GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

March 11, 2022

Shantheis Moody
Bethany Christian Services Inc-Grand Rapids
901 Eastern Avenue, NE
Grand Rapids, MI 49501-0294

RE: License #: CB410200976
Investigation #: 2022C0212006
Bethany Christian Services Inc-Grand Rapids

Dear Mr. Moody:

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 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 (616) 204-6992.

Sincerely,

Heather Reilly, Licensing Consultant
MDHHS\Division of Child Welfare Licensing
22 Center Street
Ypsilanti, MI  48198
(734) 660-8309

enclosure

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**DIVISION OF CHILD WELFARE LICENSING**
**SPECIAL INVESTIGATION REPORT**

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | CB410200976 |
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| **Investigation #:** | 2022C0212006 |
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| **Complaint Receipt Date:** | 01/26/2022 |
| | |
| **Investigation Initiation Date:** | 01/26/2022 |
| | |
| **Report Due Date:** | 03/27/2022 |
| | |
| **Licensee Name:** | Bethany Christian Services Inc |
| | |
| **Licensee Address:** | 901 Eastern Avenue NE<br>Grand Rapids, MI 49503 |
| | |
| **Licensee Telephone #:** | (616) 224-7610 |
| | |
| **Administrator:** | Shantheis Moody, Administrator |
| | |
| **Licensee Designee:** | George Tyndall, Designee |
| | |
| **Name of Facility:** | Bethany Christian Services Inc-Grand Rapids |
| | |
| **Facility Address:** | 901 Eastern Avenue, NE<br>Grand Rapids, MI 49501-0294 |
| | |
| **Facility Telephone #:** | (616) 459-6273 |
| | |
| **Original Issuance Date:** | 10/01/1994 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/28/2020 |
| | |
| **Expiration Date:** | 09/27/2022 |
| | |
| **Capacity:** | Unknown |
| | |
| **Program Type:** | CHILD PLACING AGENCY, PRIVATE |

## II. ALLEGATION

| | **Violation Established**? |
|---|---|
| Agency has failed to provide recommendations consistent with report findings twice in the past year. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 01/26/2022 | Special Investigation Intake<br>2022C0212006 |
| 01/26/2022 | Special Investigation Initiated - Letter<br>Email sent, as it was after hours |
| 01/26/2022 | Contact - Telephone call received<br>Additional information received from DCWL Area Manager |
| 01/27/2022 | Contact - Telephone call made<br>Phone call with CA and PM to start investigation. |
| 01/27/2022 | Contact - Telephone call made<br>Phone call with Chief Administrator |
| 01/31/2022 | Contact - Document Sent<br>Email with Area Manager regarding interviews. |
| 02/03/2022 | Contact - Face to Face<br>Interviews completed with staff. |
| 02/03/2022 | Contact - Document Sent<br>Email with source for additional information |
| 02/14/2022 | Contact - Document Received<br>Reviewed additional information |
| 03/02/2022 | Contact - Document Received<br>Received additional information from DCWL Director |
| 03/09/2022 | Contact - Face to Face<br>Reviewed findings with Area Manager |
| 03/10/2022 | Contact - Face to Face<br>Pre-exit with CA via Teams |

**ALLEGATION:**
Agency has failed to provide recommendations consistent with report findings twice in the past year.

**INVESTIGATION:**
On 1/26/22 it was reported to DCWL that two special evaluation reports (SER) were completed by the agency in the past year, in which the findings and recommendation did not accurately reflect the information obtained in the investigation. The source reported that it appeared the agency should have cited the foster parent for non-compliance in both incidents. However, the agency found the home in full compliance.

**Chief Administrator**

On 1/27/22 a phone call occurred with the Chief Administrator (CA), in which they were notified of the allegation and investigation. The CA provided contact information for the licensing workers that completed the reports, as well as the licensing supervisor that approved the reports. On 1/31/22 a follow-up email was sent to confirm the on-site visit for 2/1/22. The CA noted that one staff was on vacation and the other on maternity leave. It was determined with the DCWL Area Manager that interviews would be conducted remotely via Teams.

