STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

November 17, 2017

Steven Laidacker
Lakeside
3921 Oakland Dr.
Kalamazoo, MI 49008

RE: License #: CI390201235
Investigation #: **2017C0214025**
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 citation will be achieved; this includes identifying behaviorally specific action steps.
    - Repeat violations must include an explanation of why the previous corrective action plan did not result in compliance.
- Individuals directly responsible for implementing the corrective action step for each licensing statute and rule, Contract item, DHHS policy or ISEP section citation; e.g. workers, supervisors, program managers, director, etc.
- Specific time frames for each citation as to when the correction will be implemented and completed.
- How continuing compliance will be maintained once compliance is achieved; this includes identifying specific action steps for continuous monitoring.

- Signature of the responsible party and date.

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 #:	2017C0214025
Complaint Receipt Date:	08/18/2017
Investigation Initiation Date:	08/18/2017
Report Due Date:	10/17/2017
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:	09/18/2017
Expiration Date:	09/17/2019
Capacity:	124
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

	Violation Established?
Improper Supervision	Yes
Additional Findings	Yes

III. METHODOLOGY

08/18/2017	Special Investigation Intake 2017C0214025
08/18/2017	Special Investigation Initiated - On Site - Meeting with Brad Hodges (Living Services Director) and Erin Newton (Director of Human Resources).
08/23/2017	Contact - Face to Face – Meeting with Brad Hodges (Living Services Director), Erin Newton (Director of Human Resources), Daquavis Martin (Program Director of Apollo dorm), James Ray (Shift Leader on Apollo dorm), DeJuan Hollman (Youth Counselor on Apollo dorm), Resident B, and Resident C.
08/29/2017	Contact - Face to Face - Meeting with Brad Hodges (Living Services Director), Erin Newton (Director of Human Resources), Max Pennock (Youth Counselor on Poseidon dorm), Staff 1 Reece (Youth Counselor on Athena dorm), DeJuan Hollman (Youth Counselor on Apollo dorm), Resident D, Resident E, Resident F, and Resident G.
08/29/2017	Exit Conference - Meeting with Brad Hodges (Living Services Director) and Erin Newton (Director of Human Resources).
08/29/2017	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

RESIDENT A, a little red haired boy, lives in the Apollo dorm at Lakeside Resident Academy. His age is unknown. His parents are unknown. Last night, RESIDENT A was raped by another child resident living at Lakeside Resident Academy. The incident occurred in the bathroom. The staff members at the facility are not letting him get the medical treatment he needs. They are trying to hide it, so no one knows because if someone found out the facility would be shut down due to everything else

that has went on there. The staff are keeping it from the nurse because they think she would call in and report the incident.

A staff member deals drugs in the facility; their name is not known. Staff members also video record fights that take place instead of stopping them. A long time ago, a staff member beat three children staying in the facility. The people involved are unknown.

INVESTIGATION:

Meeting with Brad Hodges (Living Services Director) and Erin Newton (Director of Human Resources) at the facility on August 23, 2017. We discussed the allegations and both report that they are serious in nature but that it is very unlikely that the allegations will be substantiated. They report that Resident A is currently on a two-to-one staff ratio and that he is never (with the exception of using the bathroom) out of the site of a staff member. Both report that there have been no reports of the allegations at the facility.

Resident A was not interviewed because he struggled emotionally when interviewed by authorities regarding these allegations. Resident A has a history of being sexually abused and is experiencing significant trauma from the events in his life and discussing the allegations only re-traumatizes him.

The complainant reports being informed of the allegations from another individual (Staff 1) who was a staff member at the facility. Staff 1, who originally made the allegations was the staff who was hired without having the appropriate central registry clearance. The following is the information gathered from an interview with Staff 1 which took place on August 24, 2017 at the DHHS building in Kalamazoo.

