GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEATH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING

ROBERT GORDON
DIRECTOR

June 17, 2020

Steven Laidacker
Lakeside
3921 Oakland Drive
Kalamazoo, MI 49008

RE: License #: CI390201235
Investigation #: 2020C0207030
Lakeside

Dear Mr. Laidacker:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

Please note that violations of any licensing rules are also violations of the Modified Implementation, Sustainability and Exit Plan (ISEP) and your contract.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event I am unavailable, and you need to speak to someone immediately, please contact the local office at (866) 685-0006.

Sincerely,

Kari Muntean, Licensing Consultant
MMDHHS\Division of Child Welfare Licensing
22 Center Street
Ypsilanti, MI 48198
(734) 395-0920

enclosure

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY AND GRAPHIC CONTENT

I. IDENTIFYING INFORMATION

License #:	CI390201235
Investigation #:	2020C0207030
Complaint Receipt Date:	04/30/2020
Investigation Initiation Date:	04/30/2020
Report Due Date:	06/29/2020
Licensee Name:	Lakeside
Licensee Address:	3921 Oakland Drive Kalamazoo, MI 49008
Licensee Telephone #:	Unknown
Administrator:	Steven Laidecker, Chief Administrator
Licensee Designee:	Sandra Lealofi, Designee
Name of Facility:	Lakeside
Facility Address:	3921 Oakland Drive Kalamazoo, MI 49008
Facility Telephone #:	(269) 381-4760
Original Issuance Date:	04/01/1990
License Status:	REGULAR
Effective Date:	09/18/2019
Expiration Date:	09/17/2021
Capacity:	126
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

	Violation Established?
1a. On 04/29/20, Resident A was improperly restrained. After the restraint, he was unresponsive and transferred to the hospital where he died on 05/01/20.	Yes
1b. The agency failed to follow their facility policy to obtain emergency medical care for resident care at the time of and immediately following this incident.	Yes
1c. Numerous staff did not demonstrate the ability to perform duties of their assigned positions.	Yes
1d. The agency did not provide sufficient staff, supervisors, and administration.	Yes
1e. The agency staff is not following their Communication Log Reporting policy.	Yes
1f. The agency was not following their own written emergency procedure for COVID-19 screening.	Yes
1g. The facility staff did not follow policy and excessively restrained Resident A on 01/04/20.	Yes
1h. During the 01/04/20 incident, two youth restrained a peer while two staff were directly present and did not intervene.	Yes
1i. The chief administrator lacked the ability to perform job duties as evidenced in this investigation.	Yes
1j. The agency failed to obtain the medical consents for all youth which is required at the time of admission.	Yes
2. On 05/06/20, 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
3. Resident U reported that Resident A took a drug or was given a drug that made his breathing heavy.	No
4. On 05/15/20, information was received that indicated Resident T's mother reported at court that he had not started therapy even though he had been at the facility since September of 2019.	No

III. METHODOLOGY

Special Investigation 2020C0207030 was completed using a variety sources, including but not limited to, telephone calls, face to face contacts, onsite inspection, interviews, review of documents, employee files, policy and procedures and video. Appendix A contains detailed contacts made by the DCWL Consultant.

IV. FINDINGS

All Investigation Notes can be found in Appendix D.

ALLEGATION 1a-j:

On 04/29/20, Resident A was improperly restrained. After the restraint, he was unresponsive and transferred to the hospital where he died on 05/01/20.

APPLICABLE RULE	
R 400.4159	**Resident restraint.**
	(1) An institution shall establish and follow written policies and procedures regarding restraint. These policies and procedures shall be available to all residents, their families, and referring agencies. (2) Resident restraint shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of trauma, and done in a manner consistent with the resident's treatment plan.
ANALYSIS:	The agency is in violation of the rule, subsections (1) and (2). 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 1, to push Resident A out of his seat and initiate a restraint were significantly disproportionate to the behavior of Resident A throwing bread, and were initiated without notification to or consultation with a supervisor or coordinator, program director, or nurse as required by the agency's policy and SCM. Throwing bread is not a

	demonstration of imminent threat of harm to self or others and did not warrant physical management. Staff 1 initiated restraint of Resident A without justification as Resident A was observed sitting on the floor after being pushed from his seat. This is not in line with SCM policy for least restrictive alternatives. 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. SCM does not provide for use of body weight in restraints and identifies this as a risk to the person being restrained. Per SCM, there is 2 person and a 3-person supine hold. There is no provision for a 7 staff restraint. The restraint was not performed in a manner consistent with Resident A's treatment plan, which outlines anger management needs, and Resident A being triggered when antagonized or people putting their hands on him, and history of abuse. The staff techniques outlined in the plan call for staff to help Resident A utilize anger management and coping skills, encourage Resident A's appropriate interactions, and reinforce positive self-talk, however these were not used. There was no evidence of an identified lead staff or monitor during this restraint, which is outlined in SCM. None of the involved staff, nurse, or supervisors present, addressed or corrected the staff involved in the restraint on their positioning. The length of the restraint was 12 minutes per the incident reports, as they noted 12:48pm-1:00pm. The video review showed that Staff 1 initiated contact with Resident A and
	immediately proceeded with the restraint at about 12:48:51. The staff fully released Resident A from the restraint about 12:59:35, which confirms this to be about a 12 minute restraint. The length of this restraint is also not in compliance with SCM or agency policy, which require that youth be released at the soonest possible opportunity, and that restraints last no longer than 10 minutes. It was observed that Staff 4 did not complete an incident report for his involvement in this incident, which is required by agency policy and SCM policy.
CONCLUSION:	**VIOLATION 1a: REPEAT VIOLATION ESTABLISHED** 159(1) IS A REPEAT VIOLATION: • 2019C0207037 – CAP approved 11/13/19 159(2) IS A REPEAT VIOLATION: • 2020C0223024 – CAP due 05/04/20 • 2020C0214009 – CAP approved 01/23/20 • 2018C0112027 – CAP approved 11/16/18

APPLICABLE RULE	
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.
ANALYSIS:	The agency is in violation of the rule. The evidence indicates that facility staff failed to follow their facility 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. Video review of this incident showed Resident A was released from the restraint at about 12:59:35. Nurse 1, two supervisors, and several staff were present. Nurse 1 is the Director of Nursing. Resident A was limp and unresponsive. The staff and Nurse 1 stood around him while some attempted to touch/tap on Resident A's chest. 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 when released from the restraint; 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 1, 2 and 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.
CONCLUSION:	**VIOLATION 1b ESTABLISHED**

APPLICABLE RULE	
R 400.4112	**Criminal history check, subject to requirements; staff qualifications.**
	(4) A person with ongoing duties shall have both of the following: (a) Ability to perform duties of the position assigned.

ANALYSIS:	The agency is in violation of the rule, based on the following: Nurse 1 failed to redirect the staff involved during the 04/29/20 restraint regarding their body positioning during the restraint of Resident A. Nurse 1 further demonstrated her lack of ability after Resident A was released from the restraint, by her failure to call 911 or start CPR for approximately 12 minutes after Resident A was released from the restraint. Staff 1 lacks the ability to perform his job duties, based on Staff person's actions during the 04/29/20 restraint and the evidence gathered during this investigation. In addition to Staff Person 1's actions during the restraint incident, Staff 1 did not accurately record the events of this incident as he reported that he attempted to put Resident A in an approved restraint hold and that the restraint was justified to ensure safety. Further, Staff 1 did not initiate emergency care directly or call 911 when Resident A appeared unconscious. Staff 2 lacks the ability to perform his job duties, based on Staff person's actions during the 04/29/20 restraint and the evidence gathered during this investigation. Staff 2 denied witnessing any staff putting body weight on or laying on Resident A. Staff 2 did not initiate emergency care directly or call 911 when Resident A appeared unconscious. Staff 3 lacks the ability to perform his job duties, based on Staff person's actions during the 04/29/20 restraint and the evidence gathered during this investigation. Staff 3 did not initiate emergency care directly or call 911 when Resident A appeared unconscious. Staff 4 lacks the ability to perform his job duties, based on Staff person's actions during the 04/29/20 restraint and the evidence gathered during this investigation. Staff 4 did not initiate emergency care directly or call 911 when Resident A appeared unconscious. Staff 5 lacks the ability to perform his job duties, based on Staff person's actions during the 04/29/20 restraint and the evidence gathered during this investigation. Staff 5 did not initiate emergency care directly or call 911 when Resident A appeared unconscious. Staff 6 lacks the ability to perform his job duties, based on Staff person's actions during the 04/29/20 restraint and the evidence gathered during this investigation. Staff 6 failed to provide CPR or call 911 for an extended period of about 12 minutes. Staff 7 lacks the ability to perform his job duties, based on Staff person's actions during the 04/29/20 restraint and the evidence

	gathered during this investigation. During the time that Staff 7 observed the restraint and when he returned to the cafeteria and observed Resident A not moving, he did not initiate emergency care directly or call 911. Supervisor 1 lacks the ability to perform her job duties, based on her actions during the 04/29/20 restraint and the evidence gathered during this investigation. Supervisor 1 reported in her interview that she saw no concerns with the restraint or staff putting their weight on Resident A. Further, Supervisor 1 was present for about six minutes after this restraint ended, however, Supervisor 1 failed to provide CPR or call 911 during this time. Supervisor 2 lacks the ability to perform his job duties, based on his actions during the 04/29/20 restraint and the evidence gathered during this investigation. Supervisor 1 arrived at the cafeteria, observed the restraint, and relieved Staff 7 at Resident A's head area. It was another five minutes before the staff fully released Resident A, which was sufficient time for Supervisor 2 to redirect the staff in the positioning and use of body weight on Resident A. After the restraint was released, Supervisor 2 failed to provide CPR or call 911 while observing Resident A to be unresponsive. The agency advised that Supervisor 2 was terminated for "improper restraint." In the 01/04/20 incident, all seven staff directly involved: Staff 8, 9, 10, 11, 13, and Staff 12 who is a program director, along with the Case Manager, engaged in an unsafe and excessive restraint of Resident A. The staff reported this to be a 10-minute restraint on the incident reports and supplemental incident reports, including Staff 12 who was the program director. This is a misrepresentation of the time of this restraint.
CONCLUSION:	**VIOLATION 1c REPEAT VIOLATION ESTABLISHED** 112 IS A REPEAT VIOLATION: • 2020C0214014 – CAP approved 03/06/20 • 2019C0214063 – CAP approved 12/12/19 • 2019C0214025 – CAP approved 04/10/19 • 2019C0214008 – CAP approved 01/21/19 • 2019C0214001 – CAP approved 12/28/18 • 2018C0214030 – CAP approved 11/15/18 • 2018C0214029 – CAP approved 10/24/18 • 2018C0214026 – CAP approved 09/17/18 • 2018C0214024 – CAP approved 09/17/18 • 2018C0112027 – CAP approved 11/16/18

APPLICABLE RULE	
R 400.4126	**Sufficiency of staff.**
	The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff on duty to perform the prescribed functions required by these administrative rules and in the agency's program statement and to provide for the continual needs, protection, and supervision of residents.
ANALYSIS:	The agency is in violation of the rule. 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. During the course of this investigation, the evidence has shown that staff and facility management were present and failed to act or intervene when staff have engaged in unsafe and excessive restraint incidents. Facility policy requires staff to intervene when they themselves observe restraint that is not being completed properly, yet this did not occur during the incidents reviewed during this investigation. Review of staff incident reports indicated that staff failed to identify any problems with the restraints that they participated in. Facility supervisors, directors, including the Director of Nursing, failed to intervene when observing unsafe and excessive restraint.
CONCLUSION:	**VIOLATION 1d REPEAT ESTABLISHED** 126 IS A REPEAT VIOLATION • SIR2020C0214011 CAP Approved 3/18/20 • SIR2020C0214016 CAP Approved 3/06/20

APPLICABLE RULE	
R 400.4109	**Program statement.**
	(1) An institution shall have and follow a current written program statement which specifically addresses all of the following: (c) Policies and procedures pertaining to admission, care, safety, and supervision, methods for addressing residents' needs, implementation of treatment plans, and discharge of residents.

