JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
FAMILY INDEPENDENCE AGENCY
OFFICE OF CHILDREN AND ADULT LICENSING

MARIANNE UDOW
DIRECTOR

September 15, 2004

Diane Henneman
Havenwyck Impulse Disorder Unit
1525 University Drive
Auburn Hills, MI 48326

RE: License #: CI630201168
Investigation #: 2004C0107075
Havenwyck Impulse Disorder Unit

Dear Ms. Henneman:

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 feel free to contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please feel free to contact the local office at (734) 665-4740.

Sincerely,

Patricia L. Dudgeon-Smith, Licensing Consultant
Office of Children and Adult Licensing
Suite 358
41000 Woodward
Bloomfield Hills, MI 48304
(248) 975-5088

enclosure

MICHIGAN FAMILY INDEPENDENCE AGENCY
OFFICE OF CHILDREN AND ADULT LICENSING
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	CI630201168
Investigation #:	2004C0107075
Complaint Receipt Date:	09/02/2004
Investigation Initiation Date:	09/02/2004
Report Due Date:	11/01/2004
Licensee Name:	Havenwyck Hospital
Licensee Address:	1525 University Dr Auburn Hills, MI 48326
Licensee Telephone #:	
Administrator/Licensee Designee:	Robert Kercorian, Administrator
Name of Facility:	Havenwyck Impulse Disorder Unit
Facility Address:	1525 University Drive Auburn Hills, MI 48326
Facility Telephone #:	(248) 373-3366
Original Issuance Date:	05/13/1997
License Status:	REGULAR
Effective Date:	12/06/2003
Expiration Date:	12/05/2005
Capacity:	26
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. SUMMARY OF ALLEGATIONS

It is alleged that Supervisor 1 grabbed Resident A's arm, leaving bruising to the arm.

III. POTENTIAL RULE/STATUTORY VIOLATIONS

R 400.4137 Discipline and behavior management.

(1) An institution shall establish and follow written policies and procedures regarding discipline and behavior management. Upon request, these shall be available to all residents, their families, and referring agencies. Staff shall receive a copy of these policies and procedures and shall comply with them.
(2) An institution shall prohibit all cruel and severe discipline, including any of the following:
(a) Any type of severe physical discipline inflicted in any manner.
(b) Group discipline for misbehavior of individuals, except in accordance with the institution's discipline policy.
(c) Verbal abuse, ridicule, or humiliation.
(d) Denial of any essential program services.
(e) Withholding of any meal.
(f) Denial of visits or communications with family.
(g) Denial of opportunity for at least 8 hours of sleep in a 24-hour period.
(h) Denial of shelter, clothing, or essential personal needs.
(i) Excessive chemical, mechanical, or physical restraint.
(3) Residents shall not be permitted to discipline other residents, except as part of an organized therapeutic self-governing program that is conducted in accordance with written policy and is supervised directly by designated staff.

IV. METHODOLOGY

09/02/2004	Special Investigation Intake 2004C0107075
09/02/2004	Special Investigation Initiated - Telephone
09/03/2004	Contact - Face to Face interview with resident, staff, review of documentation
09/13/2004	Contact - Face to Face exit conference with ceo and program director

09/13/2004 Inspection Completed-BFS Sub. Compliance

09/15/2004 Corrective Action Plan Requested and Due on 10/10/2004

V. DESCRIPTION OF FINDINGS

R 400.4137 Discipline and behavior management.

On 09/03/04 Supervisor 1 was interviewed on-site. Supervisor 1 stated that on 08/31/03 Resident A's behavior were escalated on the unit, and that Resident A had ran around the unit, and had gone into a trash can and retrieved a shoe. Supervisor 1 stated that she and Staff Person 1 escorted Resident A to the behavior management room, where he "fell over on the matt." Supervisor 1 stated that she then saw that Resident A still had the shoe from the garbage, and she directed Resident A to give her the shoe. Supervisor 1 stated that Resident A refused to release the shoe, and held it over his head. Supervisor 1 stated that she then took the shoe from Resident A, and left him in the behavior management room. Supervisor 1 stated that during the escort to the behavior management room she held Resident A's left wrist with one hand, and had her other hand near his shoulder. Supervisor 1 stated that Staff Person 1 held Resident A's right wrist and shoulder in the same manner. Supervisor 1 stated that she did not touch Resident A's forearm during the escort or in the behavior management room. Supervisor 1 stated that after the incident Resident A told her that his arm was sore. Supervisor 1 stated that she looked at both arms, and did not see any marks or swelling. Supervisor 1 stated that later in the evening she observed Resident A use his arms to jump onto a counter. Supervisor 1 stated that she did not give Resident A an ice pack for his arm, as he did not have any injury. Supervisor 1 stated that the next day she observed Resident A tying string from his socks around his left wrist, causing his hand to turn blue. Supervisor 1 stated that she had to remove the string with scissors. Supervisor 1 denied that she ever grabbed Resident A's arm, or touched him in a way that caused bruising to his arm.