> “Face to face contact made with Staff 1 who appeared in the Kalamazoo DHHS lobby asking to speak. Staff 1 stated that a worker had tried to make contact with her at Lakeside Academy where she is employed and she was trying to get in touch with that worker. She did not have a name, and this discussion took place with her privately in an office. Staff 1 stated that she was there to "make a statement" about an incident regarding a child named Resident A. She went on to explain that CPS had come to Lakeside to see Resident A and they had wanted to talk with her, but she was not able to speak with them at that time. She stated that a "student had sex with Resident A and they didn't want him to have a medical". She was asked how she knows that a student did this to Resident A and she stated "it's all over campus, everyone knows about it". She was asked if she witnessed this incident and she stated that she did not. She then stated that a "therapist, Audrey heard about it". She was unable to give Audrey's last name. She stated that "DQ" a program director of the Apollo dorm "brought Resident A to CPS and he was telling him what to

say". She was asked how she knows that DQ was doing this and she stated that she could just tell. She then stated that the program director, Steve Rogers was coaching the staff on what to say and that he told her to "stop talking so much". When asked what he was referring to, she could not give a specific example or explanation as to what Steve meant. She then stated "they told us at a meeting that they didn't want Resident A to have a medical from the sexual abuse because one more incident would put us on a provisional". When asked who was giving this direction, she stated Erin, Brad and Sam, the program director from Zeus. She was asked to explain more detail about how this direction was given and she stated that this was during a staff meeting in June, but then stated that it was a meeting with only the staff in the dorm. She kept stating that there is "just so much" and "no one knows how much goes on there" and "if they knew I was here, they would kill me". She was asked what she meant by things going on and she stated that "staff are on their cell phones all the time, not paying attention" and "a boy ran off in the bushes for over 20 minutes and no one even knew he was gone". When asked for details on this, she stated that the boy ran from the Atlas workout gym and that staff was so busy working out that they did not notice the boy take off. She was unable to name the child who allegedly did this. She stated that two girls had sex with each other and that the program director told her "this never happened". She was asked how she knows that a sexual encounter occurred with two girls and she stated that one of the girls, "told me everything and all the details". She then stated that two boys had oral and anal sex in the Zeus dorm in June and that Erin Ringo was fired for this. She stated that there is sex between students all the time and the staff just do not report it. She could not provide any names or specifics from personally witnessing these acts. She then stated "there's lots of children there".

Staff 1 stated that she had a long meeting with Mark. When asked for his name, she could not remember his last name. She stated that she reported the incidents to him "in general". She stated that the staff are selling and using marijuana on campus and then blaming the kids for it. She stated that they are having inappropriate contact with the children by restraining them all the time. She stated that staff have kicked kids under the table in the laundry room, but then admitted that she did not witness any of these acts. She stated that staff are all "friends outside of there and they all hang out and smoke together". She stated that staff tells the children "you about to get this work" and that they say this about restraining children.

After noting Staff 1's concerns, she asked about working at Lakeside if a person is on the Central Registry. She then explained that she was at DHHS today to get her background check completed. She was asked how long she has worked at Lakeside and she stated that she has worked

there since April of this year. She then stated that she was worried about getting her background check. It was realized that Staff 1 was hinting that she could not pass the appropriate background checks; however, she has already been working at lakeside. Staff 1 was asking a lot of questions about the registry. It was explained to her that if a person is on the registry, then they cannot work for Lakeside. She then disclosed that she is on the registry for her "husband beating her son with a belt". She then stated that her children were removed from her and that she didn't understand why she is on the registry. She was advised that this interviewer does not know her case, but that children are not usually removed for just a one-time incident and that if she is on the registry, there must be more to the story. She then asked questions about being expunged and she asked "do other states check the registry". She was indicating that her plan was to move to another state so she could get a job working with children.

During the interview, it became apparent that Staff 1 did not have any direct knowledge of the incidents that she was talking about and that she was potentially fabricating and embellishing the stories she was sharing. She was calm and pleasant, but did not seem to be mentally stable. She was thanked for her time and she was walked back to the lobby."

Meeting with Jennifer Dixon (Staff 1's former foster care worker) at the Kalamazoo DHHS building on 8/23/17: It was stated that Staff 1 is a former client and in 2015 had her ten children removed and placed in foster care after having an open case due to domestic violence, Staff 1 was substantiated for physical neglect and improper supervision. Ms. Dixon stated that there is documentation that Staff 1 had incited a physical altercation between her daughter and another teenager and video recorded the girls fighting and posted in online. Ms. Dixon stated that there is also a case contact that included disclosure from Staff 1 that she had once smuggled cocaine in her vagina while pregnant with one of her children. It was reported that Staff 1 had completed a psychological assessment with Dr. Haugen and was diagnosed with significant mental illness.

