GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

March 10, 2021

Jennifer Stevens
Samaritas - Bay
1024 Professional Drive
Flint, MI 48532

RE: License #: CB250296641
Investigation #: 2021C0420015
Samaritas - Bay

Dear Ms. Stevens:

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:

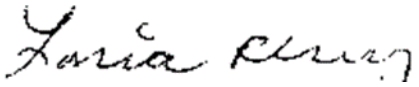
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- **An explanation why previous corrective action plans have not obtained and maintained compliance for rules found in repeat noncompliance.**
- 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.

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 the local office at (248) 975-5053.

Sincerely,



Lonia Perry, Licensing Consultant
MDHHS\Division of Child Welfare Licensing
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-3317

enclosure

MICHIGAN DEPARTMENT OFHEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING
SPECIAL INVESTIGATION REPORT
AMENDED

I. IDENTIFYING INFORMATION

License #:	CB250296641
Investigation #:	2021C0420015
Complaint Receipt Date:	01/14/2021
Investigation Initiation Date:	01/15/2021
Report Due Date:	03/15/2021
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenu Detroit, MI 48214-2691
Licensee Telephone #:	(989) 835-7322
Administrator:	Ann Meldrum, Designee
Licensee Designee:	Ann Meldrum, Designee
Name of Facility:	Samaritas - Bay
Facility Address:	1024 Professional Drive Flint, MI 48532
Facility Telephone #:	(810) 234-9324
Original Issuance Date:	03/19/2009
License **Status:**	REGULAR
Effective Date:	09/19/2019
Expiration Date:	09/18/2021
Capacity:	Unknown
Program Type:	CHILD PLACING AGENCY, PRIVATE

II. ALLEGATION(S)

	Violation Established?
On 1/06/2021, a youth attempted to overdose on anti-depressants. A staff member from the facility arrived seven hours after the youth had already been at the hospital.	No
Additional Findings	Yes

III. METHODOLOGY

01/14/2021	Special Investigation Intake 2021C0420015
01/15/2021	Special Investigation Initiated - Telephone Spoke with Complainant
01/19/2021	Contact - Document Sent Email to Chief Administrator 0 & IL-Plus Home Manager 1 RE complaint and document/information needed
01/20/2021	Contact- Document Sent Email to IL Plus Home Manager 1
01/20/2021	Contact- Document Received Email from IL- Plus Manager 1: Staff contact information, Intake form, information data
01/20/2021	Contact- Telephone call made To and received, spoke with IL Plus-Plus Home Manager 1
1/20/2021	Contact- Telephone call made Interviewed Youth A
01/20/2021	Contact- Telephone call made Left message for Staff 2
01/20/2021	Contact- Telephone call received Spoke with Staff 2
01/21/2021	Contact- Document Sent Email to IL-Plus Home Manager 1 Re: data received
01/21/2021	Contact- Document received Email from IL- Plus Manager 1
01/21/2021	Contact- Telephone call made Spoke with IL-Plus Manager 1
01/22/2021	Contact- Telephone call made And received- Spoke with Staff 3
01/25/2021	Contact- Document received Email from IL- Plus Home Manager 1
01/28/2021	Contact- Telephone call made IL-Plus Home, interviewed Youth B and Youth C, and spoke with Staff 4
01/29/2021	Contact- Telephone call received

	From IL-Plus Home, interviewed Youth D
02/08/2021	Contact- Telephone call made To and received from IL-Plus Home Manager 1 Spoke with
02/08/2021	Contact telephone call made Spoke with Staff 5
02/08/2021	Contact telephone call received Interviewed Staff 5
02/08/2021	Inspection Completed- Sub Compliance
02/09/2021	Contact- Telephone call made Exit Conference

ALLEGATION:
On 1/06/2021, a youth attempted to overdose on anti-depressants. A staff member from the facility arrived seven hours after the youth had already been at the hospital.