ANALYSIS:	The agency is in violation of the rule as it was observed that 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. Two entries per day are required by the policy, and 33 logs contained only one entry. Per Director 1 the logs are to be reviewed by the Program Director of the youth's dorm and secondarily by the Quality Assurance department, but this does not appear to have occurred, or been addressed, further demonstrating that the agency is not following their own policy.
CONCLUSION:	**VIOLATION 1e ESTABLISHED**

APPLICABLE RULE	
R 400.4151	**Emergency; continuity of operation procedures.**
	(1) An institution shall establish and follow written emergency procedures that have been approved by the department that maintain the continuity of operations for a minimum of 72 hours to assure the safety of residents for the following circumstances: (c) Medical emergencies.
ANALYSIS:	The agency is in violation of the rule as they did not consistently ensure that visitors to the facility completed COVID-19 screenings as required in their emergency response plan. This was directly observed by three DCWL employees on 10 visits to the facility.
CONCLUSION:	**VIOLATION 1f ESTABLISHED**

APPLICABLE RULE	
R 400.159	**Resident restraint.**
	(1) An institution shall establish and follow written policies and procedures regarding restraint. These policies and procedures shall be available to all residents, their families, and referring agencies. (2) Resident restraint shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of trauma,

	and done in a manner consistent with the resident's treatment plan. (8) Resident restraint shall only be applied for the minimum time necessary to accomplish the purpose for its use as specifically permitted in subrule (2) of this rule. Approval of a supervisor shall be obtained when the restraint lasts more than 20 minutes.
ANALYSIS:	The agency is in violation of the rule, subsections (1) (2) (8). The facility staff involved failed to follow facility or SCM policy regarding restraint. The staff failed to use restraint methods trained by the SCM curriculum, pushing, and forcing the resident to a couch and then to the ground, then restraining him by 7 staff, who laid across parts of his body. The staff restrained Resident A in a manner that was unsafe and not proportionate for the severity of his behavior. The resident was observed to stop moving or struggling within approximately 4 minutes of the restraint, however the restraint continued with unsafe positioning, in excess of 30 minutes, with up to 7 staff holding the resident. The staff involved documented in incident reports that this restraint lasted for 10 minutes. Facility management failed to review the video for this restraint or to identify that this documentation had been inaccurately completed by the staff involved.
CONCLUSION:	**VIOLATION 1g: REPEAT VIOLATION ESTABLISHED** 159(1) IS A REPEAT VIOLATION: • 2019C0207037 – CAP approved 11/13/19 159(2) IS A REPEAT VIOLATION: • 2020C0223024 – CAP due 05/04/20 • 2020C0214009 – CAP approved 01/23/20 • 2018C0112027 – CAP approved 11/16/18

APPLICABLE RULE	
R 400.158	**Discipline.**
	(3) Residents shall not be permitted to discipline other residents.

ANALYSIS:	The agency is in violation of this rule as residents are not permitted to discipline or restrain one another. It is clear from the video review that two residents were physically restraining a peer when two staff were present, and the staff failed to intervene.
CONCLUSION:	**VIOLATION 1h ESTABLISHED**

APPLICABLE RULE	
R 400.4116	**Chief administrator; responsibilities.**
	(1) An agency shall assign the chief administrator responsibility for the on-site day-to-day operation of the institution and for ensuring compliance with these rules.
ANALYSIS:	The agency is in violation of this rule. Director 3 lacked the ability to perform her job duties as evidenced in this investigation. Director 3 did not ensure staff compliance with agency policy or facility compliance with licensing regulations demonstrated by the number and scope of violations cited in this investigation. Director 3 was the chief administrator of the facility and a Sequel employee at the time of the 01/04/20 and 04/29/20 restraints. Sequel is the management company for the facility which hired and 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.
CONCLUSION:	**VIOLATION 1i ESTABLISHED**

APPLICABLE RULE	
R 400.4152	**Initial documentation.**
	At the time of admission, all of the following shall be in the resident's case record: (g) Authorization to provide medical, dental, and surgical care and treatment as provided in section 14 a(1), (2), and (3) of 1973 PA 116, MCL 722.124a.

ANALYSIS:	The agency is in violation as they were unable to produce the medical consents when needed and did not have all medical consents for all youth which is required at the time of admission. Additionally, seven consents were not dated, and six consents were dated 05/08/20, which was after admission for those youth. Having medical consents and being able to produce them when needed are vital components to ensuring proper and timely care for residents.
CONCLUSION:	**VIOLATION 1j ESTABLISHED**

ALLEGATION 2:

On 05/06/20 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.

APPLICABLE RULE	
R 400.4124	**Communication.**
	An institution shall have and follow a written policy regarding communication that ensures that a child is able to communicate with family and friends in a manner appropriate to the child's functioning and consistent with the child's treatment plan and security level.
ANALYSIS:	While the youth were not permitted to make calls on the night of the incident, they were allowed the following day. This is in line with the agency policy for external contacts.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION 3:

Resident U reported that Resident A took a drug or was given a drug that made his breathing heavy.

APPLICABLE RULE	
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.

ANALYSIS:	[redacted]
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION 4:

On 05/15/20, the DCWL Consultant received information that indicated Resident T's mother reported at court, that he had not started therapy even though he had been at the facility since September of 2019.

APPLICABLE RULE	
R 400.4155	**Institutions not detention institutions or shelter care institutions; initial treatment plan.**
	(3) The initial treatment plan shall include all of the following: (c) Treatment goals to remedy the problems of the resident and family, and time frames for achieving the goals. (d) Indicators of goal achievement.
ANALYSIS:	Resident T was assessed initially and was being provided therapy services. Although Resident T's mother reported that he was not getting therapy since March, when the pandemic began, Resident T reported that he had received regular individual therapy services while at the facility. The documentation provided by the facility shows that there was one week, when Resident T did not participate in any therapy services, however, this is the same week he was quarantined and isolated for his positive test results.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.4156	**Institutions not detention institutions or shelter care institutions; updated treatment plan.**
	(3) The updated treatment plan shall include all of the following information: (a) Dates, persons contacted, type of contact, and place of contact. (b) Progress made toward achieving the goals established in the previous treatment plan. (c) Changes in the treatment plan, including new problems and new goals to remedy the problems. Indicators of goal achievement and time frames for achievement shall be specified along with a specific behavior management plan designed to minimize seclusion and restraint and that includes a continuum of responses to problem behaviors.
ANALYSIS:	The agency is compliant with the rule as documentation supports that Resident T was assessed initially and was being provided therapy services. Although Resident T's mother reported that he was not getting therapy since March, when the pandemic began, Resident T reported that he had received regular individual therapy services while at the facility up until the last couple of weeks. The documentation provided by the facility shows that there was only one week, when Resident T did not participate in any therapy services, however, this is the same week he was quarantined and isolated for his positive test results.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

V. RECOMMENDATION

Due to the severity of the violations noted within this report, revocation of this child caring institution license is recommended.

June 17, 2020

Kari Muntean Date
Licensing Consultant

Approved By:

June 17, 2020

Claudia Triestram Date
Area Manager

Appendix A: Contacts conducted by the DCWL Consultant

04/30/2020	Special Investigation Intake 2020C0207030
04/30/2020	Special Investigation Initiated - Letter Received intake assignment 4/30/20 at 8:17am. Initial contact for this investigation began 04/29/20 at 5:17pm during a telephone call from DCWL Area Manager.
04/30/2020	Contact - Telephone call Initial telephone contact with the Michigan Department of Health and Human Services (MDHHS) Specialist occurred on 04/29/20. Case updates received. Ongoing contacts with MDHHS Specialist on 04/30/20 regarding investigation updates and coordination. Additional contacts with Director 1.
04/30/2020	Contact - Telephone call Video conferencing Zoom meeting to review video with Directors 1 and 2, as well as agency attorney, and MDHHS administrators.
04/30/2020	Contact - Telephone call Contacts with Director 3.
04/30/2020	Contact - Document Sent Emails exchanged with MDHHS Specialist.
04/30/2020	Contact - Document Sent Initial email exchanges occurred 04/29/20 with Directors 1, 3, 4, and MMDHHS Specialist.
04/30/2020	Contact - Document Sent Emails exchanged with Directors 1, 3, 4, and MDHHS Specialist.
05/01/2020	Contact - Telephone call made Contacts with Directors 1, 2, and 3, MDHHS Specialist. Attempted calls to Detective with one unsuccessful and one message left. Conference call with agency staff, Health Department, and MDHHS administration.
05/01/2020	Contact - Document Received Emails received from MDHHS Specialist and Supervisor.
05/01/2020	Contact - Face to Face

	On-site visits to the facility were completed on 05/01/20, 05/04/20, 05/05/20, 05/09/20, 05/14/20, 05/15/20, and 05/17/20 by DCWL Area Manager.
05/01/2020	Contact - Face to Face On-site visits to the facility completed on 05/01/20, 05/10/20, and 05/16/20 by DCWL Division Director.
05/01/2020	Contact - Document Sent Email sent to Detective 1.
05/01/2020	Contact - Document Sent Emails exchanged with Directors 1, 2, 3, and 5, MDHHS Specialist and Supervisor.
05/02/2020	Contact - Document Received Emails exchanged with Directors 1, 2, 3, 5, MDHHS Specialist, and DCWL Consultant 2.
05/04/2020	Contact - Telephone call received Contacts with MDHHS Specialist. Case conference call to MDHHS Specialist, MDHHS Specialist Supervisor, MDHHS administration for investigation coordination and planning.
05/04/2020	Contact - Document Received Email received from MDHHS Specialist with Detective copied to coordinate investigations. Reply email sent to both.
05/04/2020	Inspection Completed On-site On-site visit to facility with DCWL Area Manager. Walk-through and updated provided by Director 2.
05/04/2020	Contact - Document Sent Emails exchanged with Directors 1, 2, and 5, MDHHS Specialist, and Detective.
05/05/2020	Contact - Telephone call made Contacts exchanged with MDHHS Specialist.
05/05/2020	Contact - Document Received Emails exchanged with MDHHS Specialist.
05/05/2020	Contact - Document Received Emails exchanged with Detective 1.
05/05/2020	Contact - Document Sent

	Emails exchanged with Directors 1, 2, 5, and MDHHS Specialist.
05/06/2020	Contact - Telephone call received Contacts exchanged with MDHHS Specialist.
05/06/2020	Contact - Document Sent Email to MDHHS Specialist. Email received from MDHHS Specialist with Detective copied regarding coordination of investigations.
05/06/2020	Contact - Telephone call made Call to Complainant E, left message.
05/06/2020	Contact - Face to Face On-site visits to the facility occurred on the following dates by DCWL Consultant 2: 05/06/20, 05/07/20, 05/08/20, 05/11/20, 05/12/20, and 05/13/20.
05/06/2020	Contact - Document Received Emails exchanged with Detective 1.
05/07/2020	Contact - Telephone call received Contacts exchanged with MDHHS Specialist for updates and investigation coordination.
05/07/2020	Contact - Document Sent Emailed MDHHS Specialist, Director 1 and Director 2 invitation to Teams video conference meeting for 05/08/20.
05/07/2020	Contact - Document Sent Emails exchanged with Directors 1, 2, 5, and MDHHS Specialist.
05/07/2020	Contact - Document Received Emails exchanged with Detective 1.
05/08/2020	Contact - Telephone call made Various calls to/from MDHHS Specialist.
05/08/2020	Contact - Telephone call made Video conferenced interviews via Teams done jointly with MDHHS Specialist and the following: Nurse C, Case Manager, Director of Case Management, and Director 4. Director 1 facilitated the interviews. Attorney 2 was present as an observer to the interviews.
05/08/2020	Contact - Document Received

	Email from MDHHS Specialist.
05/10/2020	Contact – Document received Email from Director 1.
05/11/2020	Contact – Telephone call received Several contacts from MDHHS Specialist.
05/11/2020	Contact – Document sent Emails exchanged with MDHHS Specialist.
05/11/2020	Contact – Document sent Emails exchanged with Directors 1, 2, 5, MDHHS Specialist, and Attorney 2.
05/12/2020	Contact – Document sent Emails exchanged with Director 1, 2 and 5, MDHHS Specialist, and Attorney 2.
05/12/2020	Contact – Document sent Emails exchanged with MDHHS Specialist.
05/12/2020	Contact – Telephone call received From MDHHS Specialist.
05/13/2020	Contact – Document received Email updates received from MDHHS Specialist.
05/13/2020	Contact – Document received Emails exchanged with Directors 1 and 2, with Director 5 copied and MDHHS Specialist copied and Attorney 2 copied.
05/13/2020	Contact – Document received Emails received from MDHHS Specialist.
05/13/2020	Contact – Telephone call received From MDHHS Specialist.
05/13/2020	Contact – Telephone call made Joint calls made with MDHHS Specialist to the following staff who declined interviews without representation, Staffs 1, 2, 3, and 6. A message was left for Staff 5 to return the call to the MDHHS Specialist.
05/13/2020	Contact – Telephone call made

	Joint phone interview conducted with Nurse B and MDHHS Specialist. Separate joint interview completed with the Program Director and MDHHS Specialist via phone. The agency attorney was present on the phone for both interviews.
05/13/2020	Contact – Document received Emails received and exchanged with Detective 1, MDHHS Specialist, Directors 1, 2, and 5, and Attorney 2.
05/14/2020	Contact – Document sent Emails exchanged with MDHHS Specialist, Directors 1, 2, and 5.
05/14/2020	Contact – Telephone call made Contact to MDHHS Specialist.
05/14/2020	Contact – Document sent Emails exchanged with MDHHS Specialist.
05/15/2020	Contact – Document sent Emails exchanged with MDHHS Specialist, Directors 1, 2, and 5, and DCWL Division Director.
05/18/2020	Contact – Telephone call made Call to Complainant D. Left message.
05/18/2020	Contact – Telephone call Contact to Director 1.
05/18/2020	Contact – Face to face On-site visits to the facility.
05/18/2020	Contact – Document sent Emails exchanged with MDHHS Specialist.
05/18/2020	Contact – Document sent Emails exchanged with MDHHS Specialist, Directors 1, 2, and 5.
05/19/2020	Contact – Telephone call made Contact to Staff 14. Left message. Received return call and interview completed via phone.
05/19/2020	Contact – Telephone call received Contact from MDHHS Specialist for updates and coordination.
05/19/2020	Contact – Document sent Emails exchanged with MDHHS Specialist, Directors 1, 2, and 5.

