Lakeside For Children – Executive Summary

Date: 6/18/20
Facility License: CI390201235
Investigation: 2020C0207030

Lakeside For Children is a licensed child caring institution, located in Kalamazoo, Mich. Lakeside's license, originally issued April 1, 1990, has a maximum capacity of 126 beds in a non-secure setting for males, ages 11-17 years. Lakeside has Michigan Department of Health and Human Services (MDHHS) contracts for both abuse/neglect and juvenile justice contracts.

On Wednesday, April 29, the Division of Child Welfare Licensing (DCWL) initiated an investigation after receiving the following allegation:

- Resident A was pushed from his seat and improperly restrained. After the restraint, he was unresponsive and transferred to the hospital where he died on Thursday, May 1.

DCWL worked in coordination with Children's Protective Services-Maltreatment In Care staff and law enforcement to complete the licensing investigation. The investigation consisted of the following activities:

- Review of video of the restraint of Resident A on April 29.
- Review of incident reports, law enforcement reports and statements, resident record, medical documentation, facility policies.
- Review of law enforcement interviews with residents.
- Interviews with residents.
- Interviews with staff and other agency personnel.
- Visits to facility.
- Review of video of the restraint of Resident A on January 4.

Investigative findings determined the following violations of child caring institution licensing rules, based on the allegations:

- *R 400.4159 Resident restraint. (repeat violation)*
    - The video review, documentation, and supporting interviews support that facility staff and supervisors involved did not follow SCM or facility policy regarding restraint.
    - The actions of staff were significantly disproportionate to the behavior of Resident A.
    - Multiple staff participated in this restraint and several were observed on the video with their weight on Resident A's chest, abdomen and legs, making this an unsafe and excessive restraint.
    - The restraint was not performed in a manner consistent with Resident A's treatment plan.
    - None of the involved staff, nurse or supervisors present, addressed or corrected the staff involved in the restraint on their positioning.

- *R 400.4142 Health services; policies and procedures.*
    - (1) An institution shall establish and follow written health service policies and procedures addressing all of the following: (a) Routine and emergency medical, and dental, and behavioral health care.
        - Facility staff failed to follow policy to obtain emergency medical care for resident care at the time of and immediately following this incident. The facility's policy states that staff are to go to the nearest phone available and dial 911, and then contact a nurse. Nurse 1 did not call 911 until approximately 12 minutes after Resident A was released from the restraint, although Resident A was limp and unresponsive, and concerns were noted regarding Resident A's breathing, coloring and pulse. Nurse 1 was present and was responsible for taking the lead during the medical emergency. Nurse 1 was terminated from employment for failure to respond and provide proper leadership.
        - Supervisors and other staff were present during this 12-minute period and none of them called 911 or initiated CPR during this time. As the facility policy states, any of the staff present could have called 911 and initiated First Aid/CPR/AED.

- *R 400.4112 Criminal history check, subject to requirements; staff qualifications.* (repeat violation)
    - (4) A person with ongoing duties shall have: (a) Ability to perform duties of the position assigned.
        - Based on the actions of the director of nursing, seven staff, and one supervisor who were all substantiated by CPS-MIC, this rule was found in violation.
        - An additional supervisor was terminated for improper restraint, and was determined to lack the ability to perform his duties
        - Based on the findings of the January 4 restraint of Resident A, six additional staff and a case manager were determined to lack the ability to perform their duties.

- *R 400.4126 Sufficiency of staff.*
    - The facility has failed to provide sufficient administrative, supervisory, social service, direct care, and other staff to provide for the continual needs, protection and supervision of residents.

- *R 400.4116 Chief administrator; responsibilities.*
    - Director 3 was the chief administrator of the facility and a Sequel employee at the time of the January 4 and April 29 restraints. Sequel is the management company for the facility that hired and then failed to oversee the actions of Director 3, making them responsible in this matter as well. Director 5 is the new chief administrator of the facility, and is also a Sequel employee as their vice president of operations, and was Director 3's supervisor.

- *R 400.159 Resident restraint.* (repeat violation)
    - The facility staff involved failed to follow facility or SCM policy regarding restraint, during a January 4 restraint of Resident A. The staff restrained Resident A in a manner that was unsafe and not proportionate for the severity of his behavior. The staff involved documented in incident reports that this restraint lasted for 10

minutes, however, review of video revealed the restraint lasted in excess of 30 minutes.

- *R 400.158 Discipline.*
  - Staff failed to intervene when two residents physically restrained a peer.
- *R 400.4109 Program statement.*
  - Staff did not follow the agency's Communication Log Policy by not entering behavioral information for Resident A on 28 days during the period reviewed.
- *R 400.4151 Emergency; continuity of operation procedures.*
  - Facility staff failed to ensure that visitors completed COVID-19 screenings as required in their emergency response plan.
- *R 400.4152 Initial documentation.*
  - Facility was unable to produce the medical consents when needed, and did not have medical consents for all youth, which is required at the time of admission.

The following additional allegations were received and investigated:

- On Wednesday, May 6, an anonymous reporter advised that the agency did not allow youth to talk to their workers about the restraint of Resident A after it occurred. **No violation found.**
- A resident reported when interviewed that Resident A took a drug or was given a drug that made his breathing heavy. **No violation found.**
- On Friday, May 15, a resident's mother reported that her son did not receive therapy services at the facility. **No violation found.**

Based on the findings of the investigation, a recommendation for revocation of the child caring institution is being made at this time.