J was asked to explain what happened when he told Staff 8 what had happened. Resident J stated:

> He just said, “If I didn't see nothing, I can't do nothing.” Resident J said he told Staff 8 again the next night and he responded again, “If I didn't see nothing, I can't do nothing.” After that, me and Resident K switched dorms. I was moved to Helios dorm.

Resident J denied touching anyone else's private parts and said no one else has done that to him. He denied giving or having oral sex with anyone else. Resident J said he doesn't know about anyone else being involved in those sexual things. He doesn't know anything about anyone being anally raped. Resident J said he was in a room with Resident G. He said they played cards and talked. He said Resident G was only in the room for three weeks. Resident J denies doing anything sexual to Resident G or Resident G doing anything sexual to him. Resident J believes the reason Resident G was moved was because he was not doing anything right and Resident G wanted to be around a roommate who was a positive person.

Resident J was asked about night staff conducting room checks and he provided the following information:

> At night, staff do room checks and walk the halls. They come and look into the rooms every 30 seconds. When Resident K was touching me it happened during the midnight shift and those staff just sit in the bay and sleep. The shift before them do the room checks.

Resident J ended the interview by stating that he has talked to multiple people about this situation as well as writing two reports about it. He was unable to identify the “multiple people” he reports speaking too.

Interview with Resident K at the facility on 9/27/19. He reports being admitted to the facility on 6/18/19. He also reports that he has “had problems recently”. He shared the following information:

> Resident J lied on me. We used to be roommates and he said that I sucked his dick. I knew I didn’t, but he was running around telling people that. So I was gonna fight him but that would make it look like he was telling the truth, so I let it go. I decided I'm not gonna go through that. We were roommates for the first two weeks I was in the program.

Resident K denied being sexually abused by anyone or any resident at the facility. He denied "experimenting" with anyone sexually or fooling around in any way. He reports, it is not something to "play" about. He denies ever touching any other resident’s private areas or that any other resident had touched him on his private areas. Resident K suggested that the whole thing came about because he heard that Resident J liked boys. “Resident J told me when we were roommates that when he's out he likes girls but when he's in he likes boys.” Resident K was asked about the change in his room and he indicated asking his group leader, Supervisor 8 to have a room switch. He also

indicated that his room was switched a week later. Resident K added that in part he wanted a room change because Resident J "pees on himself".

Resident K was asked his opinion of the reasons behind Resident J making the allegations and he responded:

> I think it was because I was laughing and making fun of him. I did this because everyone was saying that something happened to him before he came to the facility. I think Resident J said those things to start a rumor and get back at me for making fun of him. I was told by Resident G that "Resident J would lie on me".

Resident K ended the interview by reporting that he feels safe at the facility. He did indicate that sometimes he is scared of staff but could not articulate why or identify a specific incident. He also indicated that he is not scared of any other kids at facility.

The report written by Resident J was reviewed:

> Like two months ago when Resident K was my roommate. When I was sleeping, he was jacking me off and I grabbed his head and slammed it against the pole of the bed, and the very next day he was sucking my penis and I again grabbed his head and slammed it on the bed. Resident J 4/23/19

The report written by Resident K was reviewed:

> When me and Resident J were roommates, I was sleeping he woke me up saying let's play cards. I said no and he said come on. Then we played cards then he was done and asked me to touch his thing. I said no then he got mad. Then Staff 13 said go to sleep and I did. He kept asking me and I told him no. Resident K.

Interview with Resident G at the facility on 9/27/19. He indicated being placed at the facility on 11/28/18. Resident G began the interview reporting that he has been talked to recently about some things going on at the facility. He provided the following information:

> All I know is there were rumors going about Resident J and Resident K and I don't know about that. I heard Resident K sucked Resident J's private and heard it from other kids talking. I never heard anything from Resident J or Resident K. A couple of months ago, I had Resident J as a roommate. He always used to talk sexual stuff to me, and he told me that if I didn't do this to him in a sexual way, he would tell staff I sucked his dick, which I didn't do. Then I kind of fainted. When I woke up my private part was hanging out with spit all over it. I told staff at night, Supervisor 2; the following day I switched rooms." Staff told Resident J they would text

> Supervisor 6. Resident J said he had to talk to the police. After it happened, I didn't sleep for a week because I believe he did do something to me sexual.

Resident G shared “there are other multiple things that we're not going to talk about, and those things were already taken care of by staff”. At this point, he changed the subject and suggested that he feels targeted at the facility. He refused to go into detail about this statement. The other allegation of him being raped was brought up and he was asked if he knew anything about it. He replied:

> Well, you know that kid, Past Resident L, that I don't want to talk about. I don't know how old he is. It happened in my room when I was asleep on Apollo dorm, when we were roommates. I had a flashback because I woke up in the middle of the night and my butt was bleeding, but the next day it wasn't. I don’t know where he is now, but he left a while back. This was already dealt with in the past.

Resident G indicated that “no one in his dorm is doing anything like that now and nothing like that has ever happened with staff. He reported that Past Resident L was moved to another dorm after he told what he believed happened. Resident G ended the interview by stating “And I said I don't want to talk about it." He also reported that he doesn’t like anything about the facility. **(This allegation was part of Special Investigation 2019C0214042 which occurred in May 2019 with no findings)**

Interview with Administrator A (Executive Director), Administrator B (Living Services Director) and Supervisor 6 (Program Director on Apollo Dorm) at the facility on 10/7/19. They were asked about the allegations and Administrator A provided the following information,

> The police told me I could not speak to Resident J because he was considered the victim. I was able to speak to Resident K (gathering information for the complaint) and he indicated that they were playing cards on the floor. Resident K indicated that he noticed Staff 9 walking the halls and doing room checks that evening. He also indicated that Resident J sat between the wardrobes out of sight of staff and made sexual gestures towards him. Resident K then reported that Staff 8 told them to wrap up the card playing but was unable to see what Resident J was doing between the wardrobes. Resident K denied that anything happened between him and Resident J. He finally told me that Resident J told him “on the outside I get girls but when locked up I get dick”. Resident K told me he never told anyone else because he was fearful of getting teased. We heard this statement before from Resident G about Resident J. Resident G also never said that something with Resident J happened here.

They were asked about the room assignments of the three residents identified in the complaint and provided the following:

> Around the beginning of August, Resident J and Resident K were moved to different rooms. When Resident G said something about Resident J's behaviors they were separated and placed in different room in the middle of May. Resident J is now in a single room. We are very sensitive to this type of issue and will quickly move a resident to another room to be safe.

