STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

February 19, 2020

Kelly Stone
Lakeside
3921 Oakland Dr
Kalamazoo, MI 49008

RE: License #: CI390201235
Investigation #: 2020C0214014
Lakeside

Dear Ms. Stone:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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

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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 #:	2020C0214014
Complaint Receipt Date:	01/09/2020
Investigation Initiation Date:	01/09/2020
Report Due Date:	03/09/2020
Licensee Name:	Lakeside
Licensee Address:	3921 Oakland Dr Kalamazoo, MI 49008
Licensee Telephone #:	Unknown
Administrator:	Sandra Lealofi, Designee
Licensee Designee:	Sandra Lealofi, 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?
A resident was pushed and physically assaulted by staff, causing injury to the child.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/09/2020	Special Investigation Intake 2020C0214014
01/09/2020	Special Investigation Initiated - Telephone
01/14/2020	Contact - Face to Face interviews with Supervisor 1, Staff 1, Staff 2, Staff 3, Resident A, and Resident B.
01/14/2020	Contact - Document Received: Incident Report, Resident information and Staff Personnel information.
01/15/2020	Contact - Document Received: Incident report.
01/16/2020	Contact - Document Received: Resident information.
01/16/2020	Contact - Face to Face interviews with Resident C, Resident D and Resident E.
01/17/2020	Contact - Document Received: Staff personnel information.
01/21/2020	Contact - Document Received: Staff personnel information.
01/22/2020	Contact - Document Received: Resident information.
01/29/2020	Contact - Face to Face interview with Staff 1.
01/29/2020	Inspection Completed-BCAL Sub. Compliance
01/29/2020	Exit Conference

ALLEGATION:

A resident was pushed and physically assaulted by staff, causing injury to the child.

INVESTIGATION:

The allegation in full reads as follows:

> On 01/05/20, around 8:30AM Staff 3 is alleged to have gotten in between Resident A and another resident that was fighting. Resident A is alleged to have been giving Staff 3 a hard time. Staff 3 was observed on camera shoving Resident A to a seated position on the couch. Staff 3 is alleged to have slapped, choked and scratched Resident A during this incident. There was a point when Staff 3 was alone with Resident A for approximately 30 seconds in his room. Resident A on 01/08/20, is observed with a mark on the neck from the incident. This incident is currently being investigation by the facility. Staff 3 is currently on suspension while the incident is being investigated.

I interviewed Supervisor 1 in collaboration with the DHHS Specialist at the facility on 1/14/20. He was interviewed because he is the supervisor for the dorm where the indictment took place. He reported being aware of the situation and allegations but not being present. He viewed the video recording and was asked about the appropriate interaction of Staff 3 in dealing with Resident B. He reported that Staff 3 did not follow the appropriate de-escalation techniques and indicated that Staff 3's interaction only escalated Resident B. He stated upon viewing the video recording, "Staff 3's interactions were worse than first believed".

I interviewed Staff 1 in collaboration with the DHHS Specialist at the facility on 1/14/20. She was interviewed because she was working on the dorm when the incident took place and she can be seen in the video recording. She indicated viewing the interaction between Staff 3 and Resident B and when asked about Staff 3's involvement she stated, "he was not responding appropriately to the situation". She denied observing the situation when Staff 3 pushed Resident B down and suggested that she must have looked away. She was asked about her observations when Resident B and Staff 3 were in his bedroom. Staff 1 was observed standing in the doorway of the room. She suggested that Staff 3 kept his distance from Resident B, even though, Resident B pushed him in the back. She indicated that Resident A was choking Resident B and she entered the room to help Staff 3 separate the two residents. She reports that she left the area after Staff 2 tapped her out and began to help Staff 3. She viewed the video recording and agreed that Staff 3's interaction was not appropriate and did not help Resident B deescalate.

I interviewed Staff 2 in collaboration with the DHHS Specialist at the facility on 1/14/20. He was interviewed because he was working the dorm during the incident. He reported not being in a position to observe the interactions between Resident B and Staff 3. However, upon viewing the video recording, he indicated that Staff 3 did not follow the appropriate behavior management techniques to deescalate Resident B. He reported leaving the area and going to Resident B's bedroom because of the noise he was hearing. He also reports that he observed Resident B swearing at Staff

3 and saying that he will not listen to him. He indicated that everyone in the room was standing and Staff had appropriate proximity with Resident B. He denied observing anyone choking or using inappropriate behavior management techniques in the bedroom.