05/19/2020	Contact – Telephone call made Interview with Complainant E.
05/20/2020	Contact – Telephone call made Follow-up interview with Complainant E.
05/20/2020	Contact – Telephone call made Call to Director 5 to discuss investigations and follow-up.
05/20/2020	Contact – Telephone call made Call to Complainant D-left message. Call to Complainant E-left message.
05/20/2020	Contact – Telephone call received Call from Complainant E.
05/20/2020	Contact – Document received Email received from Detective 1
05/20/2020	Contact – Document sent Emails exchanged with Directors 1, 2, 5, and Licensee Designee.
05/21/2020	Contact – Document received Emails received and exchanged with MDHHS Specialist, Detective 1, Directors 1, 2, 5, and Licensee Designee.
05/21/2020	Contact – Telephone call received Call from MDHHS Specialist to discuss case.
05/21/2020	Contact – Telephone call made Joint telephone interviews attempted with MDHHS Specialist for the following: Nurse 1-left message, Staff 5-left message, Supervisor 1-number disconnected, and second number not recognized, Staff 4-number disconnected, Staff 7-left message.
05/26/2020	Contact – Document received Emails received and exchanged with MDHHS Specialist, Detective 1, Directors 1, 2, 5, Licensee Designee, and DCWL Consultant 2.
05/26/2020	Contact – Telephone call made Call to MDHHS Specialist.
05/27/2020	Contact – Document received Emails exchanged with Directors 1, 2, 5, and Licensee Designee.

05/28/2020	Contact – Document sent Emails exchanged with Directors 1, 2, and 5, and MDHHS Specialist.
05/28/2020	Contact – Telephone call made Separate calls made to: MDHHS Specialist; Resident U's worker; Teacher.
05/28/2020	Contact – Telephone call made Left a message for Attorney 1.
05/28/2020	Contact – Telephone call made Attempted calls to Nurse 1-mailbox full; Director 4-number disconnected. Interview completed with Staff 7.
05/28/2020	Contact – Telephone call made Left a message for Staff 5.
05/29/2020	Contact – Document sent Emails exchanged with Directors 1 and 5.
05/29/2020	Contact – Telephone call made Call to Resident U's worker. No answer.
06/01/2020	Contact – Telephone call made Interview attempts made to the following: Nurse 1-no answer, mailbox full, Staff 1-Left message, Staff 2-spoke with Staff 2 and set interview for 06/02/20, Staff 3-spoke with Staff 3 who declined to participate in interview, Staff 5-spoke with Staff 5 who declined to participate in interview.
06/01/2020	Contact – Telephone call made Separate calls with: Director 3, MDHHS Specialist, Resident U's worker, Resident U, Resident T's worker-left message, Resident T's mother-left message and she called back and was interviewed.
06/01/2020	Contact – Document sent Emails sent to and exchanged with MDHHS Specialist, Directors 1, and 5, and DCWL Consultant 2.
06/02/2020	Contact – Document received Emails received from and exchanged with MDHHS Specialist, Directors 1, 4, and 5, DCWL Consultant 2, and Attorney 2.
06/02/2020	Contact – Document sent Emails exchanged with Detective 1.

06/02/2020	Contact – Telephone call made Joint interview of Staff 2 with MDHHS Specialist via phone.
06/02/2020	Contact – Telephone call made Separate calls made. Interview of Director 5. Follow-up interview with Director 4. Update on case with Detective 1.
06/02/2020	Contact – Telephone call made Call to Director 3.
06/03/2020	Contact – Document sent Emails exchanged with MDHHS Specialist, Directors 1 and 5, and DCWL Consultant 2.
06/03/2020	Contact – Telephone call made Telephone calls with MDHHS Specialist for case updates. Report made to Centralized Intake-Log ID 71015665.
06/04/2020	Contact – Telephone call made Interview with Director 3.
06/04/2020	Contact – Document sent Emails exchanged with Directors 1 and 5, and DCWL Consultant 2.
06/05/2020	Contact – Document received Email received from MDHHS Specialist.
06/08/2020	Contact – Telephone call received Calls received and exchanged with MDHHS Specialist. Separate call to Director 3.
06/08/2020	Contact – Telephone call made Interview of Complainant C via phone.
06/08/2020	Contact – Telephone call made Joint telephone interview of Supervisor 2 with MDHHS Specialist.
06/09/2020	Contact – Telephone call received Calls received from MDHHS.
06/09/2020	Contact – Telephone call made Call to Director 3.
06/09/2020	Contact – Telephone call received

	Call received from Resident T's worker.
06/09/2020	Contact – Telephone call received Joint phone interview of Medical Examiner with MDHHS Specialist.
06/09/2020	Contact – Document sent Emails exchanged with Directors 1 and 5.
06/10/2020	Contact – Document sent Emails exchanged with MDHHS Specialist, Directors 1 and 5.
06/10/2020	Contact – Telephone call made Joint call made to Resident A's worker with MDHHS Specialist.
06/11/2020	Contact – Document received Emails exchanged with MDHHS Specialist, Directors 1 and 5, and DCWL Area Manager.
06/12/2020	Contact – Document received Email from MDHHS Specialist.
06/15/2020	Contact – Document sent Emails exchanged with Directors 1 and 5.
06/15/2020	Contact – Telephone call made Call to MDHHS Specialist. Joint phone interview of Supervisor 1 with MDHHS Specialist.
06/16/2020	Contact – Document sent Email to Director 1.
06/16/2020	Contact – Telephone call received Call from MDHHS Specialist.
06/17/2020	Contact – Document received Email from Director 1.
06/17/2020	Contact – Telephone call made Calls exchanged with MDHHS Specialist.

Appendix B: Resident Interviews

Detective 1 interviewed Resident B. He stated he was not in the lunchroom at the time of the incident with Resident A.

Detective 1 attempted to talk to Resident C, who refused to be interviewed.

Detective 1 interviewed Resident D. Resident D stated he was sitting at another table with his back to the incident when they went on a “critical.” During the incident Resident A “didn’t say one word.” There was a lot of noise, but he did not recall anything specific said by staff. When asked what else he has heard about this situation, Resident D said, “The restraints. Those mother fuckers be on some bullshit with that.” This was the only incident that Resident D saw since he got to Lakeside that was serious. Resident D said he has not been restrained. When asked what behaviors lead to a resident being restrained, Resident D said, “messing up, being a dummy, just not following instructions basically.”

Resident E was interviewed by Detective 2. He stated he had been there just over 1 month. Resident E said he has known Resident A since he got to Lakeside, noting they were close friends. Resident E said he was sitting on the other side of the cafeteria when the incident with Resident A occurred. When asked about the incident, Resident E said he saw Resident A throw food. Staff told him to stop and he continued. Resident E said staff tried to grab him to restrain him, Resident A fell, and then was restrained. Resident E said he left out for a walk, returned, and watched the incident from outside through the window. Resident E said he could not hear anything said by staff or Resident A, but noted Resident A was not fighting back during the restraint. Resident E said he has seen other restraints occur about seven or eight times. He said that the number of staff in a restraint depends on how big the youth is that they are restraining.

Resident F was interviewed by Detective 2. He stated he has been at Lakeside about 10-11 months. Resident F said he knew Resident A and noted that they did not get along. Resident F stated that he was in the cafeteria on the day of the incident and stated Resident A was throwing bread at his peer. Staff told Resident A to stop but Resident A continued and was restrained. Resident F said Resident A kept trying to resist during the restraint. Resident F reported that he did not hear anything said by staff or Resident A, and only saw the beginning of the restraint. Resident F said he has been restrained and stated that the number of staff restraining a youth depends on how strong the youth is. Resident F said that fighting and being unsafe will lead to a restraint. When asked for an example of being unsafe, a clear explanation was not reported.

Resident G was interviewed by Detective 2. He stated he lived with Resident A and got along with him. He stated he was not in the cafeteria when this incident occurred. Resident G denied being restrained or witnessing other restraints. Resident G said being unsafe will lead to restraint but did not provide much detail.

Resident H was interviewed by Detective 1. He was interviewed while inside his room with a staff present at the door and the Detective in the hall, [redacted]. Resident H has been at Lakeside four or five months. Resident H said he knew Resident A and was in the cafeteria when he was restrained. Resident H said he was not really paying attention when the incident occurred. Resident H said he heard Resident A say, “When I get up you guys are fucked.” The video of this interview freezes 2 ½ minutes in and the other 3 ½ minutes are unrecoverable.

An interview was attempted with Resident I, by Detective 2, but Resident I refused to give his name or be interviewed.

Resident J was interviewed by Detective 2. Resident J said he knew Resident A and noted Resident A was throwing stuff at people and trying to fight people in the cafeteria. Resident J said that when residents are being unsafe it builds up to a restraint and the staff put you on the ground and hold you until you calm down. Resident J did not hear staff or Resident A say anything. When Resident J left the cafeteria, the staff were getting ready to let Resident A up. Resident J denied being restrained while at the facility but noted that he has seen other restraints. Resident J said that he would say there is about one restraint per day. Resident J reported that behaviors like throwing stuff, having balled up or clenched fists, trying to walk up on others aggressively, and talking “shit” to people will lead to residents being restrained. Resident J said during restraints the staff hold legs and arms but do not lay on the resident.

Resident K was interviewed by Detective 2. He has been at Lakeside for eight months and knew Resident A for about five months. Resident K stated that he was in the cafeteria when the incident occurred. He said Resident A was throwing food at other kids and staff pushed him out of his chair and restrained him. Resident K said that Resident A was saying things like, “I eat them,” and, “restraints are nothing.” Resident K stated that after the restraint Resident A was twitching and had foam in his mouth. He said Resident A was saying, “I eat the restraints” the whole time but then his body just gave out. He said Resident A was talking for a minute but then stopped talking for a bit. Then staff let him go and he did not move. Resident K said staff were saying “Come on [Resident A].” As Resident K was walking out of the cafeteria, the staff cut Resident A’s shirt open and called an ambulance. Resident K said that he has seen restraints like this all the time and it is a common restraint; the “supine,” but he had never seen this happen before. Resident K said that this time, “they had more staff on him, and I don’t think that was right. They were big ass staff. The supine’s not for your stomach, it’s for your hands and your feet.” When Detective 2 asked for clarification as to whether staff were on Resident A, Resident K stated that he thought they had to put more pressure on Resident A because he was resisting the whole time, but noted the staff was laying across Resident A’s legs. He said he did not see staff on Resident A’s chest or stomach.

Resident L was interviewed by Detective 2. He has been at Lakeside for about four months and has known Resident A the entire time. Resident L said that he was in the cafeteria when the incident occurred. He said that Resident A was mad and throwing food when staff told him to stop. Resident L said that this was common for Resident A to not listen to staff but also noted that Resident A is not the type to attack someone. Resident L said Resident A continued to talk back to staff and again said that this was just Resident A being himself. Resident L said that he was not sure if the staff got irritated with Resident A, but staff threw Resident A on the ground and restrained him. Detective 2 asked if Resident L saw this occur and he stated he saw it and then demonstrated a staff pushing Resident A from the seat. He said that this is not normal but, “Lakeside does what they want.” Resident L said that it looked like Resident A could not breathe and said that staff kept picking up his head during the restraint. Resident L said that Resident A was not saying anything but had a “constipated” face. Resident L said he was not sure if Resident A was just trying to hold in a scream to not look weak, but he restated that he had a constipated face. Resident L said that he thought staff were doing too much and got mad when he told them that they were doing too much, and that Resident A was not even mad. Staff told Resident L to just look forward. The staff then directed the other youth to leave the area. Resident L said Lakeside just does too much, but they make it look good on camera. Resident L reported that he got a bruise on his back during an incident with a staff who “kinda choked me out.” Resident L said that this occurred about a month ago and nothing was done and noted that he had told his “PO.” In this situation, Resident L said that he got into a verbal conflict with a staff and Resident L “popped up” and the two started wrestling and the staff could not get a hold on him. During the incident, Resident L said the staff “kind of grabbed me by my neck.” Resident L then said he thought the incident had been written up. (It is notable that this was previously investigated by both DCWL and MDHHS with no violations noted. SIR 2020C0214021 dated 03/25/20) Resident L went on to report that he has told staff, “Now that you guys finally killed one of us you guys want to stop this and feel sorry for us, right?” Resident L said that staff previously acted like this kind of restraint was ok. Resident L reported that he has been restrained four times. He stated that the staff are “extra” and when restraining they push your arms in harder than what they have to. Resident L explained that when on the ground staff hold your arms over your head and another staff holds or sits on your feet, depending on the staff. Resident L said it is hard to breathe like that. Resident L said that if it is on camera, they only hold for 15 minutes because that is all they are allowed, but, “if you’re off camera you’re fucked. You’re getting fucked up.” Resident L said he did not know if staff restrain youth for less than 15 minutes. He said that restraints happen when kids fight, argue, or if the staff do not like you. He also said restraints happen if a youth is being unsafe or trying to harm themselves.