**Document Review**

SER #1 summary: Authored by Worker 1

It was alleged on 9/3/21 the foster child (Youth A) and foster mother (FP1) got into an argument while in a parked car. FP1 grabbed Youth A by the arm. No injuries were noted. Youth A then exited the car and walked to the other side of the car and opened the door to retrieve her daughter. FP1 was in the driver's seat and pulled the car forward while Youth A was leaning into the car. Youth A was half-in and half-out of the car as it moved. During interviews, FP1 reported pulling the car forward as an attempt to shut the door and keep Youth A from entering the vehicle. The foster father (FP2) reported not being present at the time of the incident. He arrived shortly after and indicated they were not willing to let Youth A into the car because of her behavior of yelling at another youth in the car. Law enforcement and DHHS responded. No arrests were made. Youth A moved from the home to another placement. DHHS determined no findings in the incident. However, DHHS noted concern as it appeared FP1 did not have concern for Youth A or the youth's child in the moment. The agency concluded insufficient information to establish a violation.

**Licensing Supervisor**

On 2/3/22 an interview was conducted with the Supervisor via Teams. Regarding SER 1, the Supervisor remembered discussing the investigation with Licensing Worker 1 and reading the report. Supervisor recalled that Youth A was in an argument with another child in the car. Youth A then tried to remove her child from the car. The foster parents then called law enforcement (LE) and DHHS. It was her understanding that DHHS and LE were mainly concerned the foster parents intended to leave Youth A behind. Both entities determined the foster parent locked Youth A out of the car as a means to protect the other children and did not intend to leave Youth A behind. The agency moved Youth A to another placement after this incident. DHHS chose not to open a case regarding the incident.

When asked how the agency came to their determination in SER 1, Supervisor stated they felt FP1's actions were due to her concern for the safety of the children in the car. Supervisor indicated there had previously been concern about how Youth A behaved with her child in the past. It was noted that Youth A's child is not a state ward. The foster parent was worried Youth A may take her child and leave or put her in danger, which would then put the foster parents at risk of failure to protect. When asked why the agency did not determine a violation for FP1 moving the car with Youth A partially in the door, the Supervisor indicated that DHHS did not open a

case and therefore the agency felt their recommendation was in line with what DHHS found. The Supervisor stated the agency felt the investigation was inconclusive regarding the foster parent grabbing Youth A and therefore did not believe a violation could be found.

**Worker 1**

An interview was completed on 2/3/22 via Teams. Regarding SER 1 Worker 1 stated the investigation was mostly focused on the physical harm aspect of FP1 grabbing Youth A's arm. As the investigation was inconclusive about if this occurred, a rule violation was not found. Worker 1 stated that she did not focus on the piece about FP1 and Youth A with the car, as determining if abuse occurred with the arm grab seemed most urgent. However, Worker 1 noted that after the investigation concluded she realized there may have been a violation due to FP1 driving the car away while Youth A was leaning into the back seat. However, Worker 1 stated she would not know how to cite that. Worker 1 explained that during the incident Youth A was upset and FP1 did not want her in the car. They were in a van with a sliding door. FP1 pulled forward in an attempt to make the door slide shut. FP1 understood it was not the best decision, but in the heat of the moment, she was concerned about the safety of the other children and wanted to keep Youth A out of the car. I discussed with Worker 1 which rules the incident could have been cited under. Worker 1 stated that since DHHS determined they did not need to investigate, she was under the impression there would not be any findings by the agency either.

Worker 1 reported that she was not aware of any concerns regarding Youth A or her ability to care for her child or interact with other children in the home. Worker 1 was not aware of any history of physical violence with children that the foster parents needed to be concerned about in this incident. However, she did note that Youth A has a history of becoming escalated easily and becoming verbally aggressive. Worker 1 reported she did not have any concerns about the family or the safety of children in their home. Although, she noted that she could see how someone from the outside may view the situation. Worker 1 indicated that she could see how a violation may have been cited for this incident.

