Violations at Sequel Facilities in Michigan

The Michigan Department of Health and Human Services substantiated the following violations and requested corrective action on each of these counts. The violations can be read in their entirety at: https://cwl-search.apps.lara.state.mi.us/. Allegations that were not substantiated have not been included here but can be found on the MDHHS Child Welfare Licensing Search page.

Note: the dates are when the report was uploaded but the actual incident may have occurred months earlier. Exact dates are in the violation reports.

*Need to update to include Renewal Inspections and corrective action plans.

Lakeside Academy (Kalamazoo, MI)

3/21/2020: A resident was touched inappropriately by another resident while transported by a staff for nighttime meds.

3/10/2020: A resident was pushed and physically assaulted (slapped, choked and scratched) by staff, causing injury to the child.

2/2/2020: Staff 1 entered a small coat closet with Resident A for several minutes. It is unknown what the staff and resident were doing in the closet. There are concerns with Staff 1’s boundaries with the male students. She shows favoritism and invades the student's personal space.

1/27/2020: On 12/08/2019, Resident D went AWOL from his placement. When he returned on that same date, Staff 4 restrained Resident D and pressed his elbow down on Resident D’s thigh hard. Staff 4 called Resident D names. Resident D does not have any marks or bruises. Multiple staff members are cussing at, physically abusing, and grabbing the children.

*It was discussed with the Administrators the importance of having a refresher training with all staff on the importance of staff holding each other accountable. They agreed that each staff must report any inappropriate techniques regardless of their rank and that staff are fully aware of which techniques are approved and which are not.

*During the investigation of Allegations 3, it was discovered that Staff 6 used improper de-escalation techniques with a youth that resulted in a restraint that was not of immediate and imminent concern. Staff 6 was terminated from the position for not engaging in appropriate behavior management techniques when dealing with Resident D.

11/29/2020: Staff 7 argued with Resident D and pushed him down.
11/29/2019: Resident K is alleged to have pulled Resident J's pants down while he was sleeping and ejaculated him. Resident J woke up and reported this incident to the unknown staff member.

11/29/2019: Staff 23 took her hand and backhanded Resident R in the face.

4/13/19: During the course of investigating an unsubstantiated allegation, Staff 6, through his own admission, stated that he made comments to Resident A that he was “milking and faking” his foot injury. Another aspect of inappropriate interactions between Staff 6 and residents was identified by Resident B’s statement that Staff 6 will joke about slapping residents if they continue to curse.

2/22/19: Evidence provided through the interviews and a review of the video tape do not support the allegations that staff were threatening to beat Resident A up. However, there is evidence to support that staff did not follow the appropriate behavior management techniques. It is clearly demonstrated in the video recording that Staff 1 did not provide the appropriate proximity, and interviews indicated that Staff 1 used a raised voice and cursed during the “verbal” with Resident A. This inappropriate use of space, verbal tones and curse words is supported by Staff 1, Staff 2, Staff 3 and Staff 4’s statements during interviews. Both Staff 2 and Staff 3 indicated that they would have handled the situation differently, suggesting that Staff 1’s behavior did not provide Resident A the opportunity to de escalate. There is no evidence that any of the staff involved “bumped” into Resident A during the incident.

2/22/19: Resident A was assaulted by an employee in his bedroom. The video recording clearly displays Staff 5 aggressively pushing Resident A at least three times and physical evidence of marks were observed on Resident A. Resident A alleges the assault went on for 20 minutes.

12/12/18: Resident has rug burn on her face, which reportedly came from being physically restrained by a staff member who pushed her face to the floor. It is clear that Resident A was seen by multiple staff, including medical staff, to have an injury to her face, but received no treatment other than cleaning with water and application of a bandage for two days.

During review of video footage, it was noted that, while multiple staff were either assisting with or observing the physical restraint of Resident A in the dorm, one resident is seen running back and forth from one bedroom to another. It is unknown what was taking place. During the restraint of Resident A there were no staff available to provide supervision of the rest of the residents in the dorm.

12/12/18: Resident A reported that she was choked, pushed, and punched in the face by a staff member, Staff 7.

12/12/18: Resident A has been at Lakeside Academy for the past year. During his fifth month there was a staff member named (Staff 3) who took Resident A in the hallway and restrained
him for no reason. During his seventh month, Staff 3 pulled him up by his shirt and slammed him against the wall. Staff 3 swears at all of the children at Lakeside Academy.

On 6/24/18, Resident A cut herself with a razor in a suicide attempt. Resident A got the razor from the once a week leg shaving. Resident A is being bullied by staff, Staff 9, and another student, Resident I. Staff 9 picks on Resident A. No details about the bullying or picking on are known. Resident A cut herself due to this. (Resident D: not keeping sharp objects locked up-when coming on shift sharps laying out-staff keys in sharps drawer-not on shift when Resident D sitting in room 37/7-room search found nothing-later day Resident D cut face and wrist-reported to Staff 2 therapist)-staff told another staff about it-doesn't believe they do room searches-Resident A has a razor claimed she has since December-staff are not doing room searches but claim that they are-Resident A told me that she is cutting herself because she is being bullied by staff (Staff 9) and student Resident I -2-3 weeks ago came out of room with blood on writs and Resident I and Staff 9 laughed at her-no sure if she received medical care).