Resident M was interviewed by Detective 3. He has been at Lakeside for three months and has known Resident A for that time. Resident M said that he and Resident A had a close relationship. He said he was in the cafeteria on the day of the

incident. Resident M said he was antagonizing Resident A and making comments about Resident A's legs. He said they were mad at each other and Resident A was throwing stuff at him. Staff told Resident A to stop throwing food, but he did not, and argued with staff, and staff restrained him in a supine "like they supposed to." Resident M demonstrated a supine as having your arms above your head. He said that he has not seen the supine restraint used often and denied having been restrained himself. Resident M stated that if a resident is being unsafe the staff will restrain them. He said that Resident A yelled for staff to get off him a couple of times and noted there were about four or five staff restraining Resident A. He said that is how many it took because Resident A is big.

Resident N was interviewed by Detective 3. He stated that he has been at Lakeside for a year and a half. He said he was in the cafeteria when Resident A got restrained. Resident N said he knew Resident A the whole time he was at Lakeside. Resident N said Resident A was throwing food before the restraint. He stated Resident A has times when he gets in moods and picks with peers and won't stop. On the day of the incident, Resident N said that Resident A was mad at Resident M, but he did not know what for. Resident N said Resident A was restrained flat on the ground but could not describe the details of how Resident A was restrained, or how many staff restrained Resident A.

Resident O was interviewed by Detective 3. He has been at Lakeside since October 2019. Resident O stated that he knew Resident A but did not describe him as a friend. Resident O said he was in the cafeteria near the kid that Resident A threw the sandwich at when Resident A was restrained, but once the restraint started, he moved away. Resident O said that staff "slammed" Resident A because he kept throwing things. Resident O said that the restraint happened because staff told Resident A to stop throwing food and when Resident A did it again "he got thrown to the floor." Resident O stated that it was Staff 1 who threw Resident A to the floor. Resident O did not recall hearing staff saying anything else. He said Resident A was trying to pick a fight with another youth before he threw food and continued to throw food after staff told him not to. Resident O said that the staff then put Resident A in a supine restraint and described a supine as staff holding legs and arms down, noting that he has been in this kind of restraint himself. Resident O said it is not really aggressive, but the staff are just holding you down and if you are fighting back, they have to hold you down tighter. Resident O noted that behaviors that lead to restraints would be fighting. He said the kids left out of the cafeteria during the restraint.

Resident P was interviewed by Detective 3. Resident P has been at Lakeside for 11 months. He said that he was in the cafeteria when the incident occurred, but he did not know Resident A well. Resident P said that he saw Resident A throw food at another kid and Staff 1 tried to stop him. Resident A fell off his seat and tried to hit Staff 1. Resident A was then restrained and tried to resist. Resident P said that staff had told Resident A to calm down and not to throw food, and let Resident A slide, but he did it again and they had to take it from him. Resident P said that during the

restraint there were five staff holding Resident A due to Resident A fighting against staff by kneeing and trying to hit staff. He said Resident A was laughing about the restraint. He only heard the staff telling Resident A to calm down. Resident P said that this kind of restraint happens all the time because kids fight against staff.

Resident Q was interviewed by Detective 3 and reported he has been at Lakeside for about six months. Resident Q said that he knew who Resident A was, but they were not friends. He said that he was in the cafeteria during the incident and saw the restraint. He said that Resident A was throwing food at another peer and staff told him if he did it again, he would be restrained, and Resident A threw food again. Resident Q said that he was in close proximity and heard the staff tell Resident A this. Resident Q said he looked at his food during the restraint. He said that he has seen other restraints but noted that restraints do not happen often. He said that staff give warnings to kids multiple times to stop doing a behavior and then “when they get tired of it, they’re like you do it again and we’ll restrain you.” Resident Q said that he heard Resident A was struggling for breath and said that sometimes staff hold residents “where your breathing is.” When asked for clarification, Resident Q said that staff sometimes hold kids on the neck and then kids lie still to comply so that staff will release them. He stated restraints occur when a kid is constantly doing something or when a kid tries to hurt another kid.

An interview was attempted with Resident R, by Detective 3, but Resident R walked off and did not participate in the interview.

Resident S was interviewed by Detective 3. The first thing Resident S asked was if Resident A was dead. Resident S said that he is from California and has been at Lakeside for about five months. He said that he knew Resident A since his placement at Lakeside. He stated he was in the cafeteria on the day of the incident and said he was eating and just thought it was a “normal” restraint. Detective 3 tried to get Resident S to describe what he saw in the cafeteria and Resident S said, “Ya’ll fired our staff for no reason.” The Detective clarified that the police fired no one.

The DCWL Consultant interviewed Resident U via phone on 06/01/20. Resident U reported that he was present during this incident and was just outside the cafeteria but saw the whole thing through the window. Resident U said that Resident A threw something at someone and got restrained. Resident U said that there are usually up to six staff on a restraint but not more. Resident U identified that he had six staff restrain him while at Lakeside also. Resident U said that he heard Resident A say he couldn’t breathe during the restraint. Resident U stated that Resident A said this twice and he heard it when a staff had opened the door.

Appendix C: Staff interviews

Staff 2:

Staff 2 was interviewed on 06/02/20, via phone, jointly with the DCWL Consultant and the MDHHS Specialist. Staff 2 reported that he has been employed at the facility since 03/02/20. Staff 2 said that this incident with Resident A began on the dorm when Resident A was trying to fight a peer. Staff deescalated Resident A and the group went to lunch while Resident A stayed back with Staff 4, who later brought Resident A to the cafeteria. Staff 2 reported that the peer was in the cafeteria and trying to avoid Resident A, but when Resident A arrived, he continued picking with the peer and threw a pile of napkins. Staff 2 warned Resident A to stop and moved the peer away from Resident A. Staff 2 said that Resident A threw pieces of his sandwich at another youth. Staff 1 also saw this and went to talk to Resident A, who threw more food. Staff 2 said that staff have been told not to give Resident A as many chances as they did, but they put Resident A in a "critical" (described as increased staff and peer attention to address behaviors). Staff 2 said that he removed Resident A's hot bowl of soup to prevent him from throwing it at anyone. Staff 2 said that Staff 1 gave Resident A expectations and Resident A threw food again. Staff 2 said this was when Staff 1 tried to get Resident A in an upper torso hold, but due to Resident A's size and him trying to fight back, Resident A fell back off his seat. Staff 2 said that Resident A landed in a sitting up and was laughing at staff, but making threats to staff and students, and had pulled the keys off of Staff 1's neck and thrown them across the room. Staff 2 said that Resident A tried to take Staff 1 down with him and once on the floor, the staff went into a supine restraint. One person was positioned over his knees and one was holding is arms/elbows. Staff 2 said that Resident A is very strong, so another staff assisted on arms and two more laid across Resident A's legs. Staff 2 said that Resident A was still breathing, talking, and saying he was going to "fuck staff up" when the restraint was over.

Staff 2 said that Supervisor 2 came in and started the release process. Staff 2 said that once released, he did not know if Resident A was playing, and noted he is a playful kid. Staff 2 said Resident A was still breathing but just lying there, and noted he was still moving his fingers. Staff 2 added that he heard Resident A's heavy breathing and saw his stomach and chest moving. Staff 2 stated that Supervisor 2 directed him to go back to the dorm to supervise the other kids. It was at this time that he left the cafeteria.

Staff 2 said that he was later interviewed by Director 3, the Chief Administrator, in her office and was told that the restraint was good. Staff 2 said that Director 3 "couldn't stress enough" that there was no problem with the restraint. Staff 2 added that Director 3 said that some staff would be suspended, but that did not end up the case, as staff started getting fired.

When asked for clarification on the initiation of the restraint, Staff 2 stated that they were told and trained to intervene sooner than they did and were told that they give

too many extra chances to residents. Staff 2 reported that he thought that Resident A tossing the bread from his sandwich justified the initiation of physical management because it could have escalated the other kids and led to a riot.

During the restraint, Staff 2 clarified that he held Resident A's right arm and stated that it was "quite a fight" to get him secured. Staff 2 said that Resident A got loose a few times. Staff 2 denied putting any of his own body weight on Resident A's body. Staff 2 denied witnessing any of the other involved staff putting their weight on Resident A's upper body. Staff 2 denied witnessing staff lying on, leaning on, putting arms/elbows on Resident A's upper body. Staff 2 said that he did see staff laying across Resident A's thighs. When advised that the video showed differently, Staff 2 maintained that he saw no staff putting their weight on Resident A's upper body. Staff 2 stated that if this were the case, other staff would have said something to correct them. Staff 2 denied that he or any of the involved staff were redirected on their holds or positioning during this incident. Staff 2 denied Supervisor 1 correcting any of the staff. Staff 2 said that there were various other "higher up people" there who said nothing regarding incorrect positioning. Staff 2 stated that Resident A made no complaints of pain or not being able to breathe.

Staff 7:

Staff 7 was interviewed via phone on 05/28/20. Staff 7 reported that he came to the cafeteria that day in response to a call for extra staff. When he arrived, Resident A was already in a supine restraint on the floor and he swapped Staff 2 out of the restraint for a break. Staff 7 said that he was holding Resident A's left arm and did so for about 1 ½ minutes. Staff 7 said that Resident A was still moving and resisting staff so much that Staff 7 had difficulty securing Resident A's arm. Staff 2 came back into the restraint and took over the left arm hold. Staff 7 said that he left the area shortly after Staff 2 took over for him. He just moved a table prior to leaving. When asked for clarification as the video showed Staff 7 near Resident A's head after holding his arm, Staff 7 maintained that he did not restrain Resident A after releasing his arm to Staff 2. Staff 7 stated that Resident A was talking during the restraint but could not recall what he said. Staff 7 additionally stated that Resident A was conscious and moving, and repeated that he could not get a secure hold of his left arm due to Resident A struggling. Staff 7 stated that although he is SCM certified, he is not sure whether there is a limit to the number of staff who can be involved in restraining a resident. He reported that the involved staff appeared to be following SCM from what he observed while there. When asked about the SCM rules and agency policy for the use of physical management, staff 7 said that there must be a physical safety threat to the youth or others and noted a "few other reasons." When asked whether a youth throwing food would justify staff using physical management, Staff 7 stated that this would justify a restraint because it could escalate others, but it would depend on the situation. Staff 7 acknowledged that he was not present for the initiation of this restraint but stated that he would likely restrain if a youth were throwing food at someone.

Nurse 2:

Nurse 2 was interviewed via phone, on 05/13/20, jointly with the DCWL Consultant, MDHHS Specialist, and Attorney 2. Nurse 2 is a Licensed Practical Nurse and has been at the facility for one year. Nurse 2 reported that Director 4 came to the office and said that there was a student unresponsive. Nurse 2 went to the scene and then went back to the office for supplies before returning. Nurse 2 said that when she arrived Resident A was on his left side with foam and sputum coming out of his mouth and nose. Nurse 2 said that Nurse 1 went to call 911 while they put Resident A on his back. They were then directed by Nurse 1 to start CPR, so compressions were started. At this time, Nurse 2 said that it was herself, Nurse 1 and Staff 6 working with Resident A. She called for the AED and when retrieved, gave it to Nurse 1 to put on Resident A. Nurse 2 said that she directed everyone to move back while they waited for the AED to analyze Resident A. The continued doing compressions and mouth to mouth. Nurse 2 got a mask and Nurse 1 switched with another staff and gave breaths. Nurse 2 then continued giving breaths but did not see Resident A's chest rising. She got a paper towel to clear away some of the foam and sputum from his mouth and continued giving breaths. On the next two breaths, Nurse 2 said that she saw his chest rising and falling and knew the breaths were working better. Nurse 2 said that they were giving 30 compressions and two breaths. They continued following the AED instructions on compressions and breaths and Nurse 3 was coaching Staff 6 on compressions before Nurse 3 took over for him. At this time, all three nurses were working on Resident A. Nurse 1 and Nurse 3 continued swapping on compressions until EMS and police arrived. Nurse 2 reported that she did complete SCM training when she was hired but doesn't usually get involved in restraints. Nurse 2 reported that only hurting yourself or others justifies a restraint and noted that if a youth were throwing food, she would deescalate him first and not just restrain him.

Nurse 3:

Nurse 3 was interviewed on 05/08/20, via video conference, jointly by the DCWL Consultant, the MDHHS Specialist, and Attorney 2. Nurse 3 reported that she is a licensed Registered Nurse and has been at Lakeside for 11 years. She was previously a direct care staff, group leader and now a nurse. On the day of the restraint with Resident A, Nurse 3 said that she was in the Nurse's office and was informed there was an incident with an unresponsive student in the cafeteria, so Nurse 2 headed to the cafeteria. When Nurse 2 yelled for masks, Nurse 3 said she went back to get masks and then went to the cafeteria. Nurse 3 said that when she arrived at the incident, she saw someone giving Resident A chest compressions, so she assessed the situation. Nurse 3 reported that she saw a pulse oximeter on Resident A's finger and the AED was already placed on Resident A's chest when she arrived. Nurse 3 said that she continued giving compressions while Nurse 1 gave Resident A breaths until the ambulance arrived and took over. Nurse 3 was asked when nurses step in when youth are being restrained. Nurse 3 said that nurses

typically do not engage in, but are sometimes present for restraints, even though they are trained. It was stated that staff contact the nurses if restraints go over 10 minutes. Nurse 3 said that staff are supposed to confront one another if a restraint is being done wrong. Nurse 3 said that she was not sure if there was a maximum number of staff allowed to engage in a restraint. She stated that justification for restraints is when a resident poses an imminent threat. When asked if throwing food was justification, Nurse 3 said that only throwing food would not be justification. Nurse 3 said that regarding nursing in general, if a youth was unresponsive on the floor, it is "our responsibility to assess." Per Nurse 3, this would be a general assessment and overall monitoring, checking breathing, and a "head to toe" assessment. Nurse 3 said that most can be done visually such as seeing a person's chest rise and fall. If nothing were happening a nurse would move on to further assessment. Nurse 3 said that it would depend on what is going on and there is no set rule for what they are to do.