They were asked about the allegation involving Resident G and gave the following report:

> Resident G was sexually abused at another placement and has reoccurring flashbacks of the abuse. What he described in the complaint and in the past special investigation is what was discovered to have happened to him at his last placement. He first told us about a possible rape on campus on 4/23/19 which led to the other special investigation. He reported falling asleep while folding laundry and woke up with his butt hurting. We had both residents taken to the hospital to be examined and the examination indicated no sexual interaction between the residents. Resident G really struggles every time his court hearing about the sexual abuse gets close. He still has to testify about the rape at his prior placement and his therapist reports that he really struggles emotionally. Resident G can't be in a room alone because he has night terrors.

They were questioned about the room checks during the late second shift and third shift. All three indicated that there has been an internal investigation which uncovered significant issues and a lack of compliance with the third shift (overnight) staff.

> We conducted an internal audit and found that room checks were not being completed as required. Since that time, we have made significant changes in the overnight staff's supervision. With the changes, we are having a Program Director and other management personnel check the dorms randomly at night. We have moved a strong person to help supervise the overnight staff. A new computer has arrived in order to increase camera review and guard one reports (Guard One is the metal wand and metal clip outside each bedroom. It records the time, date and person completing bed checks. The computer was needed to store and run reports) on a nightly basis by supervisor, and for management to run reports. Random check-in's from management in the middle of the night. Administrator B is making a schedule for PD's and Coordinators to work random shifts. During our internal investigation we found staff sleeping multiple times, not completing room checks and leaving the shift early. We have taken disciplinary action against six overnight staff which involved five being written up for not completing bed checks appropriately and the termination of one for a history of write-ups.

Interview with Staff 8 at the facility on 10/7/19. He reports working as an overnight staff on the Apollo dorm for the past thirteen months. He was asked about the allegations and provided the following report:

> I was told that Resident K was doing something to Resident J, but I don't remember either one of them telling me that something sexual was going on. I would have remembered that. If I had been told that, I would have separated them right away and informed my supervisor. I don't remember one of them slamming the other's head against something in the room, but I do remember them being roommates. I never told Resident J that if I didn't see it, I can't do anything about it.

Staff 8 was asked about his duties as a third shift (overnight) staff and replied:

> We have to make sure the kids stay asleep and attend to them whenever they need to use the bathroom or a drink of water. Ninety percent of them are sleeping and only a couple will be up writing a letter or reading a book. They ask them to wrap it up and go to sleep as soon as possible. We will walk the halls and make sure their bedroom door is open so we can check on them. When I check on them, I need to see skin or their face to ensure that they are really in bed. If I have to go into the room to check then I have a spotter at the door. We don't go into the room without a spotter present. I would have to go into the room if I can't see skin or their faces, or if they are on the floor. If they are on the floor, we wake them up to get into their bed. We did room checks every twelve minutes but now we do them every ten minutes. We are required to do six room check every hour throughout the shift. In the past we used an electronic system but now we keep a written log sheet that documents the time of the check and what the kid is doing.

Staff 8 was asked about the report that staff have been sleeping and not doing their room check. He gave the following information:

> We normally have three to four staff on duty during the time the kids are sleeping. Staff do not sleep but I have seen staff doze off once in a while. I will get their attention and wake them up. I will tell the supervisor and the supervisor will come into the area and sit. I have dozed off a few times myself, but because I have sleep apnea, so I wake myself up.

Staff 8 ended the interview by reporting that staff do hold each other accountable to do their duties.

Interview with Supervisor 2 at the facility on 10/14/19. He reports working at the facility as a Group Leader for the past year and a half. He also reports working on the

Apollo dorm. He was asked about the allegations involving Resident J and Resident K. He provided the following:

> I remember being told by Resident J, but I don't remember the day or time. He told me what happened, and I moved him to another room and followed the procedure to file a report. I informed the other staff at the shift change meeting and the team meeting. The next day we moved Resident K to a different dorm, and he told me that the incident occurred about two weeks before I was told by Resident J. Resident J also told me he told an overnight staff because it happened two nights in a row. I believe it was Staff 8 that he told but I was not present.

Supervisor 2 was asked about the allegations involving Resident G and responded with:

> This happened a long time about and I'm not able to remember the time or day. I do know that Resident G told me that he didn't feel safe in his room but refused to provide any details. I moved him to a single room on the opposite hall. I do know that I passed the reason for the room change to Supervisor 6.

Interview with Staff 9 at the facility on 10/14/19. He reports working as a Youth Counselor during the third shift on the Apollo dorm for the past ten months. He was asked about his knowledge of the allegations with Resident J and Resident K and he provided the following information:

> I know nothing about any sexual activity between residents. The supervisors would know about that kind of information. The only incident I am aware of is the situation with Resident G that happened during April of this year. I was interviewed for that situation.

Staff 9 was asked about the reported issues with third shift staff overnight and what their duties are. He gave the following response,

> The wands are down right now so we write our room checks on a log sheet. We were doing room checks every twelve to fifteen minutes but now it is less. The kids are not allowed to be out of their rooms at night. Staff will split up the hours so that each staff has an hour or two-hour break. We go for two hours at a time and I'm not sure what the other staff taking a break do. I think they normally play spades or Uno. Sometimes we will play pushup Uno to keep us awake. Some staff would watch a show on Netflix on their tablet or listen to music. I have slept on the job when I am working a double.

Staff 9 was asked about being a mandated reporter and he struggled to identify the new procedure that the facility has put into place. He suggested that he only has to tell his direct supervisor, and this was shared with the administration at the exit interview.

Interview with Staff 10 at the facility on 10/14/19. She reports working as a Youth Counselor on third shift at the facility for the past year. She also reports working on different dorms. She was asked about the allegations and provided the following:

> I have never been approached by a kid about sexual activity. I remember the incident with Resident G back in April, but I was not part of that. I have no awareness of the current situation between Resident J and Resident K.

Staff 10 was asked about her duties and the issues on third shift. She reported the following:

> We do room checks and have used a wand until it no longer worked. Now we keep track on a room check log. We used to do room check every twelve minutes but now we have to do room checks six times an hour. The time to check on each room must be variable. I know that staff will switch every two hours and some staff will watch television when the other staff are doing the room checks. I always thought that as long as the checks are getting done it doesn't matter who is doing the check. I've never fallen asleep during my shift.