I interviewed Resident A in collaboration with the DHHS Specialist at the facility on 1/14/20. He indicated being present during the alleged allegations. He also indicated that he went to assist Staff 3 when he was dealing with Resident B because Staff 3 asked for his help. He described the situation, “Resident B told Staff 3 to get out of his face and Staff 3 punched Resident B before throwing him to the ground. Resident A also suggested that he tried to get Staff 3 off of Resident A. He admitted to grabbing Resident A but only in the chest area and not around his neck. He indicated Staff 3 had his hands around Resident A’s neck during the encounter in the bedroom.

I interviewed Resident B in collaboration with the DHHS Specialist at the facility on 1/14/20. He reported not remembering why he had gotten into an argument with Staff 3. He described the interaction with Staff 3 in the bay area as him not punching but trying to push Staff 3 away from him. He also indicated that Staff 3 was yelling at him to calm down. He reports, “I walked past him and went to my room and slammed my door because I was frustrated. I was sitting on my bed when he came into my room.” He shared that Staff 3 “swung on me” and then “picked me up and slammed me to the ground”. He indicated that Staff 3 started choking him and had one hand around his neck. He also indicated that Staff 3 punched him in the face while holding his neck. He reports that he was also punched in the ribs by Staff 3 at this time. Resident B was asked about witnesses and he reported that Resident A was in the room and Staff 1 was standing in the doorway. He also reports that Resident A came into the room and told Staff 3 to stop and leave. He ended by reporting a belief that Staff 3 started trying to frustrate him in the bay and that he continued in his bedroom. He reports not feeling safe at the facility because “staff are here to hurt kids”. He was unable to provide specific situations to support this belief.

I interviewed Resident C in collaboration with the DHHS Specialist at the facility on 1/16/20. He was interviewed because he was viewed on the video recording as sitting next to Resident B during the confrontation with Staff 3. He reported that Resident B was cursing at Staff 3 and was placed in a “verbal” by Staff 3 for cursing. He also reported that Staff 3 was too close to Resident B and didn’t appear to be deescalating the situation. He indicated over hearing Resident B call Staff 3 a bitch and Staff 3 saying “then I’ll be a bitch”. He described Staff 3 as getting into resident’s face if they are being unsafe. He also indicated that Staff 3 will raise his voice if you’re being disrespectful towards him. He was asked about staff supervising residents when the three staff were observed going to Resident B’s room. He indicated that there was no staff present at that time to supervise the other residents. He ended the interview by reporting that he feels safe and comfortable “around most staff”.

I interviewed Resident D in collaboration with the DHHS Specialist at the facility on 1/16/20. He was interviewed because he was viewed sitting next to Resident B during the incident. He indicated that Staff 3 came into the bay “mad because he didn’t get enough sleep”. He also indicated the Resident B likes to play around and the situation escalated after Staff 3 told Resident B to be quiet. He reported that Resident B punched Staff 3 playing around, and Staff 3 shoved him down on the couch. He indicated that he walked over to Resident B and told him to calm down and sit down (this was viewed on the video recording). He shared talking to Resident B following the incident in his room and observing marks on his neck. He also shared that Resident B told him that Staff 3 choked him while they were in his room. The interview ended with Resident D reporting that he doesn’t feel safe at the facility because of the staff. He shared a belief that Staff 3 did something and other staff may do the same thing.

I interviewed Resident E in collaboration with the DHHS Specialist at the facility on 1/16/20. He was interviewed because he was standing near Resident B during the situation. He reported that Resident B was upset, and Staff 3 was trying to calm him down. After viewing the video recording, he admitted that Staff 3 did not deescalate the situation with Resident B but escalated him. Resident E reports not being aware of the actions that occurred in the hallway or Resident B’s room. He did report that once the other two staff went down to Resident B’s room there were no staff supervising the other residents in the bay area. He suggested that there were approximately twenty residents in the area. He ended the interview by stating that he “feels safe and staff treat kids appropriately”.

I interviewed Staff 1 in collaboration with the DHHS Specialist at the facility on 1/29/20. She was interviewed for a second time because of the report she was laughing at the situation with Resident B and was quick to suggest that the problem was Resident B. She denied laughing and reported that she made the statement that Resident B is the problem as a way of trying to let this writer know that “Resident B engages in dangerous behaviors”.