Case Manager:

The Case Manager was interviewed on 05/08/20, via video conference, jointly with the DCWL Consultant, the MDHHS Specialist, and Attorney 2. The Case Manager reported that he has been employed at Lakeside for two years, the first of which he was direct care staff. In this incident, the Case Manager said that he was told to go help on the dorms and then they were called for lunch. When he got the cafeteria, the group was told they were not ready due to a restraint, so the Case Manager went in and approached the situation. The Case Manager said he asked if they were done and was told that Resident A was about to get up. The Case Manager said that he went to get the other group for lunch and then came back and talked to Resident A, who he thought was awake. The Case Manager said that the staff tried to help Resident A sit up and then his weight dropped. Staff checked Resident A's pulse on his wrist and did not find a pulse. The Case Manager said he checked his neck and thought he felt a pulse. The Case Manager said that he tried to do the best he could and did chest compressions. They then turned Resident A on his side as he was foaming from his mouth. Supervisor 2 helped open Resident A's mouth. They then moved Resident A back onto his back and continued chest compressions with Staff 6. Nurse 1 was standing there next to him on the phone, and then began doing compressions and checking his pulse. It was at that time that Nurse 1 called 911. Director 4 ran to get Resident A's face sheet, but the Director of Case Management had already got it. This is about when the police arrived, and the Case Manager returned to the dorm. The Case Manager denied witnessing any of the actual restraint. The Case Manager said that he is trained in SCM and noted that the number of staff involved in a restraint depends on the situation. The Case Manager confirmed that the indicators for use of restraint are being a danger to self or others. When asked if throwing food would justify a restraint, the Case Manager said that is not a justifiable reason. The Case Manger went on to say that it could have and should have been addressed by removing Resident A, talking, or using other avenues to work with him other than going hands on.

Director of Case Management (DCM):

The DCWL Consultant interviewed the Director of Case Management on 05/08/20, via video conferencing, jointly with the MDHHS Specialist, and Attorney 2. The DCM reported being employed at Lakeside since August of 2018. On the day of this incident, she was with another youth and walked into the cafeteria, not knowing about the restraint with Resident A. The DCM said that she saw staff around Resident A and initially thought everything was “normal.” The DCM said that she then noticed the look of worry on the observing staff’s faces, so she walked over and saw Staff 6 patting Resident A’s face and rubbing his chest to check for responsiveness. The DCM said that she crouched down and noticed that his shirt was tight, so she loosened it, unzipped it, and pulled the collar away from Resident A’s neck. The DCM said that she saw spit, not foam, in Resident A’s mouth and it looked like he was choking on his tongue. She said that she did not hear him choking but that is what it looked like, so the staff turned him on his side and Staff 6 and Supervisor 2 cleared his airway by opening his mouth. The DCM said that she checked for a pulse on Resident A’s neck but did not feel anything. Staff 6 said that he felt a pulse on Resident A’s wrist. The DCM said that Nurse 1 said to put Resident A on his back, so they did. She said that they realized things were not improving and cleared the cafeteria of the remaining kids. The DCM said that this is when Staff 6 and Nurse 1 started chest compressions. The DCM said that the AED was given to the three nurses there at this time. The DCM said that she got down and was talking to Resident A and observed bloody foam in his mouth. As the nurses were giving compressions and breaths, the DCM said she stepped back.

The DCM said that she did not see any of the restraint. When she arrived, Staff 6 was trying to resuscitate Resident A. The DCM said that she is SCM certified. The DCM said that the maximum number of staff allowed on a restraint is three to four, noting it does not usually take more than three. The DCM stated that Resident A was big and might need an extra staff but should not need more than that. The DCM clarified that there would usually be one staff at the top near the head, one in the middle to bridge over them and keep the person from moving. She said the person bridging is supposed to be on their hands and knees and not supposed to lay on the person being restrained. She said there might be one to two staff on the legs and one supervisor watching, timing, being responsive. The DCM stated that Supervisor 2 and the Program Director were both there. The DCM stated that SCM stipulates that being an imminent danger to self and/or others is what justifies staff using hands on restraint. When asked if throwing food would meet that criteria, the DCM said no. The DCM said that the response to a resident throwing food would be to separate the youth from his peers, or remove the peer, or get between them yourself to break their line of sight, and verbally redirect them. The DCM said that if the resident were not cooperative, she would have used peer to peer positive feedback and not gone hands on unless someone got up and “went at someone else.” The DCM said that at the time she came into this incident she felt she and the staff were trying to do the best they could. The DCM said, “this should not have happened.”

Detective 1 provided his interview with the DCM for review on 06/02/20. The interview was consistent with what the DCM reported above. It was additionally noted, however, that the DCM told Detective 1 that when she walked into the incident that day, she thought they had handled it well. But later, after talking and getting more information, it was not handled well. The DCM said that there are usually three to four staff on a restraint and one keeping time and making sure things are ok. The DCM stated that staff are not supposed to lay across residents when restraining them.

Director 4:

The DCWL Consultant interviewed Director 4, on 05/08/20, via video conference, jointly with the MDHHS Specialist, and Attorney 2. Director 4 reported being employed at the facility for 12 years. On the day of this incident, Director 4 reported that when he arrived in the cafeteria, the restraint was already done. Director 4 said that Nurse 1 and other staff were there and observing Resident A, who way lying on the floor. Director 4 recalled Nurse 1 saying that Resident A's breathing was shallow and another staff saying that Resident A had let out a gasp of air. Director 4 could not recall who said that. Director 4 said that he didn't know if anyone checked Resident A's pulse or breathing. Director 4 said Nurse 1 asked for the pulse oximeter, went to get it and hooked it up to Resident A. Director 4 then said that Nurse 1 said they needed to call 911. Nurse 1 proceeded to call 911 and Director 4 said he went to get the other nurses and then called Director 3. Director 4 said that he then went to get the AED and stood back to let the nurse work on Resident A. When asked why 911 was not called for 12 minutes following the release from the restraint, and given that Resident A was not responsive, Director 4 said he did not know. Director 4 said that Nurse 1 was there, and he was letting her assess and was taking direction from her. Director 4 said that he was not sure if he was there when the staff attempted to sit Resident A up but said he had reviewed it on the camera. Director 4 did not know why Nurse 1 called 911 instead of starting CPR herself.

Director 4 said he is CPR certified but did not realize how dire the situation was. Director 4 reported that he was SCM trained. He reported that there is not a maximum number of staff allowable in SCM for a supine restraint but noted it is usually three to six in different situations. Director 4 reported that staff can initiate restraints. When supervisors are involved, they are to direct others and redirect staff if not doing something correctly. Director 4 reported that he thinks both Supervisors 1 and 2 are certified SCM trainers. Director 4 noted that justification for restraining a youth is when they present a threat of harm to themselves or others. Director 4 stated that throwing food would not justify a restraint and stated that the youth should be been deescalated and redirected in this situation. When asked if Director 4 had ever observed Resident A to fake unresponsiveness or unconsciousness after a restraint, Director 4 said that he had not seen this specifically.

Program Director (PD):

The DCWL Consultant interviewed the Program Director, on 05/13/20, via phone, jointly with the MDHHS Specialist, and Attorney 2. The PD reported that he has worked at Lakeside since 2012. The PD stated that he had just arrived to work and went in the cafeteria, so he did not know what was going on when he arrived. The PD spoke with Director 4 and noticed Resident A on the floor. The PD said that he also spoke with Supervisor 2, who advised him that Resident A had been restrained. The PD said that Supervisor 2 said something like, "[Resident A] is doing what he always does." The PD stated that Resident A has a history of being defiant, laying on the ground, and refusing to respond, and the PD said he had witnessed this. The PD provided an example of an incident a couple of months prior when Resident A was acting out in the classroom and the PD brought him into the hall. The PD said that in this example, Resident A laid on the floor and would not respond. The PD said that he poured a couple of capfuls of water on Resident A's face without any response and people got more concerned. The PD said Staff 6 started checking Resident A's pulse and breathing. Nurse 1 went to get the pulse ox machine and put it on Resident A's finger. The PD said that Staff 6 said that Resident A had a low pulse and his breathing was shallow, and that's when Nurse 1 got up and spoke to Director 4 and then called 911.

When asked why there was a delay in calling 911, the PD said he did not know and noted that the call to 911 was made by Nurse 1. The PD clarified that he saw no part of the actual restraint. The PD stated that he is trained in SCM. He reported that harm to self, others, and destruction of property justify staff restraining youth. When asked about throwing food, the PD paused and reported that it is difficult to answer that without context, but reported no, it would not justify restraint.

Director 5:

The DCWL Consultant interviewed Director 5, the current Chief Administrator, on 06/02/20, jointly with DCWL Consultant 2. Director 5 was asked about this restraint and his knowledge of SCM. Director 5 said that he was an SCM trainer and that SCM does not specify a maximum number of staff permitted on a restraint. Director 5 reported that the model teaches staff to use "least restrictive force" for any situation. Per Director 5 staff are not supposed to place their own body weight on a resident during a restraint. Director 5 reported that from his review of the incident, most of the staff were not grossly out of place, but the issue was their body weight on Resident A. Director 5 said that "bridging" over the individual being restrained is allowed, but it is not ok to put one's body weight on the person being restrained. When asked his assessment of how the situation was handled by the supervisors and nurse that were present, and the monitoring of the restraint, Director 5 reported that any staff involved in an incident should address anything wrong with restraints. When asked about the justification for going hands-on in this situation, Director 5 noted that physical interventions should only be used per licensing rules and the provided training. Director 5 was asked about the reasons for the terminations of employment for Director 3 and Nurse 1. Regarding Director 3, Director 5 stated that he quickly

assessed a need for a “face of campus” and an organizational decision was made to terminate Director 3’s employment and replace her with Director 5 as chief administrator. It is noted that Director 5 had previously been the chief administrator for a number of years at the facility. Director 5 stated that Director 3 was placed on leave on 5/2/20 and that her employment was terminated on 6/1/20.

Director 3:

The DCWL Consultant spoke with Director 3, the Chief Administrator at the time of the incident, on 06/02/20, jointly with DCWL Consultant 2. Director 3 reported that she was laid off from Lakeside on 05/02/20, until 06/01/20, when she was terminated. Director 3 reported that she wanted to speak with her attorney prior to being interviewed and would call back if she is going to participate. Director 3 was interviewed via phone on 06/04/20, jointly with DCWL Consultant 2. Director 3 recounted the incident and said that she was advised via phone from Director 4 that 911 had been called and that CPR was being conducted on a student in the cafeteria. When Director 3 arrived, she said Nurse 1 was on the phone and staff were doing CPR on Resident A. The AED was hooked up and the nurses were working on Resident A. Director 3 said there was no reason for her to intervene at that time. Director 3 said that she began directing other staff to get people out of the cafeteria, told some staff to go direct the police/ambulance, and directed some to staff to go to the dorms. Director 3 said it was about 10 minutes before the paramedics arrived.

After the incident, Director 3 said that the involved staff were taken into her office to give statements and debrief with Directors 1 and 2, but Director 3 was asked to leave the room during the interviews. Director 3 said she continued doing other duties and also watched the video of the incident. Director 2 reportedly asked Director 3 to look further back on the video to see what initiated this incident. Director 3 continued watching the video and expressed concern that “11 minutes and 32 seconds” after the restraint when numerous staff, including directors and a nurse were present and had not called 911 for Resident A. Director 3 said that it was clear to her from the video review, that Resident A was unresponsive during that time when she observed staff lift his hand and it dropped, and staff splashed water on his face, listened for breathing, and were nudging Resident A. Director 3 said that she was documenting the video as she wanted those things addressed with the staff. Director 3 said she is trained in CPR and if a person is unresponsive you assess the scene, call 911 if the person is unresponsive, and then attend to the person.

Director 3 reported that she has SCM training and used to be an instructor. Director 3 reported that her concerns were not so much with the number of staff involved in this restraint, but with their positioning. Director 3 stated a problem with the restraint, that she observed, was Staff 3 lying with his weight on Resident A. Director 3 said that he should have been on his hands/elbows and knees to keep weight off Resident A. Director 3 further stated that she observed Staff 4 kneeling on Resident A’s ankle during the restraint. Director 3 noted that staff are supposed to monitor one another

during the restraint and address positioning if it is a problem. When asked whether throwing food justifies a restraint, Director 3 reported, “Absolutely not.” Director 3 went on to clarify that from her observation of the video, Staff 1 was “not even close to putting him in a restraint. He pushed him off the chair.” Director 3 said that once pushed off the chair, Resident A was just sitting on the floor, but Staff 1 proceeded to engage in the restraint. This was not justified per Director 3. In regard to the designated monitoring staff during restraints, Director 3 said there is no set or specific manner in which this is implemented, noting it could be an extra, uninvolved staff, or a staff involved in the restraint.