Interview with Staff 11 at the facility on 10/14/19. He reports working as a Youth Counselor on the third shift over the past two years. He also reports working different dorms. He was asked about the allegations and reported:

> I know Resident J and have heard of Resident K. Neither has ever approached me with allegations of sexual acts. I never heard the rumors of the allegations. I know that I am a mandated reporter and need to take action if told about something like that.

Staff 11 was asked about the internal investigation and the issues that occur on third shift. He provided the following knowledge:

> We will swap every two hours and some staff will read or watch Netflix when it's not their turn to do the room checks. We do variable room checks so the kids can't time us on the checks. I have not slept when working and if I see another worker sleeping, I will tell the supervisor. I have not seen another staff sleeping.

Interview with Supervisor 8 at the facility on 10/14/19. He reports working at the facility as a Campus Coordinator for the past six years on second shift. He was asked about his awareness of the allegations:

> I know both Resident J and Resident K and neither approached me with the issues outlined in the allegations. I heard about the allegations when a staff told me Resident J had made a report, but nothing firsthand. I also

> know that Resident K was moved to another dorm. I know that I am a mandated reporter and if told about something like this I need to file a report.

Supervisor 8 was asked about the room check process during the time the residents are in their rooms on second shift. He replied:

> Bedtime for residents is supposed to be at 9:15. At that time we start consistent room checks. We don't give them any time because someone is looking in on them every one to two minutes until third shift staff take over. We just keep walking the halls and doing room checks. We need to see a head or other part of their body and we will use a spotter if the staff needs to go into the room to check on the resident. I think the third shift staff should also be consistently walking the halls. This keeps them safe and secure.

Interview with Case Manager A at the facility on 10/14/19. He reports working as a Case Manager at the facility and began working at the facility in March. He was asked about his awareness of the allegations and he provided the following;

> I was a Youth Counselor on the Apollo dorm when the allegations were supposed to have occurred. I was never told of sexual activity between the residents. I did hear a rumor from another staff, and I believed that is the reason that Resident K was moved to another dorm. I know that if I was told about something like this, I would need to file a report.

Case Manager A was asked about room checks on the dorms and replied:

> On second shift we start room checks when they go to bed. We have one staff on point (described as a position where staff can view two hallways at once) while the other staff constantly walks up and down the hallways. We make sure they are in their beds and need to observe skin or their face. If we need to go into the room, we have another staff spot.

A review of the personnel files of staff involved in this investigation provided the following information. Documentation in personnel file of Supervisor 2 indicated that he has received disciplinary action five times between 2/4/18 and 12/19/18 for being late for work. There was no other disciplinary action documented in his file. Documentation in the personnel file of Supervisor 8 indicated that between 2015 and 2018 he received verbal disciplinary actions for having a vehicle accident with residents in the car 2015, inappropriate supervision of a resident 2016, not having his radio on his person 2017 and failure to complete a written task 2018. Documentation in the personnel file of Staff 8 indicated that he was given a verbal and written disciplinary action for not showing up for work twice and a verbal and two written disciplinary actions for not completing room checks as required. Documentation in the personnel file of Staff 9 indicated that he was

given a verbal and three written disciplinary actions for not completing room checks as required and a verbal and written disciplinary action for not showing up for work. Documentation in the personnel file of Staff 10 indicated that she received disciplinary action in the form of a verbal warning for missing a staff meeting. Each of the files also provided a corrective action plan to address the issues documented.

A review of the internal inspection conducted by the facility of the resident supervision on third shift was conducted and involved interviews with staff and a significant review of the camera recordings during the third shift. The facility's inspection had findings of the following documentation:

> Failure to complete bed checks as required.
> Staff observed sleeping during the shift
> Leaving shift early without informing the supervisor

The results of this internal inspection involved one staff member having their employment terminated and five staff members receiving a disciplinary write-up for a failure to provide the appropriate supervision while on shift. The facility developed a corrective action plan that involved the following items:

> The POA (Plan of Action) to improve our overnight bed checks:
> 1: We are changing Staff 12's hours to help supervise the overnights
> 2: A new computer has arrived in order to increase camera review, guard one reports on a nightly basis by supervisor and for management to run reports
> 3: Random check-in's from management in the middle of the night
> 4: Administrator B is making a schedule for PD's and Coordinators to work random shifts

A review of Resident G, Resident J and Resident K's service plans provided documentation that the facility was able to assess the issues the residents presented with and developed appropriate treatment goals. The goals were measurable and identified the staff's involvement in supporting positive change. Each resident is receiving trauma focused therapy individually at least twice a week and in a daily group setting.

APPLICABLE RULE	
R 400.4127	**Staff-to-resident ratio.**
	(4) When residents are asleep or otherwise outside of the direct supervision of staff, staff shall perform variable interval, eye-on checks of residents. The time between the variable interval checks shall not exceed fifteen minutes.

ANALYSIS:	**Allegation 4:** Through face-to-face interviews and written documentation there is sufficient evidence to support the allegation that staff were not providing the appropriate required level of supervision of residents during the sleeping hours. This evidence was provided through interviews when staff admitted to sleeping or observing other staff sleeping. Further evidence supporting this violation occurred in the internal investigation that the facility conducted when they became aware of issues of supervision on the third shift. By their report, they identified through video recording, staff sleeping and through a review of the electronic record of room checks, that room checks were not being done as required. Additionally, staff stated they used to do room checks every 12 minutes, which is not variable. They now complete room checks 6 times per hour at variable intervals.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION 3:

On an unknown date and time, staff member, Supervisor 2 came into Resident F's room at his dorm and pushed him and slammed him up against the bunk bed. There was no one else around when this happened, and it is not believed he was injured during the incident. It is unknown why Supervisor 2 did this and additional information on this is unknown. Resident F did file a grievance although there has been no known follow up at this time.

INVESTIGATION:

Interviews with Administrator A and Administrator C at the facility on 10/7/19. Both report having knowledge of the allegations and they were asked about the grievance Resident F is reported to have filed. They indicated that each grievance box on campus was inspected and a grievance from Resident F was never located. They also report that because of policy there are no cameras providing a few of residents' rooms, therefore no camera recording is available.

