STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING

JENNIFER M. GRANHOLM
GOVERNOR

ISMAEL AHMED
DIRECTOR

April 17, 2008

Robert Kercorian
Havenwyck Impulse Disorder Program 2
10300 8 Mile Rd.
Ferndale, MI 48220

RE: License #: CI630287494
Investigation #: 2008C0107029
Havenwyck Impulse Disorder Program 2

Dear Mr. Kercorian:

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,

Patricia L. Dudgeon-Smith, Licensing Consultant
Bureau of Children and Adult Licensing
Suite 1000
28 N. Saginaw
Pontiac, MI 48342
(248) 975-5088

enclosure

MICHIGAN DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	CI630287494
Investigation #:	2008C0107029
Complaint Receipt Date:	02/15/2008
Investigation Initiation Date:	02/15/2008
Report Due Date:	04/15/2008
Licensee Name:	Havenwyck Hospital
Licensee Address:	1525 University Dr Auburn Hills, MI 48326
Licensee Telephone #:	Unknown
Administrator:	Robert Kercorian, Administrator
Licensee Designee:	
Name of Facility:	Havenwyck Impulse Disorder Program 2
Facility Address:	10300 8 Mile Rd. Ferndale, MI 48220
Facility Telephone #:	(248) 373-9200
Original Issuance Date:	10/08/2007
License Status:	REGULAR
Effective Date:	04/08/2008
Expiration Date:	04/07/2010
Capacity:	26
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

It is alleged that inappropriate restraint was utilized with Resident A.

III. METHODOLOGY

02/15/2008	Special Investigation Intake 2008C0107029
02/15/2008	Special Investigation Initiated - Telephone spoke to program manager
02/21/2008	Contact - Face to Face interviews with resident, staff, review of video tape, review of documents, exit conference
02/21/2008	Inspection Completed On-site
02/21/2008	Inspection Completed-BFS Sub. Compliance
04/17/2008	Corrective Action Plan Requested and Due on 05/05/2008

ALLEGATION: It is alleged that inappropriate restraint was utilized with Resident A.

INVESTIGATION:
On 02/21/08 the following documents were reviewed on-site:

- Incident report completed by Staff Person 1, dated 02/06/08. The report indicated that Staff Person 1 and Supervisor 1 intervened with Resident A, due to his aggression toward peers. The report indicated that Supervisor 1 made the decision to move Resident A to a behavior management room. The report indicated that Resident A fell to the floor to prevent staff from moving him, and was thus "pulled to the BMR."

On 02/21/08 video surveillance tape of the incident was reviewed on-site. The tape indicated that at 6:44p.m., Resident A was pulled by his arms by Staff Person 1 and Supervisor 1 down the hallway, while the resident was on the ground. The tape indicated that Resident A was pulled into a BMR. The tape indicated that inside the BMR, Resident A attempted to exit by crawling out of the room, at which time he was pulled back into the room by Supervisor 1. The tape indicated that he was then placed on the mat in the BMR, where Staff Person 1, Supervisor 1, and Nurse 1 stood over him. The tape indicated that Supervisor 1 and Staff Person 1 held Resident A down on the mat. The tape indicated that Resident A was then released at which time the three staff left the BMR. The tape indicated that the door to the BMR remained open, and that Supervisor 1 stood in the doorway. The tape indicated that Resident A entered the BMR at 6:47p.m. The tape ended at

approximately 6:50p.m., and the subsequent tape was not longer available for review. There is no documentation indicating how long Resident A was in the BMR.

On 02/21/08 Staff Person 1 was interviewed on-site. Staff Person 1 stated that on 02/06/08 he assisted Supervisor 1 with moving Resident A to the BMR. Staff Person 1 stated that Resident A was pulled to the BMR, due to the fact that he would not walk voluntarily. Staff Person 1 stated that it is not normal to pull a resident by their arms down the hallway.

On 02/21/08 Supervisor 1 was interviewed on-site. Supervisor 1 stated that "it was not a good situation." Supervisor 1 stated that she "made a bad judgment call," by pull Resident A down the hallway by his arms.

APPLICABLE RULE	
R 400.4137	**Discipline and behavior management.**
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (i) Excessive chemical, mechanical, or physical restraint.
ANALYSIS:	Based on interviews and review of documentation, and review of videotape, violation of this rule is established. The information provided indicated that Staff Person 1 and Supervisor 1 pulled Resident A down the hallway by his arms. This action is inappropriate, and constitutes excessive physical restraint.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS: During the course of this investigation, it was determined that Resident A was simultaneously restrained and secluded.

INVESTIGATION:
On 02/21/08 video surveillance tape of the incident was reviewed on-site. The tape indicated that at 6:44p.m., Resident A was pulled by his arms by Staff Person 1 and Supervisor 1 down the hallway, while the resident was on the ground. The tape indicated that Resident A was pulled into a BMR. The tape indicated that inside the BMR, Resident A attempted to exit by crawling out of the room, at which time he was pulled back into the room by Supervisor 1. The tape indicated that he was then placed on the mat in the BMR, where Staff Person 1, Supervisor 1, and Nurse 1 stood over him. The tape indicated that Supervisor 1 and Staff Person 1 held Resident A down on the mat by securing his legs and arms. The tape indicated that Resident A was then released at which time the three staff left the BMR. The tape indicated that the door to the BMR remained open, and that Supervisor 1 stood in the doorway. The tape indicated that Resident A entered the BMR at 6:47p.m. The tape ended at approximately 6:50p.m., and the subsequent tape was not longer

available for review. There is no documentation indicating how long Resident A was in the BMR.