Meeting with Daquavis Martin (Program Director of Apollo dorm) on August 23, 2017. Staff Daquavis reports working at the facility for the past four and a half years and has been the Program Director for the Apollo dorm for the past year and a half. Staff Daquavis indicates that Resident A is lodged on the Apollo dorm and has no interaction with his peers until the end of the day at "lights out". He also indicates that this is because of the severe acting out behaviors that Resident A engages in at the facility. Staff Daquavis reports that Resident A is receiving weekly therapy and is allowed to engage in activities outside of the dorm. Staff Daquavis reports that Resident A is on a two-to-one staff to student ratio because of his sexual acting out behaviors towards other residents and staff. Staff Daquavis also reports Resident A is never outside of a staff member's line of sight unless he is using the bathroom. Staff

Daquavis also reports that when Resident A is using the bathroom, one staff will stand outside of the door and no other individual is allowed in the bathroom as long as Resident A is in the bathroom. Staff Daquavis was asked about the staffing on third shift and he reports that three staff are always present on the dorm with the responsibility to “walk the halls and check on residents throughout the night”. Staff Daquavis indicated that there have been no issues overnight and the medication that Resident A takes helps him “sleep well”. Staff Daquavis gave a history of the staff to resident ratio for Resident A. “The two-to-one began around April of this year and went on for a thirty day period before we attempted to transition him back into the normal ratio on the dorm. Once we tried to transition him back, he began to act out sexually so we quickly placed him back on the two-to-one staffing ratio.” Staff Daquavis was asked about the sexual acting out of Resident A and he gave the following description. “There have been no reports of any sexual activities towards Resident A and mostly other kids would report that Resident A approached them. There were a couple of incidents of him flashing himself to other residents or a staff member.” Staff Daquavis described the conditions on the dorm where Resident A is lodged. “We have twenty-four kids on the dorm and six staff on at all times. We have had almost no fights and the last fight on the Apollo dorm was last year. We don’t have a lot of aggressive kids, we have trauma kids. If a fight was to break out between residents, then an incident report would be developed. At times kids will get into an argument while playing basketball or something but our staff are very quick to intervene to keep it from escalating.” Staff Daquavis reports that he has not seen any staff deal with the residents inappropriately. He also reports having no knowledge of any staff beating residents and that there is always a Group Leader on each shift. Staff Daquavis was asked about the allegation of staff using cell phone to video residents fighting and he replied, “cell phone can’t be used when staff are working and they can’t have them on the floor. If they need to make a call while on shift, they need to request to a supervisor that they need to make a personal phone call. If they are found with a cell phone they go home for the day and get written up.” Staff Daquavis was questioned about the allegation of staff withholding medication from Resident A and he indicated that the only staff allowed to pass out medication are the staff that are “trained and certified” and are supervisors along with the nurse. He also reports that “the supervisor has to get the medication key from the on-call supervisor”. Staff Daquavis reports never having any concerns about the passing of medication to residents. Staff Daquavis was asked about the selling of drugs by staff at the facility and he reports not knowing of any drugs being sold on campus. He did reports that “three years ago a staff with alcohol on his breath was at work but he no longer works here. I dismissed him.” Staff Daquavis was informed that a staff member had made these allegations and he reports, “why would someone report this, the first thing that comes to mind is a disgruntled employee. I have not terminated someone in a while. We have had no staff turnover lately and the last time someone was terminated was before I took over.” Staff Daquavis was asked how information about residents could be passed around the facility and he indicated that it is possible that staff not working the dorm Resident A is lodged on may have overheard issues involving Resident A. He also indicated that Resident A is well known at the facility and most staff know of the concerns because of the severity of the issues. Finally,

Staff Daquavis reports that Resident A was interviewed last week about the allegations and it took “two hours to deescalate him because he was upset and crying after being asked about being sexually abused”. Staff Daquavis continued, “This is because he is traumatized after experiencing sexual abuse in the shower”. Staff Daquavis indicated that Resident A suffered the sexual abuse in the shower prior to his admission to the facility.