On 10/7/19, the interview with Resident F was not conducted because Resident F refused to meet with this writer. After waiting twenty minutes for him to change his mind, the interview was canceled.

Interview with Supervisor 2 at the facility on 10/7/19. He reports working at the facility as a Group Leader for the past year and a half. He also reports working on the Apollo dorm. He reports being informed of the allegations and provided the following:

> Resident F said that I pushed him against his bed. This didn't happen and he admitted it in front of a group. He told the group that he said it because he was mad at me. There were several residents who overheard him say this. He has threatened me in the past and said that he knows "what to do to get staff fired". I have never restrained Resident F and I not sure why he was mad at me this time.

Supervisor 2 indicated that he was told about a grievance filed by Resident F but was also informed that it was never found. He believes that Resident F never filed a grievance.

Interview with Resident G at the facility on 10/7/19. He was interviewed because he was one of the residents identified who had heard Resident F make a statement that he was going to make a false statement against Supervisor 2. He was asked this and provided the following information:

> I remember that Resident F was mad at Supervisor 2 and said that he made up the allegation to get him back. This happened during a group meeting. He was mad at him but didn't say why. Also, I was walking by the room when at the time he said it happened and witnessed the whole thing. Supervisor 2 never pushed him.

Resident G ended the interview by stating that he felt safe at the facility.

Interview with Resident H at the facility on 10/7/19. Resident H was interviewed because he was one of the residents identified who overheard Resident F say he was going to make a false allegation against Supervisor 2. He was asked about this report and provided the following report:

> About two weeks ago, during a DCG (direct communication group) Resident F was talking and he was mad. He said that he got into a situation with Supervisor 2 and wanted to get him fired. Resident F said that he was going to tell his worker that Supervisor 2 slammed him and try to get him fired. I asked him what that would solve, and he couldn't give a correct answer.

Resident H ended the interview by stating that he has never witnessed Supervisor 2 go into a youth's room without a spotter. He also said that he feels safe at the facility.

Interview with Resident I at the facility on 10/8/19. He was interviewed because he was one of the residents identified who overheard Resident F say he was going to make a false allegation against Supervisor 2. Resident I provided the following information:

> He said "I'm going to make sure that Supervisor 2 gets fired. He said that he was going to make up lies and get him fired. I told him they have cameras to prove he didn't do anything. Then I told Supervisor 2.

Resident I ended the interview by reporting that he feels safe at the facility.

A review of the personnel file of Supervisor 2 indicated that he has received disciplinary action five times between 2/4/18 and 12/19/18 for being late for work. There was no other disciplinary action documented in his file.

A review of Resident F's last Residential Updated Service Plan provided documentation that the facility has targeted several treatment goals all associated with the issues he presented at time of intake. He continues to work on anger management techniques but as of this last quarter has begun to struggle in this area again. The facility is in the process of evaluating Resident F on the UCLA PTSD Index. Currently he is enrolled in Trauma-Focused Cognitive Behavioral Therapy. Another focus of his treatment is the development of the skills to avoid self-sabotage and mistrust of others. The final goal is the development of Independent Living skills.

ALLEGATION 5:

Last week, Resident M reported that Staff 14 punched Resident M in the ribs, then retracted the allegation and said he was just joking. Resident M then went to bed. Yesterday, Resident M said he had not been joking, and that it was true that Staff 14 had punched him. Resident M also indicated that Staff 14 had permitted play-fighting with peers. Resident M did not say whether any of this left marks or bruises. Resident M will see a nurse today. The incident would have most likely occurred Monday or Tuesday of last week. Resident M reported the punch occurred at "med cart" at the Atlas. Resident M said this happened outside, and there are reportedly no security cameras outside. The play-fighting took place at the administration building, by the bathrooms. There are cameras in that building but it is unknown whether the cameras would have caught the incident. Resident M's peer, Resident N, indicated he was there when there was play-fighting.

INVESTIGATION:

Interview with Administrator B at the facility on 10/1/19. Administrator B reports being aware of the allegations. Administrator B reports that Staff 14 has been employed here for about one year. There have been no previous incidents with children; no concerns for discipline of children. Administrator B reports that Resident M has a history of making claims against staff and peers. Administrator B reports that Resident M disclosed Staff 14 punched him, then retracted, then suggested again that it occurred. Administrator B does not know the reasoning behind this. Administrator B confirmed that Resident M did see a nurse.

Administrator B was asked about any other staff who were working during the alleged incident, video footage, and any knowledge of Staff 14 "playfighting" with students. Administrator B advised that the exact date of the incident is unknown as supposedly this occurred two or three weeks ago. He advised that there are no camera's outside the

Atlas building where this is said to have occurred. Administrator B has no knowledge or previous reports of Staff 14 playfighting with students. Administrator B advised that when this information was brought to management's attention, Staff 14 was moved to another dorm pending an investigation, as a safety plan. Administrator B advised that an Officer from Kalamazoo Public Safety was here yesterday and conducted interviews with Resident M, Resident O and Resident P.

Interview with Resident M at the facility on 10/1/19. The following are the notes of that interview:

> Resident M stated that he is 16 years old and has been here at Lakeside since February 15th. Resident M was asked if he knows why worker is here to speak with him. He responded yes, but then added it could be one of two different situations. Resident M was asked to start with one thing at a time. Resident M states the first incident was when Staff 14 hit him in the ribs at med cart. Resident M reported another student was starting to cause problems, so he yelled the "F" word at the student, and said stop staring at him. Resident M reports that Staff 14 issued him a verbal, told him to stop cussing. Resident M states that Staff 14 told him if he cussed again, he was going to punch him. Resident M advised that Staff 14 was chest bumping him, and getting in this face saying "I touched you, now what are you going to do about it? Let's take it there." Resident M acknowledged this escalated him. Resident M explained that Staff 14 was referring to wanting to fight when he commented, let's take it there. Resident M states that he tried to get past Staff 14 as they were standing in the doorway by Atlas, and Staff 14 responded by hitting him in his left side one time with his fist. Resident M denied having any marks from this incident, but he advised that it did hurt. Resident M reports that Resident N, Resident O, and Resident P all witnessed Staff 14 hit him.
>
> Resident M states that he already talked to police and filed a plea about the second situation. He advised this occurred a month ago. Administrator C was supposed to come talk to Resident M, but he states she never did. No one ever addressed the issue. Resident M advised the issue was him feeling unsafe because another student was sexually harassing him. Resident M expressed feeling upset that staff never came to talk to him about this. He reports that the harassment continues with the other student when they pass each other on campus, but he advised that they are no longer in the same dorms. Resident M acknowledged the change of dorms was staff's response to his complaint. Resident M continued and reported that the other student showed him his butt, and his penis several times. He reports that this other student said that there was mutual oral going on, but this did not happen. Resident M then reported that this student wasn't initially moved from the dorm for this reason, it was not until the student had another altercation with a different peer that he was moved. Resident M reports that staff called this "2 birds, one stone."