On 02/21/08 the Program Director and Program Manager were interviewed on-site. The Program Director stated that the staff have not considered placement in the BMR as "seclusion," defined in PA 116, due to the BMR door being kept open during a resident's time inside. The Program Director stated that residents may be encouraged to take a time out in the room, however the door remains open, and the resident should not be prohibited from exiting the room if they choose.

On 02/21/08 Staff Person 1 was interviewed on-site. Staff Person 1 stated that inside the BMR, he assisted Supervisor 1 in holding Resident A while Nurse 1 was giving Resident A medication.

On 02/21/08 Supervisor 1 was interviewed on-site. Supervisor 1 stated that she assisted Staff Person 1 in holding Resident A in the BMR while Nurse 1 gave him medication.

APPLICABLE RULE	
MCL 722.112d	**Personal restraint or seclusion; use; limitations; requirements.**
	(3) Personal restraint or seclusion must not result in harm or injury to the minor child and shall be used only to ensure the minor child's safety or the safety of others during an emergency safety situation. Personal restraint or seclusion shall only be used until the emergency safety situation has ceased and the minor child's safety and the safety of others can be ensured even if the order for personal restraint or seclusion has not expired. Personal restraint and seclusion of a minor child shall not be used simultaneously.
ANALYSIS:	Based on interviews, review of documentation, and review of video surveillance tape, violation of this statute is established. The information provided indicated that Resident A was restrained and secluded simultaneously.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS: During the course of this investigation, it was discovered that Resident A was secluded without an order for seclusion.

INVESTIGATION:
On 02/21/08 video surveillance tape of the incident was reviewed on-site. The tape indicated that at 6:44p.m., Resident A was pulled by his arms by Staff Person 1 and Supervisor 1 down the hallway, while the resident was on the ground. The tape

indicated that Resident A was pulled into a BMR. The tape indicated that inside the BMR, Resident A attempted to exit by crawling out of the room, at which time he was pulled back into the room by Supervisor 1. The tape indicated that he was then placed on the mat in the BMR, where Staff Person 1, Supervisor 1, and Nurse 1 stood over him. The tape indicated that Supervisor 1 and Staff Person 1 held Resident A down on the mat. The tape indicated that Resident A was then released at which time the three staff left the BMR. The tape indicated that the door to the BMR remained open, and that Supervisor 1 stood in the doorway. The tape indicated that Resident A entered the BMR at 6:47p.m. The tape ended at approximately 6:50p.m., and the subsequent tape was not longer available for review. There is no documentation indicating how long Resident A was in the BMR.

On 02/21/08 the Program Director and Program Manager were interviewed on-site. The Program Director stated that the staff have not considered placement in the BMR as "seclusion," defined in PA 116, due to the BMR door being kept open during a resident's time inside. The Program Director stated that residents may be encouraged to take a time out in the room, however the door remains open, and the resident should not be prohibited from exiting the room if they choose.

On 02/21/08 Staff Person 1 was interviewed on-site. Staff Person 1 stated that his understanding of the BMR placement is that "it's a safe environment where it prevents the residents from harming themselves or others." Staff Person 1 stated that the BMR is "not a time-out," and that when a resident enters a BMR, they "must sit 15 minutes appropriately on the mat." Staff Person 1 stated that if a resident refuses to enter a BMR, "we physically escort him in, if he tries to come out staff will pull him back in." Staff Person 1 was asked what the difference between "BMR" and "seclusion" placements is. Staff Person 1 stated that during seclusion placements, the door is locked. Staff Person 1 stated that he does not know how long Resident A was contained in the BMR on 02/06/08.

On 02/21/08 Supervisor 1 was interviewed on-site. Supervisor 1 stated that her understanding of the BMR placement is so "secure a resident from harm." Supervisor 1 stated that while a resident is placed in a BMR, they can exit if they choose. Supervisor 1 stated that during the placement of Resident A in the BMR on 02/06/08, she did pull Resident A back into the room when he attempted to exit, "because he normally goes out to hit or bite someone." Supervisor 1 stated that if a resident is placed into a BMR, 'he has to stay there, but not for a set time." Supervisor 1 stated that residents are permitted to leave "when they regain control." Supervisor 1 stated that she does not know how long Resident A was contained in the BMR on 02/06/08. Supervisor 1 was asked what the difference between "BMR" and "seclusion" placements is. Supervisor 1 stated that during seclusion, the door is closed and locked.

APPLICABLE RULE	
MCL 722.112d	**Personal restraint or seclusion; use; limitations; requirements.**
	(8) A licensed practitioner shall order the least restrictive emergency safety intervention measure that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. Consideration of less restrictive emergency safety intervention measures shall be documented in the minor's child's record.
ANALYSIS:	Based on interviews, review of documentation, and review of video surveillance tape, violation of this statute is established. The information provided indicated that Resident A was placed into seclusion without an order for seclusion from an LIP. The information provided indicated that although Supervisor 1 and Staff Person 1 reported that Resident A's placement in a BMR was not a "seclusion" placement due to the door not being locked; Resident A was, in fact, secluded, as he was prevented from exiting the room.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, the recommendation remains unchanged.

04/18/2008

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Patricia L. Dudgeon-Smith Date
Licensing Consultant

Approved By:

April 18, 2008

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Linda Lee Date
Area Manager