Meeting with James Ray (Shift Leader on Apollo dorm) on August 23, 2017. Staff James reported that he is Resident A’s “primary” which involves him providing all of Resident A’s needs and working with him on his treatment goals. Staff James also reports that Resident A comes to him with any issues and that they have a “positive” relationship. Staff James indicates that Resident A has been “out of culture” for several months and that Resident A has been on a two-to-one staffing ratio over the past month and more. Staff James described the “out of culture” as a resident not being involved with the other residents in the dorm but still being allowed to engage in activities outside of the dorm. Staff James also reports that Resident A is only allowed to use the bathroom by himself and that staff will stand outside the door. He indicated that no other residents or staff are allowed in the bathroom when Resident A is using it. Staff James indicated that Resident A was placed back into the culture but after he struggled, he was placed back in the “out of culture”. Staff James reports that because of the trauma Resident A has experienced, he is “quick to share if any other kids are bothering him or touching him”. Staff James continued, “He has not said anything about an issue with others and he doesn’t hold back when experiencing something”. Staff James also reports that Resident A was very upset after being interviewed last week. Staff James was asked about residents fighting and he indicated that he has not witnessed or heard of any fights between residents for the past few months. He also indicated that there have been no fights on the dorm in over a year. Staff James also indicated that if residents were to fight, other staff would be involved and an incident report would have been developed. When asked about the allegation of withholding medical treatment to Resident A, Staff James reports that Resident A will “let you know when he needs to see the nurse; he doesn’t hold back”. Staff James also reports that Resident A has never been denied treatment by the nurse or access to the nursing staff. Staff James was asked about staff using their cell phone when working and he gave the following report. “There is a strict policy that staff cannot have or use their personal cell phone when on shift or they will be sent home.” Staff James was asked about drug use or selling of drugs at the facility and he reports never hearing of staff using or selling drugs at the facility. Staff James reports never hearing of any staff assaulting a resident at the facility.

Meeting with DeJuan Hollman (Youth Counselor on Apollo dorm) on August 23, 2017. Staff DeJuan reports working at the facility for the past year and eight months and has been assigned to the Apollo dorm for the past six weeks. Staff DeJuan reports not working directly with Resident A but he did report being familiar with Resident A. Staff DeJuan also reports that Resident A is always on a two-to-one staff ratio and that whatever bathroom Resident A is going to use has to have only one toilet and one shower. He indicated that no one else is allowed in the bathroom when

Resident A is using the bathroom and that staff will stand outside the door to make sure no one else goes into the bathroom. Staff DeJuan described Resident A as, “He is quick to report if other kids are being disrespectful towards him and he is quick to voice his needs to staff”. Staff DeJuan was asked about residents fighting and he replied, “I have not seen any kids on the Apollo dorm fight and fights on campus are very rare. Staff will intervene if it looks like kids might fight.” Staff DeJuan reports never witnessing staff antagonizing or abusing residents. Staff DeJuan also reports that staff are not allowed to use their cell phones when working and that he has “seen workers being sent home for the day after using their cell phone while working”. Staff DeJuan was asked about drug use and sales at the facility and he reports, “don’t know if anyone is doing that and they would never tolerate an employee like that”.

Meeting with Resident B at the facility on August 23, 2017. Resident B reports being fifteen years old and that he has been lodged at the facility for about a year and a half. Resident B also reports residing at the Apollo dorm and that he is doing “well” in the program. Resident B gave the following information about his stay at the facility, “this place is more like a home for me”. Resident B reports that the staff are fair and that there are several staff he likes. He also reports that he can trust staff and is willing to go to them if he has a problem. Resident B suggests that he is able to avoid problems and stays out of trouble. Resident B also suggests that he “doesn’t break the rules but the residents who do, need to take responsibility for their actions and maybe to be assigned additional chores”. Resident B reports being involved in one restraint about nine months ago but also shared, “I agree with the restraint because I was throwing stuff and staff handled it right”. Resident B was asked if he has witnessed staff abusing residents and reports, “I have never seen a staff intentionally try to hurt anyone or restrain anyone unnecessary”. Resident B was asked about the bathroom procedure for residents and gave the following description, “staff stands in the hallway to watch us and they will wait for us in the hallway. There is no way that two students could be in the bathroom at the same time.” Resident B reports never seeing a fight between residents and reports “there are always staff around to stop any issues”. Resident B finished by reporting that he is the CEO of the Apollo dorm which is a leadership role and that part of his responsibility is to track and report on incidents on the dorm. He also reported that this responsibility includes tracking restraints of residents while also confronting staff if they are inappropriate.