INVESTIGATION:
On 1/15/2021 I reviewed the complaint that indicated:

- On 1/6/2021 Youth A (age 16) conducted research on how many pills she could take before she dies.
- Youth A took 30 antidepressant pills.
- Youth A arrived at the hospital and agency staff arrived seven hours later.

On 1/15/2021, I interviewed the complainant by telephone. The Complainant reported Youth A messengered her at 1:42am on 1/7/2021 to say she was in the hospital. The Complainant reported Youth A had broken up with her boyfriend Wednesday night (1/6/2021) and was upset about that. She reported the boyfriend had seen something alarming about Youth A on snapchat and called the police. The police conducted a safety check to the Samaritas Independent Living (IL) Plus home. Once the police were at the home, Youth A admitted to taking pills and was transported to the hospital by ambulance. The Complainant reported not being able to reach the IL-Plus staff and so she drove one and half hours to the hospital to be with Youth A. Youth A reported the IL-Plus staff did not know she had taken the medication. Youth A had not wanted to leave her room. Youth A had the medication in her room; it had not been locked up. Youth A said she took a number of her antidepressant pills; but Youth A was not certain of how many. Thirty was indicated based on Youth A's reporting and Youth A's pill bottle count. Youth A was discharged from the hospital to White Pines on1/7/2021 for assessment. Youth A was released from White Pines on 1/12/2021 and returned to the Samaritas IL placement.

The Complainant expressed concern the IL-Plus staff had not timely responded to her calls and showed up late to the hospital. Also, that the agency should have been aware of Youth A's depression and suicidal tendency. Additionally, that the agency has not developed a safety plan for Youth A since this incident.

On 1/20/2021 and 1/21/2021, I spoke with the IL Plus- Manager 1 by telephone. He acknowledged Youth A was admitted to the hospital on 1/6/2021. He said the staff contacted him at 3:30am to report the police visited the home and took Youth A to the hospital for suicidal ideations. The midnight staff on shift spoke with the police. IL Plus- Home Manager 1 said the staff on shift in the home could not accompany Youth A to the hospital because she had other youths in the home to supervise. He said, Staff 3 followed up with the hospital to affirm that Youth A was ok.

IL- Plus Home Manager 1 reported Youth A was placed in the home, after Christmas on, 12/28/2020. He advised the Department of Health and Human Services (DHHS) was quick to have Youth A participate in the program. He reported Samaritas did not know Youth A had suicidal ideation. That information was not verbally relayed to them; and he did not recall seeing that information in her referral package (consisting of her service plans; the referring worker's assessment form and worker referral sheet). He reported the agency does not routinely lock up independent youths' medications. The only time that would occur is if, the worker informed them there is a need, the youth self-reports a need, or after some time interacting with the youth, they discover a concern that the youth need assistance. IL- Plus Home Manager 1 advised that all the IL youths sign a medication agreement apprising the youth of their responsibilities related to their medication. He provided a copy of the medication agreement for Youth A, which indicated:

- Youth A will follow the prescribing doctor and medication dosage.
- Youth A will not stop, change, or alter the dosage of any prescribed medication without consulting the prescribing doctor and informing the IL Plus-Coordinator of the change.
- Youth A agrees to cooperate with the case plan, including administration, monitoring and proper disposal (in consultation with a pharmacist) of all medication for her.
- Youth A agrees to discuss any questions and or concerns regarding their medication with their physician and case worker.
- At no time will Youth A begin, stop, or alter the dosage of any medication or pervert its use without written documentation from the monitoring physician. Any written documentation has to be shared with the agency.
- Youth A and Staff 3 signed the medication agreement on 12/28/2020.

IL- Plus Home Manager 1 reported if they knew Youth A had suicidal ideation, they would have made plans to address it. He said, a youth can communicate a need/concern/problem to him, the on-shift staff, or the IL-Coordinator at any time. He, said, his and the IL-Coordinator's contact numbers are posted in the home. Additionally, there is a house phone, cell phone and lab top computer available for staff and youth to use, if they need to contact them. He reported prior to Youth A's return to the home he contacted Youth A's DHHS Worker about the specifics of Youth A's case and safety planning. There was a team's meeting to discuss how to transition Youth A back to the IL-Plus home, and how the team could help support her. Youth A discussed the skills she learned at White Pines and how she will utilize those at the IL- Plus home. IL- Plus Home Manager 1 reported, they will be locking

up Youth A's medication going forward and assisting her with medication administration. Youth A has acknowledged that she understood why her medications had to be locked up. Youth A would have to seek out a staff each morning to take her medication for the day.