Resident M reports that this student continues to harass him on campus; blows kisses, and mouth things to him in passing.

Resident M was asked if he sees a counselor, or if there is trusted staff he can talk to hear at Lakeside. Resident M reports that Staff 14 is his counselor, and his therapist is Therapist D. Resident M reports that he feels safe talking to his therapist, or other staff such as Staff 16, or Staff 17. Resident M states that he feels safe at Lakeside. Resident M reports that he has therapy session once a week, but he can talk to someone as often as he needs to.

Resident M was asked why he reported this to staff, but then stated it wasn't true, and later came back saying it really did happen. Resident M states that the reason is because "Staff 14 said if I told, he was going to beat my ass." Resident M reports that Resident O told Staff 16 it really did happen.

Resident M reports that prior to this incident with Staff 14, he had a good relationship with him, and could follow up with him about any issues he has.

Resident M reports that since staff learned about this incident, Staff 14 is in a different dorm and is not having contact with him. Resident M reports felling like this is a good arrangement.

Resident M was asked if he saw a nurse after the incident. He reports that he did see Nurse 2 for the pain about 2-3 hours after everything happened and she gave him ibuprofen. Again, he reports that there were no marks or bruises.

Resident M then reported that Staff 14 struck Resident N and a different youth witnessed this happen. He reports it happened the same night that Staff 14 hit him. He reports that this occurred on campus C. Staff 14 was "playfighting" another student, they were punching each other in the chest and arm for points. Resident M states this is the first time he saw this happen. Resident M states that Resident N joined in the fight, and Staff 14 grabbed him by his shirt collar, and started punching him in the ribs. Resident M states Staff 14 punched Resident N more than one time; he doesn't know how many. Resident M reports that Resident N didn't do anything after Staff 14 punched him. Resident M is unaware if Resident N was hurt, or if he had any marks or bruises.

Resident M did not have any additional information to report. He was thanked for his time, and the interview ended.

Interview with Resident O at the facility on 10/1/19. He reported that he has been at the facility for three and a half months. Resident O was asked if he knows why he is being interviewed. He stated yes and commented that it's about the situation that happened with Resident M and Staff 14 at med cart. Resident O was asked if the situation was witnessed firsthand, or if he heard about it. He reports that he witnessed the whole thing. He reports that he thinks it happened two weeks ago.

Resident O was asked to share what he witnessed. He reports that Resident M was in previous issues with Staff 14 for crossing staff boundaries. Resident M was getting verbal's, and Staff 14 told Resident M if he crossed the boundaries again, that he was going to punch him. Resident O reports that Resident M didn't think Staff 14 was serious, and he kept testing his limits. Resident O states that Resident M got another verbal and was called into med cart. He reports that Staff 14 was in the way of med cart, Resident M grazed Staff 14 trying to get by him, and Staff 14 threw a punch in Resident M's lower back, in the middle area of his back. Resident O reports that he doesn't know if there were any marks from this, but Resident M went into the nurse to take meds, said his back hurt and took ibuprofen. Resident O reported another issue happened, but he didn't see this firsthand. Resident O reports that he doesn't know what this is about, only that Resident M told him something else was going to come out about Staff 14, but Resident M wasn't allowed to tell what this was because Staff 14 would do something to him. Resident O advised he doesn't know what that's about. Resident O was asked if he feels safe at Lakeside, and he responded "yes". He reports feeling safe because (some) staff know how to properly deal with kids. Resident O reports that other staff are "really aggressive", like Staff 14. Resident O was asked to give examples of this. He said, "Like, say if I'm sitting in my room, beating on my desk, and Staff 14 said to stop, but I ignored him and kept doing it. Staff 14 would walk in my room without a witness, and he gets in my face where there are no witnesses if he strikes me." Resident O denied Staff 14 has ever struck him.

Interview with Resident P at the facility on 10/1/19. Resident P stated that he has been here at the facility for seven months. Resident P was asked if he knows why he is being interviewed. He states yes and commented it's because of the Resident M incident. Resident P advised he witnessed this and saw it happen. Resident P advised he doesn't remember the exact day, but it was last week, or the week before in the evening. Resident P reports that he heard Staff 14 raise his voice at Resident M. Resident M wasn't doing anything disrespectful. Resident M walked by Staff 14 to go inside the building, and Staff 14 punched him in his side, told him he is not going to cross his boundaries. Resident P reports that he saw Staff 14 hit Resident M with his fist on his lower left side in the back, one time. Resident M responded asking Staff 14 why he punched him. Resident P reports that there was another staff there, but he doesn't remember who it was. Resident P reports that Staff 16 was there too, but she was standing inside the door. Staff 14 and the other staff were outside. Resident P reports that Staff 14 addressed Resident M about crossing boundaries. Resident M went inside, and it all ended.

Resident P reports that he has never seen anything like this happen before. He again commented that Resident M was not being aggressive. Resident P was asked if he feels safe at Lakeside, and he responded "sometimes." He was asked to tell more about this. He reports that he was restrained the other day because he tried to walk out the door. Resident P states that they say restraints are not supposed to hurt, but they do hurt; staff twist your joints around, and this happened to a lot of kids here. Resident P commented he already had another staff fired for doing a restraint inappropriately. Resident P advised staff could do restraints so they ae not painful, but they make it hurt on purpose. Resident P was asked if there is someone he can talk to when he feels that something is happening here that shouldn't be, or if staff is not handling job duties or restraints properly. Resident P states that they are supposed to be able to call a compliance number, but they ask about this and get refused. They are told they are not allowed to make outside calls, because they were restrained. Resident P reports that there are no staff here that he can trust. He advised he refused his meds and was told he would be restrained if he didn't take them. Resident P states that if it's something about a restraint, there is no one here you can talk to. Resident P was asked if he talks to his family to report his concerns. He states he does talk to his family. Resident P commented that he thinks the system here at Lakeside is "messed up". “Staff doesn't do anything. Administrator A says she will look at a complaint, but all she does is throw them in the trash.” Resident P reports that he has seen Administrator A do this. Resident P did not have any further information or comments. He was thanked for his time, and the interview ended.