Violation cited lack of appropriate supervision; Residents in possession of razors without staff knowledge; Staff passing notes or information for residents; Staff using their phone for personal time during the shift; Staff using social media during shifts or allowing residents to use social media; Boundaries issues between staff and residents; and Bullying and inappropriate staff behaviors on the dorm.

There appears to be a culture which is not treatment based on this dorm. It appears that staff are not following the guidelines presented by the administration of this facility and have developed methods of interacting with the residents that are not supporting a trauma-based focus.

During this investigation, it was noted that several sources interviewed indicated that the facility is not providing the appropriate staff-to-student ratio on the dorm being investigated. The facility indicated that they are generally under staffed by approximately seventeen full time staff.

5/8/18: It was discovered during an investigation (for an unsubstantiated allegation) that two staff who are required mandated reporters and have had the facility’s training on mandated reporting did not follow through with the requirements of the facility’s procedure. When asked about the requirements of being a mandated reporter, he indicated that he was taught to contact his supervisor rather than contact the authorities.

5/8/18: Resident A was kissed by another student and the student put her hand down Resident A’s pants. Evidence uncovered during this investigation indicates that the facility had a staffing ratio of more than four students to one staff.

1/18/18: Improper supervision.
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.

**Starr Academy (Albion, MI)**

3/21/2020: Two residents had sexual contact while seated at the dining room table of their cottage

3/21/2020: Four residents had sexual contact while at the facility.

3/10/20: A teacher left a sharp knife on her desk unattended.

Upon review of the personnel files of staff involved in Allegation 1, it was discovered that there were numerous “write-ups” for failure to complete room checks as required. Evidence provided through written documentation does support that staff were not completing the room checks as required. The time between room checks varied from 30 minutes to 102 minutes.

During the course of this investigation, it was discovered that staff are not completing the “daily communication logs” as required by the facility’s policy/procedures.

4/13/19: It was alleged that a male staff slammed a male youth on the ground and the youth lost consciousness.

Staff completed an incident report which did not accurately reflect the restraint or youth injury.

This is a repeat violation from the 1/24/18 SIR 2018C0103021, CAP approved 7/30/18, and 3/17/19 SIR 2018C0212024, CAP pending.

4/13/19: Youth A was improperly restrained by a staff member and received an injury. Staff 1 should have continued using de escalation techniques and verbalized that he needed assistance from other staff, before initiating a restraint.

4/13/19: Youth A was struggling in the restraint and banging the back of his head on the floor. The nurse and ER documents indicate that Youth A had swelling to the back of his head. Therefore, it is likely that the cause of the concussion was due to Youth A purposely hitting his head on the floor. However, it was also noted that Staff 1 was observed to initiate an improper, one person restraint to the floor. A one person restraint to the floor was not approved as Starr staff were not trained in this method at the time of this incident. Even if Staff 1 had been trained in this technique, he reportedly completed the restraint incorrectly. In addition, it is possible that this restraint caused or contributed to Youth A having a concussion. It was also noted by Staff 3
that when the restraint was initiated Staff 1 and Youth A fell to the ground and there was a "thud" which also could have contributed to or caused Youth A's injury.

2/22/19: It was alleged that an employee supplied a resident with cigarettes. Staff 1 fell asleep and missed bed checks with the Guard One system. This action is a violation of the agency policy regarding the care and supervision of youth during sleeping hours. In addition, he did not follow agency policy regarding securing his personal belongings.

2/22/19: It was reported by the agency that staff found notes written between Youth A and Staff 1. The content of the notes was inappropriate and sexual in nature. Staff 1 wrote letters to a resident in which she stated that she wanted to "f---" her. Staff 1 and the resident deny any physical or sexual contact. However, the letter alone was inappropriate and demonstrated that Staff 1 does not have the ability to be establish effective boundaries in her assigned position.

2/22/19: Staff may not be providing adequate supervision: Youth A (16), Youth B (15), and Youth C (15) went AWOL on 7/21/18; Youth B went AWOL on 7/17/18; Youth B was caught smoking on campus on 7/16/18.

12/12/18: The facility did not follow PREA policy.

7/27/18: A staff went to sit a resident down in a chair. The resident fell onto a mop bucket and broke his finger.

7/27/18: Staff 1 stated it is common practice for staff to give residents who are leaving the staff’s personal information which is a violation of the facility’s Employee – Student/Client Relationships. Staff and directors gave conflicting information about whether they provided facility or personal contact information, but at least some personal contact information was stated to be provided.

This is a repeat violation cited during Special Investigations 2018C0103001 and 2018C0103003 with CAP’s accepted on 3/26/18 and 1/11/18.