IL-Plus Manager 1 reported the following Safety Steps for Youth A by way of email:

- Staff will keep all Youth A's medication locked in the staff's desk.
- Youth A will continue to use her support system when she feels like there is a concern regarding her mental health; and communicate with the IL-Plus case worker.
- DHHS will contact New Oakland for referral for day treatment mental health services for Youth A.
- IL-Plus Case worker was going to follow up with Youth A's school to make sure she is able to continue online.
- IL-Plus staff will monitor Youth A's emotional stability during their shift and will contact the case worker if Youth A starts having mental health issues.

Due to COVID- I interviewed Youth A by telephone on 1/21/2021. Youth A (age 17) reported being at the IL- plus program since 12/27/220. When she came to the IL-plus program the rules were explained to her. One of the rules related to medication, which was that "I'm responsible for taking my own medication". Youth A admitted to taking more of her antidepressant medication than she was supposed to. She reported, she was depressed the day of the incident and wanted to visit family. She said, Staff 3, the IL Coordinator told her an overnight visit with family was not an option because her family was in Midland, and she (Youth A) had not been in the program for 30 -days. Youth A said, then she was having a conversation with her aunt and "something (what Youth A did not report) set her off. She became more stressed. Youth A said, she did not let the on-shift staff person, know she was experiencing high stress or dealing with emotional issues. Youth A said, she had let Staff 3 know about her past mental health issues. She said, she is also in counseling; and she had spoken with her counselor, via zoom that day. She told the counselor she was okay. Youth A said as time went on, she got more stressed, but did not mention that to the on-shift staff, Staff 2. She did not really want to talk to anyone. Her stress increased and she took the pills. She was posting on social media about her stress but did not say she wanted to kill herself or was or had taken pills. Nor did she reach out to her counselor, facility staff or the other three residents to let them know what was happening with her, because it was after midnight. She did not know how or who notified the police. When the police arrived, she admitted taking pills; and they took her to Hurley hospital. Staff 2 found out about the incident after the police came and got her. Staff 2 stayed at the house because the other girls were there. Youth A was not sure if Staff 2 contacted the agency administrators about the incident.

Youth A reported telling the hospital she did not know how many pills she took. The hospital estimated she took 30-day pills because none were left in the bottle. Youth A did not know the normal capacity count for her pill bottle. She reported at some-

point she contacted her YIT (Youth in Transition) worker and told her she took the pills. Youth A said she stayed overnight at Hurley hospital. Thereafter, she went to White Pines for psychiatric assessment. She stayed at White Pines for six-days. Youth A reported, other than, perhaps allowing her to go home, there was nothing the agency could have done to have prevented the incident.

On 1/20/2021 I interviewed Staff 2 by telephone. Staff 2 reported being the midnight (11:00pm- 7:00am) staff on shift the night of the incident. Youth A, and three other residents were in the house. Staff 2 reported being surprised when the police arrived between 1:00am and 2:00am and asked for Youth A by name. The police reported they had received a call from a friend of Youth A's. That Youth A had posted on social media Youth A wanted to hurt herself. Staff 2 said, prior to the police arriving, she had no knowledge anything was wrong. Youth A had not come out of her room, nor reported a concern. Staff 2 reported when she arrived at the IL-Plus house, the youths are normally in bed during her/the midnight shift. If a youth is awake, their conversation with her is brief. She alerts the youths when she comes on shift by knocking on each youth's door. If the youth does not respond, she opens their door and looks in. Youth A did not answer the door knock that night, so Staff 2 looked into Youth A's room. Youth A appeared to be asleep. Staff 2 said, after the police arrived and she went upstairs to check on Youth A. Youth A said she was ok. Youth A was oriented, did not appear over medicated, just sleepy. Youth A told the police she was okay. Youth A was told if she felt depressed or something, the police could take her to the hospital. Youth A said ok, and the police took Youth A to the hospital. Staff 2 ensured that Youth A had the staff contact numbers to take with her She also asked Youth A whether Youth A had any medications and to take it because the hospital asks for things like that. Staff 2 said at that time she did not know Youth A was on antidepression medication.