Interview with Resident N at the facility on 10/1/19. He reports being at the facility for the past four and a half months. Resident N was asked if he knew why he was being interviewed and he reported that it involved Resident M. Resident N reports that Resident M kept getting verbal's and was going up levels. Resident N explained what levels mean. He reports that the first level is a verbal reminder, second level students can initiate; provide group support. Resident N states everything starts with a friendly non-verbal, then a concerned non-verbal, then friendly verbal, concerned verbal- helpful communication. Resident N states that staff can only call verbals. Resident N states he can't remember what started the incident between Resident M and Staff 14 but recalls Resident M continuously kept saying he was going to beat Staff 14's ass. Resident N advised that Staff 14 responded to Resident M in a calm manner, telling him he's not going to do that. Resident N reports Staff 14 was speaking positively to Resident M, telling him he doesn’t want things to go this way and it’s not going to help him get off IEP (Individual Program Enhancement Plan which involves 1:1 staffing ratio). Resident N reports that Resident M turned around to walk away, and Staff 14 tried to grab Resident M, and Resident M turned around saying Staff 14 was trying to hit him. Resident N states he was confused when Resident M said he witnessed something, because he saw Staff 14 grab Resident M, not punch him. Resident N was asked if he recalls any other student's or staff being present when this happened. He reports that maybe Resident Q and Resident O were there, but he feels like Resident Q was inside, and Resident O was outside but not engaged or paying attention to what was going on. Resident N states that from what he observed he felt that Staff 14 responded fairly to Resident M and was not escalating. Resident N was asked if he feels safe at Lakeside,

and he responded “yes”. He reports feeling this way because staff are respectful no matter what, even if they don't like you. Resident N states that staff's main priority is keeping everyone safe, and he feels they do a really good job with this. Resident N was asked if Resident M has problems with students and staff here. He shared that Resident M commonly has problems with other students in the same dorm. He has caused multiple fights and is constantly antagonizing other students, setting them up for failure. Resident N described a time where several students in the dorm got into trouble for inappropriate way of releasing sexual urges. Resident M made something that was supposed to help you masturbate, then passed them out to the students in the dorm. Resident M got into trouble for having this and proceeded to tell staff " by the way, I gave everyone one." Resident N states that Resident M will mouth words, or call staff names, like "bitch" behind their backs in front of the other students. Resident N was asked if something happened here at the facility, is there someone he feels comfortable talking to about it. He reports that there are many staff he feels comfortable talking to; Staff 17, Staff 18, Staff 19, Staff 20, Staff 14 and of course his family.

Phone interview with Nurse 2 at the facility on 10/1/19. Phone contact with Nurse 2 because she is currently on maternity leave. She does recall Resident M coming in for ibuprofen sometime the last week she worked before going off on leave. Nurse 2 could not recall the exact day, but thinks it was the last Thursday of September. Nurse 2 advised that Resident M came in and asked for ibuprofen, this is common due to him having pains in his thighs from pulled muscles. Nurse 2 reports that Resident M provided her no back story about any issues with a staff, and to her recollection the reason for the ibuprofen was for leg pain. Nurse 2 reports that her boss, would be able to look up notes for medication that was provided to Resident M. Nurse 2 recalls there being no physical injuries shown to her and having no knowledge that Resident M was hit by a staff.

Interview with Staff 14 at the facility on 10/2/19. He reports working as a Youth Counselor at the facility on the Zeus dorm for the past year. Staff 14 advised understanding the meeting today is to discuss the allegations made alleging he physically abused Resident M, and Resident N. Staff 14 adamantly denied the allegations. He was asked to report what he recalls taking place.

Staff 14 advised that he was coming up to med cart. Staff 21's group was already inside and possibly heard this. Resident M was talking rude to staff, cussing. Staff 14 states that this all happened a few weeks ago; he does not recall the exact day. Staff 14 states that Resident M was being addressed for his poor med cart norms. Staff 14 states he used a "stern, raised voice" in providing Resident M intervention; verbal warning to stop the negative behavior. Staff 14 states that Resident M didn't like the way this was said and started cussing out Staff 21. Staff 21 addressed Resident M outside of the Atlas building, and then Resident M entered the building, Staff 21 left with this group. Staff 14 reports that Resident M stood at the top of the stairs and was not moving, so he gave Resident M a "touch prompt" meaning his hand on Resident M's shoulder to move him. Staff 14 explained that Resident M was at the front of the line, and everyone else was waiting behind him. Staff 14 reports that this is all that happened. He denied striking or

hitting Resident M at any point. Staff 14 was asked if he permits any "playfighting" with youth. He advised that he has been employed here for over a year and has seen other staff get in trouble for this and has never allowed this to occur. Staff 14 denies saying to Resident M that he was going to beat his ass. Staff 14 reports that he does not swear at youth. Staff 14 was asked why he thinks Resident M, or anyone else would say he did this. He reports that Resident M doesn't want him as his primary, and does not like his prime brother, Resident Q. Staff 14 advised he thinks Resident M made this up so he could get another primary. Staff 14 advised that kids talk on campus, and he has heard things. He reports that kids know things before staff do, and this is what he is hearing the kids say. Staff 14 states that he heard Resident N say something about him allowing kids to play fight, and supposedly this happened at Campus C. Staff 14 reports that this is “absolutely not true”. Staff 14 was asked about the dynamic between Resident M and Resident N. Staff 14 reports that the two students do not really interact. He advises that per Resident M's IEP, he is not supposed to interact with the group while they are in the dorm. He advised Resident M is allowed to interact with students at school. He states that Resident M has been in an IEP 90% of the time that he has been here. Staff 14 was asked if video cameras captured the incidents, what they would revel. He reports that video would show that at the med cart, Resident M was acting upset because he was addressed. Staff 14 reports that Resident M is overreactive, and if he is calm, then he knows and is accepting that he was wrong. Resident M likes to gain the attention of a group. He advised that there are many staff here that Resident M has no respect for. Staff 14 advised that Resident M's mood determines his behavior; one minute he is good/calm, and respectful, and the next he is cussing and being disrespectful.