On 09/03/04 Staff Person 1 was interviewed on-site. Staff Person 1 stated that on 08/31/04 he observed Resident A's escalated behavior on the unit. Staff Person 1 stated that he observed Supervisor 1 give Resident A a directive to return to the behavior management room, and then observed Resident A run to the garbage can, take the shoe out, and then carry it to the behavior management room. Staff Person 1 stated that he and Supervisor 1 entered the behavior management room and that Supervisor 1asked for the shoe several times. Staff Person 1 stated that Resident A refused to release the shoe, and that he observed Resident A lying on the mat in the behavior management room, holding the shoe to his chest with both arms. Staff Person 1 stated that he observed Supervisor 1 reach down and pull Resident A's arms apart and take the shoe. Staff Person 1 stated that he observed Supervisor 1

hold Resident A's forearms. Staff Person 1 stated that he was standing in the doorway, to the side of Supervisor 1, and that he could see both Supervisor 1 and Resident A. Staff Person 1 stated that Resident A resisted Supervisor 1's efforts to get the shoe from him, and struggled with her. Staff Person 1 stated that he and Supervisor 1 then left the behavior management room. Staff Person 1 stated that he continued to observe Resident A in the behavior management room. Staff Person 1 stated that Resident A cried for "about 15 minutes," saying that his arm hurt, and saying that Supervisor 1 "broke his arm." Staff Person 1 stated that he did not look at Resident A's arm. Staff Person 1 stated that Resident A had initially walked to the behavior management room on his own, after he took the shoe out of the garbage can. Staff Person 1 stated that he and Supervisor 1 walked behind Resident A. Staff Person 1 stated that neither he nor Supervisor 1 physically escorted Resident A. Staff Person 1 stated that he documented in milieu progress notes on 08/31/04 that Supervisor 1 gave Resident A an ice pack for his sore arm after Resident A requested one. Staff Person 1 stated that he did not observe Supervisor 1 give Resident A an ice pack, however Supervisor 1 informed him later in the shift that she had given Resident A an ice pack; after Staff Person 1 told Supervisor 1 about Resident A's statements that his arm hurt.

On 09/03/04 Resident A was interviewed on-site. Resident A was observed to have several red bruises on the inside of his left forearm, and two small bruises on this left elbow area. Resident A stated that on 08/31/04 he was "acting out," by running around the unit, and that he "pulled a shoe out of the garbage, and wouldn't give it back." Resident A stated that Supervisor 1 "grabbed my arm and twisted it," to get the shoe back. Resident A stated that this incident occurred in the behavior management room. Resident A stated that Supervisor 1 initially grabbed his left wrist, and that her hand slid up to the middle area of his forearm. Resident A stated that Staff Person 1 was present during this incident. Resident A stated that Supervisor 1 "grabbed" his arm in an attempt to retrieve the shoe from him. Resident A stated that he told Staff Person 1 that his arm hurt after the incident. Resident A stated that he did not receive ice for the arm on 08/31/04.

On 09/03/04 Therapist 1 was interviewed on-site. Therapist 1 stated that she became aware of the incident on 09/01/04, during a family session with Resident A and his stepmother. Therapist 1 stated that the stepmother brought to her attention that Resident A had bruising to his left forearm. Therapist 1 stated that she was not aware at that time that there had been a behavioral incident involving an escort or any restraint of Resident A on 08/31/04. Therapist 1 stated that Resident A does not want to remain at the facility, and has stated that he wants to leave. Therapist 1 stated that Resident A does have a history of self-abuse, which includes pulling his eyebrows, picking at his skin, and scratching his skin. Therapist 1 could not identify any incidents of Resident A engaging in behavior to cause bruising to his skin.

On 09/03/04 documentation involving the incident including an incident report completed by Supervisor 1, and milieu progress notes were reviewed on-site. It is noted by Nurse 1 that she examined Resident A on 09/01/04, describing "bruising

was apparent on L forearm, appearing as 4 finger prints to area."

VI. CONCLUSIONS

R 400.4137 Discipline and behavior management.

(2) An institution shall prohibit all cruel and severe discipline, including any of the following:
(i) Excessive chemical, mechanical, or physical restraint.

Based on interviews and review of documentation, violation of this rule is determined. Resident A sustained bruising to his left forearm, allegedly as a result of Supervisor 1 restraining his arm to retrieve the shoe he was holding. Resident A's description of the incident and Supervisor 1's actions is consistent with that of Staff Person 1, who also stated that he witnessed Supervisor 1 pull the arms apart to get the shoe. Supervisor 1 reported that the only physical contact she had with Resident A was while she and Staff Person 1 escorted him to the behavior management room; however this is not supported by Staff Person 1, who reported that there was no physical escort. While is does not appear that there was any intention to cause harm or injury to Resident A during this incident; the information provided indicates that Resident A sustained several bruises to his arm as a result of Supervisor 1 attempting to retrieve the shoe from him.

VIOLATION ESTABLISHED

VII. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, the license recommendation for Havenwyck Impulse Control Disorder Unit, remains unchanged.

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Patricia L. Dudgeon-Smith Date
Licensing Consultant

Approved By:

_____

Linda Lee Date
Area Manager