Staff 2 reported, it was not unusual for youths diagnosed with depression, or who take medications to be in placement at the IL- Plus home. Nor was it unusual for staff to assist a youth with administration of their medication, if needed. It's a case-by-case situation with the youth's case manager making that decision. The staff would lock the medication and assist the youth by taking out/assuring one pill at a time is taken. If Staff 2 were to awaken/remind the youth about taking their medication, the prior shift staff would let her know. If the youth would not take their medication, Staff 2 would let the next shift-staff know that. Staff 2 reported information about a youth's specific needs/concerns is discussed at group chats/meetings, but she was not aware of specific concerns with Youth A.

Staff 2 reported prior to the police departing she advised them of the Samaritas program type and that someone would follow up with the hospital. Staff 2 contacted IL-Plus Manager 1 and Staff 3 about the incident. The next morning, someone from Hurley hospital called the office and reported on the status of Youth A.

On 1/22/2021, I interviewed Staff 3, the IL Coordinator, by telephone. Staff 3 was not onsite the night of the incident. Staff 2 texted her about incident around 2:20am indicating Youth A was taken to the hospital by the police for suicidal ideation.

Staff 3 reported seeing Youth A, three times that week, Monday, Tuesday, and the Wednesday before the incident. Youth A was happy, cheerful, and showed no signs of being upset. Youth A reported missing her family. They discussed that Youth A got to see family for the new year, on a holiday pass. They talked about Youth A getting a weekend overnight pass when two-three weeks had passed. Staff 3 advised youths normally must be in the program 30-days prior to such, but she can adjust that at about three weeks. Day visits are permissible, but Youth A acknowledged that would be difficult given that her family members live so far away (Midland).

Staff 3 reported completing Youth A's intake into the program, but not seeing Youth A's actual referral package. No medication administration concerns, or suicidal issues/history were reported by the DHHS Worker (Worker X), nor by Youth A when Staff 3 spoke with Youth A. Staff 3 said when she spoke with Youth A's worker regarding the intake, Worker X advised Staff 3 of Youth A's diagnosis of depression, twice weekly therapy via Zoom, and therapist. Services with the named therapist continued; and medication reviews/prescription needs would be followed up by way of and Hope Network in Flint. Worker X advised that Youth A was taking her medication on her own.

Staff 3 reported after Staff 2 apprised her of Youth A's hospital transport, she advised Staff 2, she (Staff 3) or IL- Plus Home Manager 1 would go to the hospital in the morning. That Youth A should be ok until then. Staff 3 acknowledged that Youth A's, YIT worker had contacted her. The YIT worker left a voice message on Staff 3's work phone. Staff 3 received that message after Staff 2 had contacted her via her (Staff 3's) personal cell phone. Staff 3 said she went to the hospital at 8:30am. Hurley hospital staff would not allow her to see Youth A because the YIT worker was with her. Staff 3 tried a couple of times to explain her role. The hospital contacted the social worker. The hospital social worker thought her to be aggressive given her persistence, so Staff 3 left and make contact with the agency and Youth A's DHHS worker.

On 1/28/2021, I interviewed Youth B and Youth C by telephone. I interviewed Youth D by telephone on 1/29/2021. The youths knew or had heard the police took Youth A to the hospital. Neither had specific information about the incident.

Reviewed:
Information as reported earlier in this report.

Youth A's intake package (intake checklist dated 12/21/2020 asking for information, reports) referral form completed by Worker X dated 12/18/2020; and Caregiver Assessment completed by the caregiver and Worker X dated 12/21/2020.