Interview with Administrator A (Executive Director), Administrator B (Living Services Director) and Administrator C (Director of Human Resources) at the facility on 10/8/19. They provided updated information on Resident M. They indicated that his worker has removed him from the program for a lack of progress. They also indicated that he is now back in detention in his home state. Administrator A was asked about the allegation of her throwing a grievance away and she denied every taking such action. She shared the process for a grievance and that the facility takes grievances very seriously.

Interview with Staff 14 at the facility on 10/8/19. Staff 14 updated his current situation. He reported that he remained off the dorm that Resident M was lodged on until Resident M was removed from the program. He was asked about his history of initiating restraints and he reported that he has only initiated three restraints in the time he has worked at the facility. He was asked about any disciplinary action taken against him and he shared that he “received a write-up for not covering his shift”.

Interview with Staff 15 at the facility on 10/8/19. She reports working as a Youth Counselor on the Zeus dorm at the facility for the past year. She was presented with the allegations and asked for her knowledge of the incident.

> Staff 16 and myself were in the staff office after dinner when Resident M said that he had a staff concern. He said that at the med cart, he

> witnessed Resident N get punched in the ribs by Staff 14. He said this happened on a Friday (September 20th). He also said that he was punched the same week in the ribs at campus chore (when residents work on cleaning up campus). He called Resident N over and asked him if he remembered the incident. Resident N started laughing and said, "yea I remember when Staff 14 punched him in the ribs". After Resident M told us these things he said, "I feel so bad now; I feel like I am going to get him in trouble." Then he asked if he was going to get a new primary.

Staff 15 was asked her opinion of Resident M and Staff 14,

> Resident M is very smart but uses his intelligence for negative things. He tends to be very untruthful. I believe he was scamming to get a new primary which seemed to be his primary focus. As for Staff 14, he interacts with the kids well and is a good staff. He can get loud at times but is not demanding with the kids.

Staff 15 ended the interview by stating that she doesn't believe the incident occurred.

Interview with Staff 16 at the facility on 10/8/19. She reports working at the facility for the past 3 years and is currently on the Zeus dorm as a Group Leader. She was asked about her knowledge of the allegations and she provided the following,

> Resident M first came to me and told me that he was hit by Staff 14 while at the med cart. When I followed up with him, he denied that it had happened and the next time we talked he was again saying that it did occur. A week had passed between him saying it didn't happen, to reporting it did happen. He also said that Resident N was a witness to the incident.

Because Staff 16 supervises Staff 14, she was asked about her opinion of him and his interactions with the residents.

> He is a good staff. He has appropriate boundaries with the residents and good relationship with them. He doesn't really restrain kids but rather talks with them.

Interview with Resident N at the facility on 10/8/19. A follow-up interview was conducted with Resident N in an effort to clarify information. He was again asked about his interactions with Staff 14 and he reported that "the most he has done with me is pat me on the shoulder". Resident N also reported that "the staff here are not physical and they don't fight us. They also don't let us fight each other." Resident N was again asked for his impression of Resident M and he stated, "he has gotten multiple people in trouble. He will find out things about you, then tease you and blow it up." Resident N indicated that the program is very helpful for him and that he has made progress on developing coping skills and anger management.

Interview with Staff 21 at the facility on 10/22/19. He reports working as a Youth Counselor on the Apollo dorm for the past year at the facility. He was asked about the incident and reports not recalling the situation or Resident M. He was unable to recall the day of the reported incident.

The local police interviewed Resident M, Resident O and Resident P and the following are the interviews that was conducted on 9/30/19:

> INTERVIEW WITH VICTIM / COMPLAINANT (RESIDENT M):
> I made contact with Resident M, DOB: xx-xx-xxxx. Resident M was identified verbally.
> Resident M stated that around Monday, 09-23-2019, or Tuesday, 09-24-2019, he was standing outside of the Atlas Building at Lakeside Academy, where he currently is court ordered to reside. He stated that it was approximately 2000 hours. He advised as they were waiting outside the building to head to "med cart" (where they get their daily medications from the nurse) he yelled at another student for staring at him. He stated he told the student "Stop fucking staring at me." He stated that a staff member, Staff 14, put him in a "verbal." He advised this is when they give them their expectations of what they should be doing, when they do something wrong. Resident M stated that when it was his groups turn to go into the building to head to med cart, Staff 14 said "Go in!" He advised that when Staff 14 said this, he punched him with a closed fist in his mid-section, on the left side of his back, near his ribs. He stated that after Staff 14 punched him, he turned around and said, "If you do it again, I'll punch you." He advised him and Staff 14 continued to argue back and forth briefly. He stated Staff 14 kept saying "Try me, try me." He stated that he told Staff 14 "If you touch me again, we can take it there." Resident M stated that as they continued to move towards inside the building, Staff 14 then pushed him and said "Yeah, I touched you again, let`s take it there." Resident M stated that there were other students who witnessed the encounter, being Resident O, and Resident P.
> Resident M stated that he feels safe around Staff 14 and does not desire prosecution.
>
> INTERVIEW WITH WITNESS (RESIDENT O):
> I made contact with Resident O, DOB: xx-xx-xxxx. I advised Resident O of the matter I was investigating and informed him to only tell me something if he witnessed it firsthand. I advised him to tell the truth and do not relay any information to me that was "told to him." He stated he understood.
> Resident O stated that approximately two weeks ago he was at Med Cart at the Atlas Building. He stated that his group was waiting outside for the people inside the building to transition out of the building. He stated that he heard Staff 14 tell Resident M to "stop crossing his boundaries." He

stated that that Staff 14 then said if Resident M did it again (crossed his boundaries), that he was going to "start throwing on" Resident M.
Resident O stated this meant he would assault Resident M. He stated that Resident M and Staff 14 were arguing, and Staff 14 put Resident M in a "verbal." He stated that when Resident M went to pass Staff 14 to get into the building, Staff 14 moved only partial way out of the doorway. He stated that this caused Resident M to brush passed Staff 14. He stated he then saw Staff 14 turn and punch Resident M.
Resident O stated that Resident M then began yelling at Staff 14.
I asked Resident O why he did not report the matter to any other staff, that he witnessed a staff member assault a student. He stated that Staff 14 advised them not to say anything to anyone.