**Documents Reviewed**

SER #2 summary: Authored by Worker 2

On 11/22/21 it was alleged that FP1 grabbed Youth B by the back of neck. DHHS was assigned. It was noted this was the third complaint regarding the use of physical force with foster children at this home. "Safety Plans" had been developed with the foster parents in the past to refrain from using physical force. During interviews Youth B reported FP1 believed she was hiding a cell phone at school. Youth B denied having a phone and walked away to calm down. It was noted this was one of the Youth B's coping skills. Youth B reported she remained on the property but hid behind a barn for a few hours. Youth B then walked back to the house where FP1 yelled at her, grabbed her by the back of the neck, then "sat" her down on the couch. No bruises or marks were observed on the youth's neck. When interviewed, FP1 and FP2 stated Youth B was posting inappropriate things online while at school. FP2

was not present when FP1 confronted Youth B about the phone. FP1 stated that Youth B escalated and left the property. FP1 went out to look for Youth B but could not find her. When Youth B returned, FP1 reportedly put her hand on the youth's shoulder to guide her to sit down. Other children in the home corroborated FP1's version of events. However, the other children also noted that FP1 will "use her body to move (another foster child) out the door to calm down". A safety plan was implemented that FP1 will never be home alone with the other foster child. DHHS did not have any findings from this investigation. The agency report indicated no licensing violations found.

**Licensing Supervisor**

On 2/3/22 an interview was conducted with Supervisor via Teams. Regarding SER 2, Supervisor recalled the investigation and stated that DHHS was involved as well. Therefore, Worker 2 "shadowed" the DHHS Worker. Supervisor stated that she believed their investigation was in-line with DHHS findings. When asked why FP1 felt the needs to go "hands on" with Youth B, Supervisor indicated that DHHS determined the action was not inappropriate. Therefore, the agency did not believe they could find a violation. Supervisor further stated this foster family is experienced with difficult teens and generally does very well with them. In this situation, the foster parent was worried if Youth B ran away, she may self-harm. Which is why FP1 did not want Youth B to go to her room. FP 1 then used her hand to guide Youth B to sit down.

Supervisor was asked about the statement in the report regarding FP1 using her body to move another child out the door and the "safety plans". It was noted there were no safety plans uploaded in MiSACWIS. Supervisor clarified the safety plans were something the foster parent did on their own. It was not something completed with or approved by the agency. Supervisor also clarified that FP1 "using her body" meant that when the child is escalated, she blocks him with her body to prevent him from accessing the other children. Typically, FP1 has this child step outside or to another room to calm down.

Supervisor stated that overall, the agency thinks the foster parents do a really good job and there are no concerns.

**Worker 2**

On 2/3/22 an interview was completed via Teams with Worker 2. Regarding SER 2, Worker 2 reported she coordinated her investigation with DHHS. Worker 2 confirmed that Youth B left the home after being instructed by FP1 to stay in the house. Youth B had a history of self-harming, which made the foster parents concerned about her being alone somewhere. When Youth B returned to the house, FP1 wanted to talk with her about the cell phone incident. Youth B wanted to go to her room as that is one of her coping mechanisms when she is confronted with something she does not want to talk about. FP1 was either concerned about Youth B self-harming or wanted Youth B to sit and listen. FP1 felt she could deescalate Youth B and have a conversation about the situation. FP1 put her hand on Youth B as an attempt to

have the youth focus. FP1 denied shoving Youth B and denied keeping the youth from leaving. Worker 2 reported that DHHS did not have any findings as it was inconclusive about whether the foster parent pushed the youth or guided them with her hand. Therefore, the agency did not have any findings.

