

STATE OF MICHIGAN FAMILY INDEPENDENCE AGENCY OFFICE OF CHILDREN AND ADULT LICENSING



January 28, 2004

Diane Henneman Havenwyck Hospital 1525 University Dr Auburn Hills, MI 48326

> RE: License #: Cl630201167 Investigation #: 2004C0216023 Havenwyck Center

Dear Ms. Henneman:

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

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

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

Please review the enclosed documentation for accuracy and feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (248) 975-5053.

Sincerely,

Betty Lee, Licensing Consultant Office of Children and Adult Licensing Suite 358 41000 Woodward Bloomfield Hills, MI 48304 (248) 975-5066

Enclosure

MICHIGAN FAMILY INDEPENDENCE AGENCY OFFICE OF CHILDREN AND ADULT LICENSING SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #: Cl630201167

Investigation #: 2004C0216023

Complaint Receipt Date: 12/04/2003

Investigation Initiation Date: 12/05/2003

Report Due Date: 02/02/2004

Licensee Name: Havenwyck Hospital

Licensee Address: 1525 University Dr

Auburn Hills, MI 48326

Licensee Telephone #: (248) 373-4074

Administrator/Licensee Designee: Robert Kercorian, Administrator

Name of Facility: Havenwyck Center

Facility Address: 1360 Doris Road.

Auburn Hills, MI 48326

Facility Telephone #: (248) 373-4074

Original Issuance Date: 12/01/1992

License Status: REGULAR

Effective Date: 12/07/2001 **Expiration Date:** 12/06/2003

Capacity: 35

Program Type: CHILD CARING INSTITUTION, PRIVATE

II. SUMMARY OF ALLEGATIONS

Facility was aware of a resident's suicidal tendencies. On 12/01/03, staff gave this resident a razor to shave her legs. The resident cut her arms, was transported to the hospital and required 17 stitches for 3 wounds.

III. POTENTIAL RULE/STATUTORY VIOLATIONS

R 400.4126 Sufficiency of staff.

(1) The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff to perform the prescribed functions required by these administrative rules and to provide for the needs, protection, and supervision of residents.

IV. METHODOLOGY

12/04/2003	Special Investigation Intake 2004C0216023
12/05/2003	Special Investigation Initiated - Telephone
01/06/2004	Contact - Telephone call made Contact FIA worker
01/27/2004	Contact - Face to Face Interview with Resident A
01/27/2004	Contact - Face to Face Interview with Staff Person 1, Kristine McClellan
01/27/2004	Contact - Face to Face Interview with Staff Person 2
01/27/2004	Contact - Face to Face Interview with Staff Person 3
01/27/2004	Contact - Document Received Reviewed Resident A's Case File

V. DESCRIPTION OF FINDINGS

R 400.4126 Sufficiency of staff.

Resident A stated that she slashed her wrist while taking a shower because she heard voices that told her to cut herself.

She cut her left arm in three different places, which resulted her required emergency medical care. Resident A received 17 stitches for the three cuts to her arm that were approximately two inches in length. Resident A said she also made two other cuts on her that were approximately one to two inches in length. Resident A had several other cuts on her arm where she said she cut herself while in previous placements.

Resident A said that she heard voices that told her to cut herself two days prior to her actually cutting her arm. She said that when she heard the voices the first time she told staff about the voices and gave staff her razor after shower so that she would not attempt to follow the commands of the voices. Resident A said that on the day that she cut herself she told two staff about the voices. Resident A said that Staff Person 1 "processed with her" by asking her about the voices and told her to sit near the office so she would feel safe. She said that Staff Person 1 told Staff Person 2 about the voices when Staff Person 2 arrived for duty around 2:30 PM on the day of the incident. Resident A said that Staff Person 2 also told her to sit by her near the workstation so that she would feel safe.

Resident A said that when they had their shower around 5:00 PM she asked Staff Person 2 for her shaver for grooming while having her shower. She said Staff Person 2 asked her if she was okay and if she was still hearing voices. She said she lied and told Staff Person 2 that she was not hearing the voices that told her to harm herself. Resident A said she was not intending to harm herself when she went into the shower with the shaver, but once she was in the shower the thought of harming self resurfaced. She said she cut herself without thinking.

Resident A said that after she cut herself, she realized that it was inappropriate. She said she got Staff Person 2's attention and they took her to Crittenton Hospital for emergency treatment.

Staff Person 2 said that when Resident A told her of the voices she "processed" the situation with Resident A by encouraging her to talk about what she was hearing and by identifying ways to cope with the intrusive messages. Staff Person 2 said that when Resident A heard voices she would seek staff's attention. She also said that Resident A gave her shaving razor to staff just two days previously when she heard voices that told her to harm herself. Staff Person 2 said that on the day that she gave Resident A the shaving razor, Resident A denied hearing

voices. Staff Person 2 said that because Resident A gave her the shaving razor two days earlier to prevent harm to herself, she trusted Resident A when she told her that it would be safe to give her a razor during showering so she could do personal grooming. Staff Person 2 said that the therapist is made aware of residents' behaviors though case narratives, which are kept in the residents' case files.

Staff Person 3 said that Resident A came to the program with a history of cutting. However, Resident A did not engage in any cutting behavior for approximately four months since the most recent incident. Resident A was placed in the program on November 13, 2003. Staff Person 3 said that Resident A would inform staff when she heard self-harm voices and that just before she cut herself she gave staff the shaving razor to prevent this from occurring.

Staff Person 4 shared essentially the same information as the other staff regarding Resident A's behavior before and on the day that she cut herself in the shower.

The case file revealed that Resident A was placed in the Havenwyck program on November 13, 2003. Cut herself on December 1, 2003. Resident A is currently on a special plan to assure that she does not engage in any additional cutting behavior.

VI. CONCLUSIONS

R 400.4126 Sufficiency of staff.

(1) The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff to perform the prescribed functions required by these administrative rules and to provide for the needs, protection, and supervision of residents.

Based on the findings, the facility did not have sufficient staff to assure the safety and protection of the Resident. Although the facility was in ratio with the staff to resident ratio, Resident A was engaged in self-harm by cutting herself.

VIOLATION ESTABLISHED

VII. RECOMMENDATION

I recommend that the institution's regular license remains unchanged. This recommendation is based upon the institution submitting an acceptable corrective action plan.

Betty Lee	Date
Licensing Consultant	
Approved By:	
Approved by.	
Barbara Smalley	Date
Area Manager	Date