Meeting with Resident C at the facility on August 23, 2017. Resident C reports being sixteen years old and that this is his second placement at the facility. He indicated being at the facility five years ago before leaving for another placement. Resident C reports that “things are good on Apollo” and that he gets along well with staff. Resident C also reports, “Staff respect me and will help me if I need help”. Resident C indicated that he doesn’t get restrained but that he has witnessed other residents being restrained “when they are unsafe or trying to hurt someone”. Resident C also indicated that he has never witnessed any staff trying to hurt anyone. Resident C was asked about Resident A and reports knowing Resident A. Resident C reports that Resident A is in “OTC” which he reports is “out of the culture” and that it means Resident A is “not around any of the other kids”. Resident C continued, “He has two

staff with him all the time". Resident C was asked about the bathrooms on the dorm and reports, "there are only individual bathrooms here and there is never more than one kid in the bathroom at a time. The staff monitor when someone goes into the bathroom to make sure." Resident C was asked about staff using cell phones when working and he reported that he has never seen a staff playing on their phone or taking pictures or recording kids with their phones.

Meeting with Brad Hodges (Living Services Director) and Erin Newton (Director of Human Resources) at the facility on August 29, 2017. Staff Brad and Staff Erin gave this writer a tour of the Apollo dorm and it appeared appropriate and free of any safety risks. The bathrooms were observed and each is set up for only one resident to use at a time. Staff Brad and Staff Erin were asked about the allegation of staff using drugs at the facility and both report having no knowledge of staff using or selling drugs at the facility and the only incidents involving drugs with residents occurred when a resident came back from a home pass with three Tylenol and another resident tried to trade Xanax for clothing. Staff Brad provided further information on this incident and reports talking with both residents and they admitted to the allegations. They were asked about having any concerns about Staff 1, who was hired without the Central Registry Clearance. Staff Brad reports that he spoke with Staff 1's supervisor (Staff Celery) after being told by the supervisor that staff 1 was telling other staff that she had concerns. Staff Brad indicated that Staff Celery is off on extended leave and had told him (Staff Brad) that she (Staff Celery) had not confronted Staff 1 about all of the stories at this point. Staff Brad did indicate that Staff Celery did confront Staff 1 about the allegation of staff horse playing with residents and Staff 1 is reported to have denied saying anything about staff horse playing. Staff Brad also indicated that another staff (unidentified) told him that Staff 1 had concerns and he (Staff Brad) informed the staff reporting this to him, to confront Staff 1 immediately. Staff Brad reports being unsure if the staff followed through with his directions and confronted Staff 1. Both Staff Brad and Staff Erin reports that Staff Celery (Supervisor) told them Staff 1 reported having a miscarriage and needed time off work. Staff Erin reports that facility gave Staff 1 time off.

Meeting with Max Pennock (Youth Counselor on Poseidon dorm) on August 29, 2017. Staff Max reports working at the facility since May 2015. Staff Max was asked about staff using and or selling drugs at the facility and he reports "don't know what people do in their home life but I don't see it on campus".

Meeting with DeJuan Hollman (Youth Counselor on Apollo dorm) on August 29, 2017. Staff DeJuan reports working at the facility for the past year and eight months and has been assigned to the Apollo dorm for the past six weeks. Staff DeJuan was interviewed on August 23, 2017 but with the new allegations he was interviewed a second time. Staff DeJuan reports never smelling drugs on any staff and that he doesn't really pay attention to that "sort of thing". Staff DeJuan was asked about the restraint with Resident B and he reports that he "heard about it but was not part of it". Staff DeJuan also reports that Resident B told him "he got restrained because he was

mad and didn't want to be around the group at the time. I don't know the details just that when he sees me he wants to talk."