Director 3 said employees who were involved were terminated the following day but noted that that she was not involved in the decisions nor delivering this information. Director 3 denied meeting with Staff 2 in-person and denied telling him that this was a good restraint or saying anything to him about the quality of the restraint. Director 3 also denied that she told Staff 2 about any possible suspensions. Director 3 said that on Friday morning my phone call was the first phone call she received, and it was to advise of Resident A’s death. Director 3 said that corporate administration took over after that. She was asked to take time off and was subsequently fired on 06/01/20.

The DCWL Consultant conducted a follow up interview with Director 3, via phone on 06/09/20. Director 3 was asked for her assessment of how this restraint with Resident A occurred. Director 3 said that there was a focus on staff training, implementation of blocking pads to minimize restraint, and improving trauma focused care. Director 3 said that there was no reason for this to occur. Director 3 reported that she observed staff working with Resident A earlier in the day, allowing him to vent and walk to deescalate. This is what staff were supposed to do. Director 3 said that she did not ever expect to see staff respond like Staff 1 did in this instance, noting that Staff 1 is not involved in many restraints.

Supervisor 1:

The DCWL Consultant interviewed Supervisor 1 jointly with the MDHHS Specialist, on 06/15/20, via phone. Supervisor 1 reported that she did provide a supplemental incident report after this incident, but not the day of. She reported being a supervisor on another dorm. Supervisor 1 stated that when she and her group of youth arrived at the cafeteria Resident A was already in a restraint. Supervisor 1 went over to where the restraint was occurring and helped supervise the other youth as many staff were involved in the restraint. Supervisor 1 stated that she asked the staff involved in the restraint if they needed help and they said no. Supervisor 1 said that she wiped off tables when the cafeteria staff complained that they were dirty. She did not participate in the restraint. Supervisor 1 said that when she observed the restraint, she saw one staff holding each hand and one staff on each leg, with one staff bridging the thigh/knee area. Supervisor 1 said that Supervisor 2 came in and she told the staff to move, but she was not sure what they were exactly being told. At that time, Supervisor 1 said that she helped get additional staff to take the group out.

Supervisor 1 said that after the restraint, Resident A was laying on the floor. Supervisor 1 said that Supervisor 2 was talking to him and there were other staff and a nurse around. Supervisor 1 said that she heard staff say he was breathing and that his stomach was moving. Supervisor 1 said that she saw Resident A's eyes, noting that he looked at her but did not say anything or respond. Supervisor 1 could not identify who was the monitor for this restraint, noting the nurse was there, along with other staff, but she was not sure who was there from the beginning. Supervisor 1 said that staff can correct one another if their positioning is wrong during a restraint but noted that it is usually a SCM trainer who does this as it would be their responsibility. Supervisor 1 said she is not a trainer. Supervisor 1 said that she did not see anything wrong with staff's positioning during this restraint, but noted she was not completely focused on that as she was monitoring the other youth. Supervisor 1 said that she did not notice or have concerns with staff putting their body weight on Resident A during the restraint.

Supervisor 1 reported that physical restraint is to be used when kids are being unsafe to themselves or others and that throwing food would not justify a restraint. Supervisor 1 did not hear Resident A make any complaints during the restraint but did report hearing him say he was going to "whoop staff's ass." Supervisor 1 said that after the restraint Resident A was laying on the ground and she thought he was playing at first. He reportedly did this "playing dead" another time, per Supervisor 1. Supervisor 1 did not know if anyone physically checked Resident A. She noted that she got down and talked to him, but he didn't respond. Supervisor 1 said that she and Supervisor 2 attempted to sit Resident A up. Supervisor 1 said that she was not sure if Resident A chose not to sit up or could not sit up, so they laid him back down. Supervisor 1 said that the staff told her they were "good" and did not need her, so she took her group out of the cafeteria. Supervisor 1 said that it was not until she was leaving the cafeteria that she thought the situation with Resident A could be serious. When she went to return, she was not permitted to go back into the cafeteria.

Supervisor 2:

The DCWL Consultant interviewed Supervisor 2 jointly with the MDHHS Specialist, on 06/08/20, via phone. Supervisor 2 reported to have been employed at the facility for 2 years and is a group leader. Supervisor 2 recalled the incident and noted he was in the school when he heard about the restraint in the cafeteria. Supervisor 2 said that when he arrived Resident A was trying to get out of the restraint. Supervisor 2 directed other staff to get kids out of the cafeteria and told Staff 7 to let him take over holding Resident A's hands. Supervisor 2 said he told Resident A to calm down and asked him if he was ready to be released. Supervisor 2 said that Resident A shook his head yes and he began telling the staff to start releasing from the legs up. Supervisor 2 said that he is the group leader every day and he knew that Resident A knew his voice and would calm down. After being released Supervisor 2 said that Resident A laid on the floor and did not respond to staff. At first, Supervisor 2 said that he and other staff thought Resident A was "playing" and noted that he heard

Resident A snort and his eyes were open. Supervisor 2 said that he and Supervisor 1 tried to help Resident A up to a seated position, but he fell limp against Supervisor 2's leg and then fell back. At this time, Supervisor 2 said he knew something was not right with Resident A. Supervisor 2 said he and other staff looked at each other and at Nurse 1 to see what to do. Supervisor 2 said that Nurse 1 was standing there "like a deer in headlights" not doing anything. Supervisor 2 said that someone went to get the AED and they put that on Resident A and then he went to direct police/ambulance.

Supervisor 2 did not recall what staff were positioned where for the restraint and noted that he was only involved for about two minutes. Supervisor 2 commented that when he arrived in the restraint, he said, "Woah, there are way too many people over there." Supervisor 2 said that he meant there were too many people involved in the restraint and too many people standing around. Supervisor 2 went on to clarify that after they tried to sit Resident A up, and he fell over limp, that Resident A was foaming in his mouth. Supervisor 2 said that he, the Case Manager, and Staff 6 rolled Resident A on his side and Supervisor 2 opened Resident A's mouth for the spit/foam to come out. That is when Supervisor 2 said staff started checking for a pulse. Supervisor 2 said Nurse 1 was there but not doing anything, so he felt they had to do something. Supervisor 2 said that Nurse 1 "snapped out of it" and started moving. Supervisor 2 said that he did not personally check Resident A's pulse, but he did feel Resident A's cheek and head and noted that he was getting colder. Per Supervisor 2, Staff 6 was checking for a pulse and he thinks Staff 6 gave breaths too.

Supervisor 2 said that he is trained in SCM and is also a trainer. Supervisor 2 said that staff are not supposed to be across a youth's waist or midsection. Supervisor 2 said that he did not address the staff positioning when he arrived at the incident because he was focused on getting Resident A to calm down so the staff could release him. Supervisor 2 said that he did follow up with the staff after the restraint and told Staffs 1, 2, and 3 that they should have tried to remove Resident A from the situation instead of going hands on. Supervisor 2 said that he told the staff it should not have taken five or six staff to restrain Resident A and that Resident A can usually be calmed down by talking to him. Supervisor 2 reported that Staff 1 should not have went to the ground as there was not a supervisor there to approve it. Supervisor 2 said that Staff 1 said he should have just held Resident A in an upper torso. Supervisor 2 clarified that throwing food would not justify a staff going hands on with a youth.

The DCWL Consultant interviewed the Medical Examiner (ME) on 06/09/20, jointly with the MDHHS Specialist via phone, in follow up to his report. The ME reported that he reviewed the video of the incident, but he had no opinion as to who was responsible for Resident A's death. [redacted] The ME reported that the nurse was not identified on the video and had no opinion on her actions.

The DCWL Consultant interviewed Resident A's Foster Care Worker (FCW) via phone, on 06/10/20, jointly with the MDHHS Specialist. The FCW reported that she had never received written or verbal notice for a 30-day removal of Resident A from Lakeside. The FCW said that there were discussions and Family Team Meetings for placement preservation, but no removal notice was given. Additionally, the FCW denied notification from the agency that Resident A faked, pretended, or acted as if he was unresponsive after any other restraints. The FCW said that she received notifications of restraints and the behaviors that led to them but did not ever hear that Resident A was pretending to be unconscious after a restraint.

Attempts were made to interview the following parties, but were unsuccessful as noted:

- Staff 1- No response.
- Staff 3- Declined to participate.
- Staff 4- Number disconnected.
- Staff 5- Declined to participate.
- Staff 6- Declined and hung up.
- Nurse 1- No response.
- Supervisor 1- Number disconnected.

Appendix C: Investigation Notes

Allegation 1:

On 04/29/20, Resident A was improperly restrained. After the restraint, he was unresponsive and transferred to the hospital where he died on 05/01/20.

Investigation notes for 1a-1d:

Names are coded in this report including within quoted text. In-person interviews were substituted in some instances with video conferencing and phone interviews due to COVID-19 restrictions and precautions.

Director 1 and a second complainant called in notification of this incident to Centralized Intake on 04/29/20, Log ID 69215666. The complaint noted the following:

> Resident A (16) resides at Lakeside Academy. On 04/29/20, Resident A was restrained by unknown staff. Specifically, Resident A was pushed down onto the ground and his hands placed behind his back. Resident A then went into cardiac arrest. Resident A was down for about 10 minutes. Staff did complete CPR on Resident A. Resident A was then transferred to Bronson Methodist Hospital. Resident A is in critical condition as he is intubated, and his pupils are fixed and dilated. It is unknown if being restrained caused this or if there was an underlying medical condition. Kalamazoo Department of Public Safety is involved.

A follow up complaint was received on 05/04/20, Log ID 69395650. This complaint reported the following:

> Resident A (16) was a State Ward placed at Lakeside Academy. Staff 1 is a staff member of Lakeside Academy. On 04/29/2020, Staff 1 pushed Resident A off of his seat and he fell to the ground. Staff 1 and six or seven other staff members then restrained Resident A on the ground. Resident A was on his back while the staff members held down his arms and legs and laid across his chest and torso for approximately ten minutes. Resident A continued lying on the ground for about ten minutes after staff had gotten off of him before his pulse was checked. Staff realized something was seriously wrong and began CPR. Staff called 911 at 1:12 PM. Officers from Kalamazoo Department of Public Safety arrived, followed by paramedics. CPR was continued for a significant amount of time and Resident A was given several doses of epinephrine. He regained a pulse and was transported to Bronson Emergency Room. Resident A remained in critical condition, was intubated, and his pupils were fixed and dilated. A brain exam at 3:00AM on 05/01/2020 showed no activity. He was pronounced deceased at 3:05 AM on 05/01/2020. The cause of death is suspected to be cardiac arrest due to restraint. The autopsy results are not known at this time.

A telephone interview was completed with the second complainant on 05/04/20, who noted that this additional complaint was called in to document Resident A's death. The complainant further clarified, during a subsequent telephone call, that she confirmed the 1:12pm time of the 911 call directly with dispatch. It is notable that this report will continue to document the time of the 911 call as 1:11pm documented on the First Responding Officer's report.

Video review:

Video review of this incident was completed from two camera angles provided by the agency. The restraint is approximately 12 minutes in duration. Notable events along with the corresponding video timestamps are outlined as follows:

The video shows the cafeteria beginning at approximately 12:40 p.m. on April 29, 2020. Resident A enters and sits near a peer and an exchange is seen where Resident A throws paper napkins at the peer. The youth separate and get their lunch trays. Resident A returns to his seat, and the peer sits at another table. At 12:46:00, Resident A throws part of a sandwich at peers. Staff 1 and Staff 2 approach Resident A. Staff 2 removes Resident A's lunch tray, but Resident A takes his sandwich and milk first. Both staff stand near Resident A and appear to be talking to him. At 12:48:51 Resident A tosses food again and Staff 1 pushes him with both hands in the chest causing Resident A to fall backward off his seat onto the floor. The restraint begins with Staff 1, followed by Staff 2, and then Staff 3, who was seated nearby. Staff 3 is viewed laying across Resident A's midsection, while Staff 2 pulls Resident A's legs out straight, and Staff 1 lays across Resident A's upper torso. Staff 4 approaches and gets on Resident A's right leg. Staff 2 moves to hold Resident A's left leg. Staff 5 arrives and positions himself on Resident A's left side, however there is not a clear view of Staff 5. Staff 6 approaches and pulls Resident A's arms out above his head. Staff 4 is observed kneeling on Resident A's right leg.

Supervisor 1 approaches and observes the restraint and then walks around addressing other youth in the area and looking at the restraint. At this time, there are six male staff placing their weight on Resident A during the restraint. Staff 1, Staff 2, and Staff 3 are very large in stature. Throughout the restraint, various staff are seen laying on Resident A's upper chest and abdomen (Staff 1, Staff 3, and Staff 6), and Staff 4 is seen kneeling on Resident A's right leg. At most times there were six to seven male staff on Resident A. Staff 7 approaches and switches out with Staff 2 on Resident A's left arm. Staff 3 is observed laying across Resident A and remains there for the duration of the restraint. Staff 2 returns to hold Resident A's left arm and Staff 7 moves to the right side of Resident A by his head. At this time, there are seven men restraining Resident A. Supervisor 2 approaches and observes, then crouches down by Resident A's head and appears to take hold of Resident A's hands. Approximately 10 minutes into the restraint, Nurse 1, the Director of Nursing, approaches and observes the restraint.