Regarding the statement about FP1 using her body to move another child, Worker 2 stated she recently reread the report and realized there were details missing. Worker 2 explained there was a safety plan for this youth as he could become aggressive towards FP1 when escalated. The safety plan was something the family instituted, not the agency. The foster parents used their bodies to block access to other parts of the house and guide the youth to his room or outside when escalated. This technique had been successful with helping the youth deescalate. Worker 2 noted the agency was not aware of this safety plan, or of the youth being aggressive, until SER 2. I explained to the worker that additional detail and investigation were necessary regarding this situation.

**DCWL Director**

On 2/25/22 a meeting was held with agency members and the DCWL Director regarding a placement exception request. In the meeting, the Director expressed her concern regarding both incidents. The concerns expressed are in alignment with the findings of this report.

| **APPLICABLE RULE** | |
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| **R 400.12327** | **Special evaluation.** |
| | **(5) Within 15 days of the conclusion of the evaluation, an agency shall complete a written report that includes all of the following information:**<br>**(e) Findings of fact, based upon the evaluation.**<br>**(f) Conclusions regarding licensing rules compliance or noncompliance based on the findings of fact.** |

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| **ANALYSIS:** | The agency is found to be in violation of this rule as the conclusion of two special evaluations did not accurately reflect the information contained in the report.<br><br>SER #1- A violation should have been found due to the foster parent's behavior. While it was unclear if the foster parent grabbed the youth's hand, or the phone in her hand, this action was unnecessary as the youth was not harming anyone with the phone. This action also escalated the youth, leading to the incident with the car. The foster parent admitted to moving the car in an attempt to close the car door, knowing the youth was leaning into the car. The foster parents indicated this was an attempt to keep the youth out of the car as they were afraid of what she would do to the children in the car, although there was no history of the youth being physically violent.<br><br>SER #2- A violation should have been found due to the foster parent actions. In this situation, the youth returned to the foster home willingly, and in a safe manner. The youth wanted to be alone to deescalate. Yet the foster parent insisted on discussing the situation that caused the youth to leave the home initially. The foster parent also insisted the youth stay in one area of the home and put her hands on the youth to "guide" her to a seat. While the investigation from DHHS was inconclusive about the youth being pushed or guided by the foster parent, the physical interaction by the foster parent was unnecessary as the youth was not harming anyone. The foster parent should have used other techniques to address this situation or reached out to the agency for guidance. A CAP identifying additional training in this area could have benefitted the foster parents.<br><br>**<u>TECHNICAL ASSISTANCE:</u>**<br>• DHHS and agency findings may not match, as they are assessing different criteria. While DHHS may not have findings in their investigation, or may chose not to open an investigation, the agency may still find a violation of licensing rules.<br>• During investigations, staff must detail all information in reports as if the reader has no knowledge of the case history or foster family.<br>• During investigations, staff must review any documents referenced in the report and indicate what information the document provided.<br>• Regarding SER 2, the foster parent's action of confronting the youth when they returned to the home, and placing their hand on the youth, may be escalatory or triggering for a youth with |

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| | a trauma and a history of self-harm. The foster parent would benefit from additional training regarding the use of coping skills, de-escalation techniques, conflict resolution, crisis management, or working with kids that have experienced trauma.<br>• As this home has multiple allegations of physical management and no corrective actions plans or safety plans, the agency was informed that it appeared they were not identifying violations or developing CAPs. Any "safety plans" implemented by a foster parent, must also be approved by the agency. Any findings of non-compliance, must have an approved CAP.<br>• Reviewing a foster home's investigation history is part of the investigation process, in order to identify and address a pattern of behavior or needs of the foster parent.<br>• The agency was reminded that consultation with DCWL is always available if they are ever unsure about investigation processes or findings. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an acceptable CAP, I recommend no change in the license status.

March 10, 2022

Heather Reilly — Date
Licensing Consultant

Approved By:

March 11, 2022

Jessica VandenHeuvel — Date
Area Manager