Meeting with Resident D at the facility on August 29, 2017. Resident D reports that she is seventeen years old and has been at the facility almost a year and has been in the Athena dorm. Resident D reports never feeling unsafe or uncomfortable at the facility. Resident D was asked about an allegation that staff allow residents to fight and she reports, "Staff never allows girls to fight and if they do fight they will get restrained". Resident D continued, "I've never been in a restraint that I didn't bring on myself and I would only get mad because I couldn't move not because I was hurt".

Meeting with Resident E at the facility on August 29, 2017. Resident E reports that she is thirteen years old and has been at the facility for the past nine months. She reports being in the Athena dorm. Resident E reports never feeling unsafe or uncomfortable since she began staying at the facility. She was asked about staff allowing residents to fight and she reports, "I saw multiple fights between girls but there was never a time that staff let them fight. Staff would restrain them."

Meeting with Resident F at the facility on August 29, 2017. Resident F reports that she is fifteen years old and has been at the facility since March 2017. She reports being in the Athena dorm. Resident F reports always feeling safe at the facility with all staff.

Meeting with Resident G at the facility on August 29, 2017. Resident G reports being fourteen years old and that she has been at the facility for the past two and a half months. She report being on the Athena dorm. Resident G indicated always feeling safe with all staff since being in the program.

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 of individuals, staff, and residents does not support the allegations made by the complainant. The care provided to Resident A does not allow for the allegations since Resident A is always within line of sight of staff and is currently on a two-to-one staffing ratio. The facility does not allow staff members the use of their personal cell phones during working hours and each staff interviewed understood this rule. Each staff interviewed also understood the process of informing the supervisor of any staff who is inappropriate with residents. There is no evidence to support the withholding of medical treatment for Resident A and there is no evidence of drugs being sold or consumed at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Meeting with Brad Hodges (Living Services Director) and Erin Newton (Director of Human Resources) at the facility on August 18, 2017. They were informed of new allegations against the facility and Erin was asked for a list of employees that were in the process of termination from the agency. She provided a list and this writer requested to review all of the hiring documentation for these files. It was discovered that an employee was hired without the appropriate back ground clearances. The employee was hired on 1/23/17 and had the Michigan State Police background check but there was no Central Registry check present in the file. Staff Erin reports that she “missed the email from the state that indicated they were unable to send the check” to the facility. She reports trying to obtain the background check again in June 2017 but was informed that the State was unable to send the check. Staff Erin reports that the facility was going to suspend this employee until they were able to get the Central Registry check completed and cleared. Staff Erin also reports that she was going to call this employee today to inform her of this decision.

Meeting with Brad Hodges (Living Services Director) and Erin Newton (Director of Human Resources) at the facility on August 23, 2017. Staff Erin reports talking to the employee and informing her that they need a clean Central Registry background check before she can work at the facility again.

Meeting with Brad Hodges (Living Services Director) and Erin Newton (Director of Human Resources) at the facility on August 29, 2017. The focus of this meeting was on the staff member who was allowed to interact with residents without having the appropriate Central Registry Clearance. Staff Erin reported that this staff was “let go

on 8/18/2017 because of the lack of a clear Central Registry Clearance. Staff Erin also reports that she told this individual that if she is able to obtain a clear Central Registry Clearance report she should call for a possible rehire.

APPLICABLE RULE	
R 400.4113	**Employee records.**
	An institution shall maintain employee records for each employee and shall include documentation of all of the following information prior to employment or at the time specified in this rule: (i) Documentation from the Michigan department of human services, the equivalent state or Canadian provincial agency, or equivalent agency in the country where the person usually resides, that the person has not been determined to be a perpetrator of child abuse or child neglect. The documentation shall be completed not more than 30 days prior to the start of employment and every 12 months thereafter.
ANALYSIS:	Evidence found in the employee's file and in the interview with Erin Newton support that the facility hired the employee without the appropriate background check. The facility allowed this employee contact with residents even though there was evidence that the employee was likely on the Central Registry.
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

10/12/2017

Paul Fatato — Date
Licensing Consultant

Approved By:

October 31, 2017

Claudia Triestram — Date
Area Manager