The latter two documents contained information that indicated:

- Youth A had gone through a lot in her life but still she has a good attitude and drive about her future and her circumstances.
- Youth A has proven that she is ready to be independent.
- She may struggle with things throughout the day, but with the help she is receiving she will be alright.
- The caregiver is open to staying involved.
- Youth A "has some issues emotionally and mentally but she has good coping skills and does well with coping".
- Youth A needs to be held accountable, but she is a good kid and will listen.
- Youth A's current medication is Fluoxetine (used to treat depression).

APPLICABLE RULE	
R 400.12505	**Supervision.**
	(1) An agency shall provide supervision for a youth in independent living consistent with the youth's need for supervision, as required by R 400.12504(2)(e).
ANALYSIS:	The evidence does not support a lack of supervision. Youth A appeared happy and cheerful earlier in the day. She did not report feeling stressed or depressed to the staff. The staff did not have knowledge she was experiencing suicidal thoughts. Nor that she had problems taking her medications correctively or would abuse it. Once the agency was alerted by the police, the staff encouraged the youth's transport to the hospital, attempted to check on her the next morning and worked with her worker on a safety and medication administration plan prior to her return to the IL-home from her six-day psychiatric facility stay.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:
During the investigation it was revealed staff were sleeping on their shift and leaving residents in the home without notifying the residents the staff had left the home.

INVESTIGATION:
On 1/20/2021, I interviewed Youth A by telephone. Youth A reported the night of her incident on 1/6/2021, she went downstair around 11:30pm. Staff 2 was sleeping on the couch. Staff 2 did not know she was present. Staff 2 was snoring. Youth A went back upstairs.

Staff 2 was interviewed by me via telephone on 1/20/2021. Staff 2 denied the allegations. She admitted sitting in the staff's room after checking on the youths, but not sleeping on the couch. She said if a youth was to come downstair, the youth cannot she her on the couch. They would have to actually come into the living room to see her; but she has never taken a nap on the job.

Youth B and Youth C were interviewed by me via telephone on 1/28/2021.

Youth B reported the staff that sleeps on the job is Staff 5 and Staff 2. Youth B did not recall Staff 2 sleeping on the job the night the ambulance came for Youth A but said Staff 2 was sleeping on the couch most recently one day last week (from 1/28/2021). Youth B did not give specific times when Staff 5 was sleeping but said Staff 5 can be rude. Youth B reported finding Staff 2 asleep at times that she (Youth B) goes down to take her medication. Youth B said she hates to wake Staff 2 up. She reported knowing Staff 2 is sleeping because, first, she (Youth B) waves her hands near Staff 2; and when she gets no response, she raises her voice. Youth B reported this has occurred many times.

Youth C reported she normally does not interact with or ask the midnight staff for anything. She basically sees those staff if she goes downstairs. She reported observing Staff 2, and Staff 5 sleeping on their shifts. She said, Staff 5 normally works the afternoon or morning shift; and Staff 5 often sleeps on her shift. She said, Staff 2 comes to work usually when they are in bed and she has seen Staff 2 sleeping on the couch on more than one occasion. Youth C reported Staff 5 has also left the facility on a few occasions. They have found out Staff 5 has left, either when they returned from being out or came downstairs and Staff 5 was gone. Youth B reported the incidents have been in the past and recently, but she could not give specific dates.

Youth B and Youth C reported reporting these concerns to a supervisor or Staff 4, because it's easier; and Staff 4 can alert Staff 3. Youth B said Staff 4 would alert IL-Plus Home Manager 1, because it was reported a week ago. Youth C reported they have also mentioned it at team meetings. Youth C was not sure if IL-Plus Home Manager 1 had done anything about the matters, because she only met him once.