I reviewed the video recording and it shows Staff 3 approach Resident B and bump into him. They moved in front of the couch and Staff 3 can been observed pushing Resident B down into the couch. Staff 3 stands over Resident B and their faces almost touch, he is so close. Staff 3 then moves away, and Resident B tries to kick Staff 3. Resident B stands up and walks towards Staff 3. They push at each other until Staff 3 strongly pushes Resident B to the couch. Resident B gets up and moves towards his room. Part way down the hall, Staff 3 can be seen pushing Resident B into his room. Resident A is present and Staff 1 walks to the doorway of the bedroom. Resident B is in his room and Staff 3 walks into the room. Staff 3 comes out and it appears that Resident B pushes him from behind. Resident A goes quickly into the room followed by Staff 3. Staff 1 stands in the doorway and Staff 2 is observed walking down to the room. There are no other staff present in the video recording of the bay area where the other residents are located.

I reviewed the latest Updated Residential Treatment Plan for Resident B and documentation shows the facility is addressing the presenting problems in the plan. Required Staff interventions appear appropriate and they are aware of the significant emotional and mental health issues of Resident B.

I reviewed the Human Resources documentation for the staff involved and Staff 3 has been disciplined in the past (8/16/19) for improper supervision of a resident. There is no documentation of the action taken in regard to the discipline. The other two staff have no documentation of discipline issues in their personnel file.

During the exit conference with Administrator 1, Administrator 2, Administrator 3, Administrator 4 and Administrator 5 they report that upon reviewing the video recording, Staff 3 is going to be terminated because of his failure to follow the behavior management techniques. They also report that since being made aware of the allegations. Staff 3 has not been allowed back on campus.

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:	Evidence provided through interviews and a video recording support the allegations of Staff 3 using inappropriate behavior management techniques when addressing Resident B. This is supported by three other residents present in the bay area and Resident A's report of the situation in Resident B's bedroom. **Technical Assistance:** The importance of documentation of disciplinary action taken with staff was discussed. It was suggested that the personnel files have this documentation and they indicated that the facility is working on updating their documentation for personnel files.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

During this investigation, it was discovered upon reviewing the video recording that the two staff present went to Resident B's bedroom to assist Staff 3. This left

approximately twenty residents unsupervised for approximately one minute and fifteen seconds

INVESTIGATION:

I interviewed Resident C in collaboration with the DHHS Specialist at the facility on 1/16/20. He indicated that during the situation when Staff 1, Staff 2, and Staff 3 were dealing with Resident B in his bedroom, there were no staff supervising the other residents on the bay.

I interviewed Resident E in collaboration with the DHHS Specialist at the facility on 1/16/20. He also indicated the same as Resident C that there were no staff supervising the residents in the bay during the situation with Resident B in his room.

I interviewed Staff 1 in collaboration with the DHHS Specialist at the facility on 1/14/20. She was asked about the supervision of residents during the incident with Resident B in his bedroom and she reported that the only staff supervising the residents in the bay were herself, Staff 2 and Staff 3. When she reviewed the video recording and noticed that the three staff were in the bedroom area, she admitted that the rest of the residents were unsupervised from the time Staff 2 left the area and she returned to the area.

I interviewed Staff 2 at the facility on 1/14/20. He reported that the only staff working at that time on the dorm were himself, Staff 1 and Staff 3. After viewing the video recording, he agreed that there was no staff supervision during the time the three staff were dealing with Resident B in his bedroom.

A review of the video recording of the incident documented that there were no staff present to supervise residents for approximately one minute and fifteen seconds. The three staff assigned to supervise the residents were engaged with Resident B in his room.

APPLICABLE RULE	
R 400.4126	**Sufficiency of staff.**
	The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff on duty to perform the prescribed functions required by these administrative rules and in the agency's program statement and to provide for the continual needs, protection, and supervision of residents.

ANALYSIS:	Evidence provided through interviews and a video recording support the additional finding that staff did not provide the appropriate supervision for approximately one minute and fifteen seconds during the situation with Resident B in his bedroom.
CONCLUSION:	**VIOLATION 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

1/30/2020

Paul Fatato — Date
Licensing Consultant

Approved By:

February 19, 2020

Claudia Triestram — Date
Area Manager