INTERVIEW WITH WITNESS (RESIDENT P):
I made contact with Resident P, DOB: xx-xx-xxxx. Resident P was identified verbally. I advised Resident P of the matter I was investigating and informed him to only tell me something if he witnessed it firsthand. I advised him to tell the truth and do not relay any information to me that was "told to him." He stated he understood. Resident P stated that he is in a different dorm than Resident O and Resident M. He stated that his group went to med cart first last week, while Resident M`s group was waiting outside for them to finish. He stated that as he came outside, and Resident M`s group began to transition inside, he turned to look at Resident M`s group because he could hear Staff 14 getting loud at Resident M. He stated as he turned to look, he saw Staff 14 punch Resident M in his back. He stated he heard Staff 14 then say "Don`t ever cross my boundaries again." He stated that after this, Resident M and Staff 14 went inside the building and he did not witness anything else firsthand. Resident P stated that he knew Resident M did not report this matter to anyone else, so he took it upon himself to report the incident. He stated he is of "higher seniority" at Lakeside, so he is able to attend weekly meetings they have regarding issues at Lakeside. He stated he brought the assault up in their last meeting. He stated that he believes this is how the incident ended up being reported to me.

SUSPECT INFORMATION / INTERVIEW (STAFF 14):
I made contact with Staff 14, DOB: xx-xx-xxxx. Staff 14 was identified by his Michigan Ops. Staff 14 stated that Resident M was acting up outside of the Atlas building during the alleged incident. He stated that he tried to put Resident M in a verbal; however Resident M kept trying to walk away. He stated that he does not remember even arguing with Resident M during this incident. I asked Staff 14 why Resident M and two other students would all state they saw him assault Resident M. He stated he feels students lie to get certain staff members moved to different dorms, if they do not like that staff member. He stated that this is what he feels Resident M was trying to do with him. I asked Staff 14 if there was ever a time, he

> had to use physically touch Resident M during this alleged encounter. He advised he "may have used a touch prompt" for Resident M to move forward, but that he never punched him, nor restrained him. Staff 14 advised that any time he has to use physical force on a student he tries to make sure it is on camera. I asked him if he said the things that Resident M advised me, he argued with him about. He stated he did not because that would cause the student to "escalate" and that his job to "deescalate the students."

A review of the personnel files of Staff 14 provided the following information. During the period of 12/19/18 to 12/20/18 he received a written warning for missing team meetings and a written warning for being late to work. There is no documentation of the corrective action taken.

A review of the video recording was not completed. The day and time of the incident were not identified therefore no review of the recording took place.

A review of Resident M's discharge summary provided by the facility indicated the following.

> During this recording period, Resident M continues to struggle behaviorally and not hold himself accountable. He struggles with aggression, impulse control, defiance, disrespect, suicidal threats, not following staff directions, bullying behaviors, manipulation younger peers, grooming, lying, and not following rules on campus. He was creating and giving younger students on his dorm sex toys. He has stolen the teacher's passwords to her computer and was giving it to kids on campus. Resident M has yet to show he can keep himself or other safe. Resident M has made very little progress. Resident M has had a negative weekly rating since March and his behavior is getting worst. Resident M has not shown that he wants to better or have empathy for his victims. Resident M is still a "future status" in the program and doesn't see improvement.

A review of Resident O's Residential Service Plan provided the following information:

> During this reporting period Resident O has struggled with learning the norms and expectations of Lakeside's campus. Resident O has struggled with following simple directives and also using racial slurs towards staff and using profanity. Resident O's aggressive behaviors have become more prevalent and he has been rated negatively because of them. Resident O has been seen throwing objects, growling at staff, yelling at peers and staff, flipping off peers, and using profane language when upset and speaking to his peers. Resident O has been participating in group and individual therapy, as well as Pathways workbook group. Resident O has one individual therapy session per week, two group therapy sessions per week, and one Pathways workbook group

per week. Resident O is currently working on the vocabulary quiz, this quiz helps our students learn the terms that will be used throughout the Pathways workbook. Until this quiz is passed our students cannot begin working in their Pathways workbook.

A review of Resident P's Residential Service Plan provided the following information:

Overall Resident P has done well during this reporting as evident of his primarily positive behavior ratings. However, Resident P still demonstrates behavioral inconsistencies at times and has room for improvements in areas. Resident P typically follows staff directives, completes his schoolwork on time and volunteers to help out around the dorm and campus. On occasions, Resident P has become disrespectful toward staff and peers. Resident P typically does well accepting intervention regarding his behaviors and typically attempts to utilize the feedback he receives in order to improve his behavior. It has been reported that while on a home pass, Resident P violated the terms our Lakeside Academy's pass contracts by creating a Facebook account. Resident P has been able to maintain his Titan status throughout this reporting period.

A review of Resident N's Residential Service Plan provided the following information:

During this reporting period Resident N has been more negative than positive but the treatment team has seen improvement in his behaviors. Also at times Resident N has shown some leadership qualities within the group. Resident N has not been able to sustain any positive behaviors and has not been consistent with his behaviors. Some days Resident N's behaviors are inconsistent from hour to hour depending on which peers are around him the most. Resident N is working on Chapter 3 of 14 in his Pathways Sexually Reactive workbook. Resident N has done a good job while in the school setting, receiving all positive ratings in the school.

APPLICABLE RULE	
R 400.4157	**Behavior management.**
	(2) At a minimum, the behavior management system shall include all of the following: (b) Positive intervention strategies to assist residents in developing improved problem solving, self-management, and social skills.

ANALYSIS:	**Allegations 3:** Through face-to-face interviews and written documentation there is insufficient evidence to support the allegation that Supervisor 2 pushed and slammed Resident F against his bed. Other residents indicated that the allegations are not true and Resident F refused to participate in interviews. **Allegations 5:** Through face-to-face interviews and written documentation there is insufficient evidence to support the allegation that Staff 14 used inappropriate behavior management techniques with Resident M. Evidence uncovered through written documentation (Residential Service Plans) suggest that Resident M was struggling to be cooperative and investing himself in the program. It appears that he was engaged in behind the scenes in negative ways towards peers and staff. Residents M, O, and P report that this did occur, and Staff 14 and Resident N report that it did not. As there are conflicting stories, no video, and no evidence of the alleged act, a violation cannot be established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

With an acceptable corrective action plan, it is recommended that no change be made to the license of this child caring institution

11/04/2019

Paul Fatato Date
Licensing Consultant

Approved By:

November 13, 2019

Claudia Triestram Date
Area Manager