Staff 4 was interviewed by me via telephone on 1/28/2021. Staff 4 reported working second shift (3:00pm-11:00pm). She said the shifts are normally a one staff person shift unless they are training another staff. Staff 4 stated most of the girls in the house have reported concerns of other staff members sleeping on the job. The girls reported they do and not feel comfortable waking the staff. Youth A, and Youth B named Staff 2 and Staff 5; but all the girls have not been shy, to complain to her. Their focus on Staff 5 was more about Staff 5 not being open to interacting or talking with them. Also, about Staff 5 leaving the house, or them not feeling listened to. Staff 4 said, the girls may have been having emotional issues and wanted to talk but reported the staff person would either be on their phone or sleeping. Staff 4 said

these concerns have been going on for a month. Once the concerns are reported to her, she sends a text message about it to Staff 3 and IL-Plus Home Manager 1. She has also called. Staff 4 stated she has reported the matter to administration more than once. The most recent reporting was two weeks ago. Staff 4 was not knowledgeable of camera footage capturing staff sleeping. She said, they have only had cameras for about a month; and they have malfunctioned. Staff 4 was not sure if there have been any consequences to staff related to the concerns. Staff 3 has indicated the matter is being handled.

Youth D was interviewed by me via telephone on 1/29/2021. Youth D reported not being sure what staff do on their shifts. She said if she has a need, a staff will assist her on all shifts. She denied knowledge of any staff sleeping on the job or leaving the house during that staff's shift. Youth D reported, she never goes downstairs on the midnight shift; and on the afternoon shift, the staff is always there. Youth D reported hearing the other girls talking about staff sleeping on the job, but she never saw such, or reported such.

On 1/20/2021, and 2/8/2021, I spoke with IL-Plus Home Manager 1 about these allegations and inquired about possible video footage. IL-Plus Home Manager 1 initially did not believe there would be video footage. He reported they only put cameras up last month. He said, there were camera battery issues, and there is no video footage of the alleged staff sleeping. IL-Plus Home Manager 1 denied prior knowledge of allegations pertaining to Staff 2 or Staff 5 sleeping on the job. He said, it was brought to his attention that Staff 5 was leaving her shift; but Staff 3 nor anyone advised him of a staff sleeping on the job. Staff should not be sleeping on the job. He said, he addressed the issue of staff leaving their shift. A staff reported leaving to get lunch. He advised all that the afternoon staff (and of course midnight staff) must be present. He advised of the importance of them remaining on shift. That if they have to leave the house, they must alert him. However, if there are residents onsite, they can't leave.

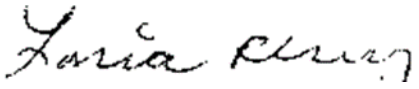
On 2/8/2021, I interviewed Staff 5 by telephone. Staff 5 was informed of the allegations. After requesting to call me back, Staff 5 admitted to the allegations of sleeping on her shift and leaving the house during her shift. She reported during such on more than one occasion. She reported, during the times she has worked the 11:00pm-7:00pm shift, she has "dose off". She reported being disciplined about three weeks ago for her behavior of leaving her shift. She reported she has not been sleeping on her shift lately because she keeps busy doing various tasks.

APPLICABLE RULE	
R 400.1208	**Job description.**
	(2) Each job description shall contain all of the following information: **(4) Practice shall conform to the job description.**

ANALYSIS:	Three of four of the IL-Plus youths living in the home reported Staff 2 and Staff 5 have been seen sleeping on the job or they had to wake the staff to take their medication. Also, that Staff 5 has left her shift/ left them unattended. Additionally, Staff 4 reported the youths have reported these allegations to her; and she in turn reported them to upper administration. Staff 2 denied the allegations, but Staff 5 admitted to them. The staff did not adhere to or confirm to the requirements of their job description and requirements related to youth assistance or supervision during their shifts.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

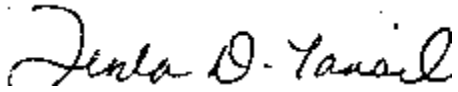
Upon receipt of an acceptable corrective plan, continuation of the facility's current licensing status is recommended.



March 5, 2021

Lonia Perry — Date
Licensing Consultant

Approved By:



March 10, 2021

Linda Tansil — Date
Area Manager