Staff release Resident A from the restraint after approximately 12 minutes, but he remains lying on the floor motionless. The staff pull Resident A up to a seated position, but he is limp with his head dropped down and his arms fall limp when released. The video showed Resident A fall slowly over to his right side and roll onto his back apparently unconscious. There are seven to eight staff standing near and looking at Resident A, including Nurse 1 and Supervisor 1. Supervisor 1 bends over and taps/touches Resident A. The other staff begin touching/tapping Resident A. Director 4 arrives in the area. The staff and Nurse 1 are still standing near Resident A. Approximately five and a half minutes after release, Nurse 1 takes Resident A by the right hand momentarily and releases it. Nurse 1 walks out of the building and returns minutes later. Nurse 1 is seen bent over Resident A, reportedly running a pulse oximeter on Resident A's finger. This is approximately 10 minutes after the staff released Resident A from the restraint, and there has been no call to 911 for emergency medical help. The Program Director and Supervisor 2 are present and nearby. Staff 6 appears to check for Resident A's breath and Director 4 brings water to put on Resident A's face. After approximately 12 minutes, Nurse 1 is observed getting on her phone and walking out. It is at this time that 911 was called. Nurse 1 returns to camera view briefly and walks back out while on the phone. Staff 6 starts chest compressions and the Case Manager approaches and assists. The Director of Case Management approaches Resident A. The staff roll Resident A onto his left side. Nurse 1 returns and is still on the phone. Nurse 2 arrives to the incident. Approximately 15 minutes after the restraint ended Nurse 1 is seen getting down on the floor next to Resident A and begins chest compressions. Director 4 ran to retrieve the Automated External Defibrillator (AED). Once the AED is connected, the staff clear, then Nurse 1 restarts chest compressions. Staff 6 assists with chest compressions. Nurse 3 arrives and relieves Staff 6 doing chest compressions. The three agency nurses are now doing cardiopulmonary resuscitation (CPR) for Resident A. The First Responding Officer arrives about 1:18:30 and begins working with the nurses. Additional police and paramedics arrived shortly thereafter and take over treatment.

During the 04/30/20 video review, Director 2 reported that she had staff participate with law enforcement interviews and then debriefed with them one on one afterward. Director 2 was asked about the number of staff involved in the restraint, and responded that the reason staff gave her for the number of staff involved in this restraint was Resident A's size and strength, noting staff said it was difficult securing a hold on him. When asked about the justification for the restraint, Director 2 said that the reason staff provided for initiating the restraint was they felt Resident A was being aggressive by throwing food at others and thought he was going to attack others. When asked about Nurse 1's response, Director 2 reported that Nurse 1 said that she saw Resident A breathing and thought he was playing like he couldn't move. When asked what Director 4 was doing on the phone during much of the video, Director 2 said that he was calling other directors. When asked why Nurse 1 went to call 911 leaving Staff 6 to start CPR, Director 2 said that Nurse 1 reported that the pulse

oximeter showed a low pulse, so she determined it was necessary to call 911. Nurse 1 reportedly made the call because she was calm and knowledgeable, and staff know CPR and are trained.

Resident witness interviews:

On 05/05/20, Kalamazoo Department of Public Safety Detectives arrived on campus to interview staff and residents prior to residents discharging to their home state or new placements. Body cameras were used to record interviews to preserve them for their own investigation and for use by MDHHS. Appendix B includes summaries of those interviews.

Documentation review:

Documentation reviewed as part of this investigation included the Incident/Investigation Report, dated 4/30/20 for incident at Lakeside 04/29/20, Case Number 20-006271, authored by the First Responding Officer, with a time of 1:11p.m. Detailed information regarding the Incident/Investigation Report is contained in Appendix D.

Incident Reports for this incident were received, reviewed, and are summarized in Appendix D.

Incident Reports for Resident A, from 11/06/19 to present, were received and reviewed for documentation of Resident A “faking”/acting/playing/seeming unresponsive after a restraint. No incident reports noted this behavior.

Additional Information reviewed as part of the investigation is listed below:

- Safe Crisis Management (SCM) Participant Workbook and Safe Crisis Management Instructors Manual
- Agency policy for Emergency Safety Physical Intervention
- Agency policy for use of physical holds with children and youth
- Medical Examiner and Forensic Services report
- Residential Service Plans
- Communication logs
- Agency policy for emergency medical procedures
- Employee files

Documentation reviewed as part of this investigation is as follows:

Incident/Investigation Report dated 4/30/20 for incident at Lakeside 04/29/20, Case Number 20-006271, authored by the First Responding Officer, with a time of 1:11pm. The report noted that the First Responding Officer assisted with CPR upon arrival and when relieved, went to agency administration and reviewed the video. The summary of the video in the police report is consistent with the expanded review noted above. Various responding officers conducted CPR when needed and assisted

in treating Resident A and assisting EMS. Officers also conducted interviews with staff on 04/29/20. Summaries of the interviews are as follows:

Responding Officer 2 interviewed Staff 6. Staff 6 reported that he responded to a call for assistance and held Resident A's right arm as he appeared to be trying to assault staff. The restraint lasted about 10 minutes and Resident A was released and asked if he was "good." Staff 6 said he thought Resident A nodded. He then heard Resident A gasp but thought that Resident A was trying to hold his breath for attention. Staff 6 said he eventually checked for a pulse and felt it weak but directed Resident A to get up, but he did not respond. Staff 6 checked his pulse again and did not feel one. He then started chest compressions and Nurse 1 and Nurse 3 assisted. Staff 6 reported he did not see anything concerning with the restraint.

Responding Officer 2 interviewed Nurse 1, who was identified as the head nurse. Nurse 1 arrived at the incident and observed "five to several" staff restraining Resident A and noted this as not concerning due to Resident A being difficult to restrain. Nurse 1 reported that Resident A was not struggling in the restraint and was released. Nurse 1 stated that she thought he was "faking" because she saw him moving. They removed the other kids from the area, and then Nurse 1 reported noticing Resident A's complexion turning "dusky." She got the pulse oximeter but could not get a result. Nurse 1 reported she observed Resident A foaming from the mouth and decided to put him in a "recovery position" (lateral position). Nothing further was reported.

Responding Officer 2 interviewed Nurse 3 and the report was consistent with my interview of Nurse 3.

Responding officer 2 interviewed Staff 1, who reported that Resident A was throwing food so he stood near Resident A so he would behave. Staff 1 said that after the third time and some verbal warnings to stop, he tried to "wrap him up and go to the ground" but there was a struggle. The report notes:

- "Staff 1 explained that he was the first one to go hands on with Resident A and that when he 'wrapped him up' he grabbed Resident A by the upper chest/shoulders area which caused Resident A to fall backward off of his seat at the lunch table."
- "Staff 1 mentioned that he was lying on Resident A across his upper chest area."

Staff 1 reported that Resident A was threatening to "fuck them up" once released. Staff 1 reported the restraint to be about 10 minutes and after released, staff checked Resident A's pulse because he continued to lay on the ground and noted his pulse was "good." Staff 1 said that staff sat Resident A up and laid him back down, and Resident A continued to lay on the floor. Staff 1 left the incident and returned to the dorms. The report notes Staff 1 to be 6'5" tall and 240 pounds.

Responding Officer 2 interviewed Staff 7. His report to the police officer was consistent with my interview.

Responding Officer 2 interviewed Staff 5, who reported that Resident A was already in a supine restraint when he arrived to help. Staff 5 said that he laid across Resident A's legs due to Resident A kicking. Staff 5 reported restraints are only to last up to 10 minutes, and staff are to release, even if a youth is agitated. Staff 5 estimated that he was laying on Resident A's legs about eight or nine minutes, and that at 10 minutes Resident A was released. Staff 5 said that Resident A was asked if he was ready to get up and he responded "yeah." After the restraint, Staff 5 said Resident A continued to lay on the floor with his eyes closed but was still breathing. Staff 5 said he saw Resident A open his eyes in response to a staff saying, "quit playing." Staff 5 then returned to the dorm. Staff 5 clarified that he mainly held Resident A's left leg. The report notes, 'He (Staff 5) mentioned that while being restrained, Resident A told staff that when he let him go they were going to "go back at it again" but never complained that he couldn`t breathe or was hurt.' The report notes Staff 5 to be 6'5" tall and 215 pounds.

Responding Officer 2 interviewed Supervisor 2 and the report was consistent with the DCWL Consultant interview of Supervisor 2.

Responding Officer 3 interviewed Staff 4, who reported that he was called over to assist in the restraint by Staff 1. The report notes, 'He (Staff 4) explained that when he was called to assist, he grabbed on to Resident A's right leg one hand above the knee the other below and pinned his leg to the ground.' Staff 4 identified the restraint as a supine restraint and noted Staffs 1, 2, and 3 were also engaged in the restraint. He said he was directed to release the hold by Supervisor 2.

Responding Officer 3 interviewed Staff 3, who said he was in the cafeteria when this incident occurred. Staff 3 reported that he saw Resident A throw something and noted that as he got up Resident A went from a seated position to lying on his back on the floor. Staff 3 said he did not see how this occurred. Staff 3 said that he immediately assisted in the restraint. The report notes:

> He stated that he went across Resident A's body to hold him down. I then asked if he was on top of him and he then explained that he put hands over Resident A at his waist area "bridging" him. I asked him to clarify what "bridging" meant and Staff 3 replied, stating that his hips and torso were on the ground alongside of Resident A, not on top of him. He stated that he had his left arm extended across Resident A while he was struggling underneath his arm.

Staff 3 further reported that Resident A was making threats to staff during the restraint. The report notes that Staff 3 appeared to be about 400 pounds to Officer 3, but his documented weight was 370 pounds and he is 6'2" tall.

Responding Officer 3 interviewed Staff 2. Staff 2's report to the police differed from his interview documented above. Notably, the police report indicates, "Staff 2 stated

that he intervened and attempted an ‘upper torso restraint’ that failed and Resident A fell off the seat and onto the floor.” Staff 2 reported to the police that he held Resident A’s right arm, however reported in his interview with me and the MDHHS Specialist that he held the left arm, and that Staff 1 initiated the restraint.

Responding Officer 4 interviewed Director 4 to inquire about Resident A’s history and Director 4 referred the officer to the Director of Case Management.

Responding Officer 4 interviewed the Director of Case Management (DCM) who reported working with Resident A for seven or eight months. The DCM provided some behavioral information and contact information to the officer. The DCM noted that a 30-day removal notice had just been submitted the day prior to Resident A’s Foster Care Worker.

Incident Reports for this incident were received, reviewed, and are summarized in as follows:

- Incident Report Number 2020-04-29-058, dated 04/29/20, 2:27pm, authored by Staff 1. Time of incident was 12:48pm-1:00pm. The report noted Resident A was throwing food at peer and verbally threatening peers. The reason for the restraint was noted as follows:

  > Resident A ignored staff de-escalation measures and continued to hit his peers with food and verbally threaten peers and staff. Resident A was in an incident about 30 minutes prior where he tried to assault a peer, the other student had to leave the room, and staff had to use Ukeru (large pads), to stop anyone from getting hurt. It was this same peer that Resident A started to threaten in the cafeteria.

Staff 1 reported that he tried to put Resident A in a single person upper torso assist, but they fell to the floor. A supine extension followed. The report notes that Resident A was awake and coherent, and that staff tried to help him sit up afterward, but he laid back down. It was further noted that Nurse 1 was present and assessed Resident A. The report further notes that the hold was, “necessary for the students and staff safety.” The following staff were documented as being involved in the restraint with Staff 1; Staffs 2, 3, 6 and 7. Supervisor 2 and Nurse 1 were documented as observing the restraint. There is an amendment to this report, dated 04/30/20, with a time of 1:53pm, authored by Director 2. The amendment notes the following:

> This writer interviewed the authoring staff during the time in which they wrote this incident report, but did not have an opportunity to review the video until a later time. Upon review of the video, it is evident that the single person upper torso hold referenced in this report was not attempted. Further, upon review of the video, Sequel and Lakeside do not endorse the opinion that the hold was necessary for the students' and staff safety.

- Supplemental Report, dated 04/29/20, 8:02pm, authored by Staff 2. This report described a prior incident of escalation with Resident A. Staff 2 reported that Resident A was name calling, throwing things, and making threats, and he was asked to stop but did not. Staff 2 noted the following, “During the restraint, Resident A was talking and moving and continuing to threaten staff. After the restraint, I saw his chest moving and saw him moving his fingers.” Staff 2 noted that he held Resident A’s left arm and reported difficulty due to Resident A struggling.

- Supplemental Report, dated 04/29/20, 6:45pm, authored by Staff 3. Staff 3’s report noted that he was in the cafeteria at the same table when he heard Resident A get addressed for throwing food. The report then notes:

  > In this current (2nd) situation, I observed Staff 1 trying to place Resident A in a single person upper torso and then go to the ground where Staff 2 and myself assisted in the supine assist. When the release process ended, I heard Resident A speak. I bridged over the waist in the supine assist.

- Supplemental Report, dated 04/29/20, 7:51pm, authored by Staff 5. Staff 5’s report noted that Resident A was already in the supine restraint with multiple staff holding him when Staff 5 arrived. Staff 5 reported that once they released Resident A, he observed that Resident A’s foot and toes moved slightly, he was breathing slowly, and Resident A briefly opened his eyes. Staff 5 reported, “I assisted by bridging over the students legs with my upper torso.”

- Supplemental Report, dated 04/29/20, 5:56pm, authored by Staff 6. Staff 6 noted in this report that Resident A was already being restrained when he arrived, so he assisted by securing Resident A’s arms. The report noted the following:

  > I was in charge of his right arm and his wrist in the ESI. After release, I started checking for his pulse, which I found on his neck and wrist, but it started getting slower each time I checked. A nurse checked with a pulse-ox and I put my ear to his mouth. When the pulse-ox showed he was not breathing, I started CPR chest compressions. When the student started foaming at the mouth, I turned him on his side too. When EMS came, I stepped away.

- Supplemental Report, dated 04/29/20, 8:19pm, authored by Staff 7. The report provided was concise, but consistent with Staff 7’s interview.

- Supplemental Incident Report, received on a Word document and not the agency format, unsigned but reported to have been completed by Supervisor 1 on 04/30/20. The report noted that Supervisor 1 was in the cafeteria with her group for lunch and went to help monitor Resident A's group due to the staff being involved in his restraint. Supervisor 1 noted that she was an "observer" in this instance. The report noted the following:

  > During the time of helping focus the other children away from the physical hold, I observed Resident A laying on the floor in a supine extension. At this point the were multiple staff involved, one staff securing each hand, one staff securing each leg and one staff over the bridge. I observed Resident A threating the staff at this time stating, "Just wait until I get up." During this time, we got extra staff to help clear the group and take them back to the dorm. After this is when Resident A was released from the physical hold. After he was released, he was seen just lying there, this is when myself and Supervisor 2 attempted to help transition him to sit up. He was unable to sit up on his own, so we then transitioned him back to laying down. During this time, myself and others were seen trying to talk to Resident A and get him to give us a response, which he did not do. I noticed that he coughed during this time. Shortly after it was time for my group to wrap up with lunch, so I was asked to return with my group.

- Supplemental Report, dated 04/29/20, 8:52pm, authored by Supervisor 2. The report was concise, but consistent with Supervisor 2's interview.

- Nursing Assessment, dated 04/29/20, 4:27pm, authored by Nurse 1. Nurse 1's Nursing Assessment noted the following,

  > I walked into the cafeteria while Resident A was involved in an ESI (emergency safety intervention). I observed Resident A in a supine restraint. Staff were communicating with Resident A that they were ready to start the release process. Resident A was instructed to remain calm and not move while staff stopped holding his feet. Resident A did not respond and the ESI was discontinued. Resident A did not answer to questions from myself or staff. He was observed taking breaths as evidenced by his chest rising and falling and exhaling of breath through mouth. Color was good. This continued for approx. 2 minutes. Resident A continued to not respond to verbal cues. Breathing became less consistent and his color was questionable. I left to go to the nursing office to grab our pulse ox. When I returned to the cafeteria, I placed the pulse ox on his finger and waited approx. 30 seconds for a reading. When I didn't get a reading, I changed the finger of the pulse ox, again without a reading. I checked for radial pulse and did not feel a pulse. Staff noted foaming at the mouth, so he was rolled to the recovery position. I decided to activate the EMS system and called 911 while staff-initiated chest compressions. I called for an AED and additional nursing staff. We continued CPR until EMS arrived,

after approx. 5-10min. Prompts were given from the AED, which did not indicate need for shock, but continued chest compressions.

- Notification Report for this incident #2020-04-29-058, dated 04/29/20, authored by Director 6. Notifications to Resident A's worker and Centralized Intake were documented.

Safe Crisis Management Participant Workbook and Safe Crisis Management Instructors Manual:

- Emergency Safety Interventions:
  - Least Restrictive Alternative: The use of emergency safety physical intervention refers to the application of force that restricts mobility or movement or that disengages from harmful physical contact… This means that intervention must be employed in the least amount necessary to ensure a safe outcome... The techniques do not employ the use of pain compliance, bone locks or body weight.
  - Types of Emergency Safety Interventions:
    - 5. Emergency Safety Physical Interventions (ESPI) "Physical restraint is an application of physical force by one or more individuals that reduces or restricts the ability to move his or her arms, legs or head freely"
    - Types of emergency safety physical interventions:
      - Floor assists – single or multiple-person: Supine assists-restriction while an individual is lying face up. Single or multiple person.
        - Injuries may occur if staff use excessive pressure or force. Positional risks include:
          • Restricted breathing, cardiac and/or respiratory arrest
          • Misuse of body weight and bone locks
  - Duration of emergency safety physical interventions… Emergency safety physical interventions must end when an individual's behavior indicates there is no longer a danger to self or others…. It is expected all other SCM emergency safety physical interventions be ended within ten (10) minutes. During all emergency safety physical interventions, a health safety monitor should be present and actively monitoring the intervention for safety and appropriateness.
  - Evaluate the Situation: During an escalating situation, staff should closely assess individuals, themselves, available resources, and the environment. The purpose is to evaluate how these variables impact the immediate situation, potential interventions, and the outcome.

- 1. Conditions for emergency safety physical intervention:
    a. Imminent threat and/or danger to self or others

Agency policy for Emergency Safety Physical Intervention:

- Procedure: Emergency Safety Physical Intervention is a last resort option to ensure safety and security of students and employees... Employees will only intervene utilizing techniques taught in the training and only when a student is imminently and immediately compromising someone's safety and will always utilize the least amount of force necessary to gain control of the student's physical movements as trained in the JKM Safe Crisis Management system.
    - B. A Lakeside Academy student may only be placed in an Emergency Safety Physical Intervention if they are displaying behavior that meets one or more of the following criteria.
        - 1. a danger to himself (imminently and immediately),
        - 2. a danger to others (imminently and immediately),
    - C. When the student's behavior meets these criteria employees may initiate a standing emergency safety physical intervention. This is an effort at keeping the student and others safe and also allow for de-escalation.
    - G. The employee present will call the on-duty Coordinator/Program Director or above. The Nurse or a Licensed Independent Practitioner is contacted to provide verbal orders for the restraint.
    - Physical restraint time limits in excess of 10 minutes (unless specifically approved by a mental health professional and/or Director) are also prohibited.

Agency policy for Use of physical holds with children and youth:

- Clients may only be physically held when all of the following criteria are met:
    - 1. They pose an imminent and/or immediate threat to the physical safety of themselves or others
    - 2. Less restrictive interventions have been unsuccessful or are not feasible
    - 3. Authorized to do so by a qualified professional
- Physical holds shall not be used as punishment, coercion, discipline, retaliation, for control, for convenience of staff, or in a manner that causes physical discomfort, harm, or pain.
- Application of physical holds (excerpts):
    - 7. Clients in physical holds are monitored continuously to ensure the individual's physical safety through continuous in-person observation by an assigned staff member who is not involved in the hold, is competent, is

fluent in the current language of the consumer (spoken or signed), and is trained in accordance with the standard...
    - 10. Behavioral control is not a requirement for discontinuation of physical holds if the client's safety or physical wellbeing becomes compromised by the application of the physical hold. If a client's safety or wellbeing is jeopardized, the physical hold must be immediately discontinued.
    - 11. Staff will follow all other applicable policies and procedures regarding the provision of emergency medical services, as necessary.
    - 13. Physical holds must be terminated at the earliest time it is safe to do so. Once the client can demonstrate behavior that does not pose a threat to self or others, the physical hold should end….
- Facility specific addendum to policy:
    - Physical holds and physical restraints may only last ten minutes.

[redacted]

Review of Resident A's case record (excerpts):

- [redacted]
- [redacted]

Communication Logs for Resident A from 01/28/20 – 05/01/20 were reviewed. There was no documentation of Resident A lying on the floor "faking" or otherwise

pretending to be unconscious. There was one entry on 04/05/20 that noted Resident A had, "…laid down in the bay refusing to go to bed until 3rd shift arrived."

Agency's Emergency Medical Procedures policy:

- 1. In an emergency situation the employee should go to the nearest phone available and dial 911, then call the Nursing Department or Nurse on call.
- 3. If Needed:
  - a. Initiate First Aid/CPR/AED
  - b. Summon ambulance service (911 if warranted)
  - c. Stay with student
  - d. Remove the student from area

Email received from Director 1, on 05/26/20, providing the names, dates, and reasons for termination of the following involved employees:

- Staff 1- 4/30 for improper restraint
- Staff 2- 4/30 for improper restraint
- Staff 3- 4/30 for improper restraint
- Staff 4- 5/4 effective 4/30 for improper restraint
- Staff 5- 4/30 for improper restraint
- Staff 6- 4/30 for improper restraint
- Supervisor 1- 5/1 effective 4/30 for failure to respond and provide proper leadership
- Staff 7- 5/1 effective 4/30 for improper restraint
- Supervisor 2- 4/30 for improper restraint
- Nurse 1- 4/30 for failure to respond and provide proper leadership

Email received from Director 1, on 06/09/20, noted the following in response to questions related to incident report documentation:

- "… All staff that are involved in the restraint are expected to do a supplemental incident report. We do not have a policy specifically on incident reports, but below is a blurb from the ESPI policy:
  A. All staff involved with an Emergency Safety Physical Intervention may not leave campus until the initial and all supplemental incident reports have been completed. Incident reports will be filed electronically unless for some reason the electronic system is inoperable."

Employee Files:

Employee files were reviewed applicable to First Aid/CPR training, SCM training, and related disciplinary action for Staffs 1, 2, 3, 4, 5, 6, 7, Supervisor 1, Supervisor 2, Director 4, Nurses 1, 2, 3, Program Director, and the Director of Case

Management. Based on the documentation provided, it is notable that of the eight individuals who actively participated in this restraint, Staff 7 has not had SCM training since 08/16/18, and Supervisor 2 has not had SCM training since 08/13/18.

Investigation Notes 1e:
During the course of this investigation, the DCWL Consultant reviewed Resident A's communication logs from 01/28/20-05/01/20. A review of these communication logs found the following, based on the entries' timestamps:

- Seven dates had no entries and 21 dates only noted that Resident A switched or moved dorms. As such, there was no behavioral information documented on seven sporadic days, and for the following extended periods of time, 03/31/20-04/03/20, 04/07/20-04/23/20. This totals 28 days without behavioral information noted in the communication logs for Resident A during the timeframe reviewed.

- 33 dates had only one entry that included behavioral content. Of these, seven were during the period when other staff were only reporting Resident A switched or moved dorms, indicating that staff were able to enter information during that period.

The DCWL Consultant interviewed the Program Director (PD) on 05/13/20, via phone, jointly with the MDHHS Specialist, and Attorney 2. The PD said that communication logs are completed by every shift, at least two times per day to document resident behaviors from shift to shift. It was noted that each youth has their own log.

Email received from Director 1 on 05/15/20: "Attached are communication logs for the past 3 months for Resident A. It looks like after he switched dorms to Kratos on 4/5 his dorm wasn't changed appropriately in the EHR so he still showed up under the incorrect dorm, which is why they documented "switched/moved dorms" for most of the shifts after that date."

Email received from Director 1 on 05/28/20: "The Program Director over the dorm should be reviewing the communication logs, with a secondary overall review monthly by the QA department to ensure they are being completed."

Agency's policy on Communication Log Reporting: Objective: To accurately record pertinent information (minimally 2 times daily) regarding each student's behavior, family situations, court appointments, education progress, phase packet work, clinical needs or concerns, program participation, student to primary counselor discussions and program progress. Procedure… A. A narrative pertaining to each student will be written by staff at a minimum of twice daily (am and pm shifts).

Investigation Notes 1f:
During the course of this investigation, it was repeatedly observed that the agency was not following their own written emergency procedure for COVID-19 screening. The DCWL Consultant visited the facility on 05/04/20 and 05/18/20. The agency did not screen me on 05/04/20.

DCWL Manager visited the facility on the following dates: 05/01/20, 05/04/20, 05/05/20, 05/09/20, 05/14/20, 05/15/20, and 05/17/20. The manager was screened on the last two dates only.

The DCWL Division Director was on-site at the facility on 05/01/20, 05/10/20 and 05/16/20 and was not screened.

Documentation reviewed:
Agency's Coronavirus (COVID-19) Emergency Response Plan, dated 03/16/20. In part, this written policy notes:

- Visitors will be screened before (if possible) and/or upon arrival to the facility. Visitors will report to the clinic for screening.

All contractors and non-Sequel personnel on campus will be complete the COVID-19 screening.

Investigation Notes 1g and 1h:

During the course of the initial allegation, it was found that the facility staff did not follow policy and excessively restrained Resident A on 01/04/20. On 06/02/20, Detective 1 reported concerns regarding a restraint he reviewed from 01/04/20. Detective 1 stated that he reviewed video of this restraint and observed five to six staff restraining Resident A for a period of about 30 minutes.

During the course of this investigation, the video and documentation from the 01/04/20 restraint with Resident A was reviewed. It was observed that two youth restrained a peer while two staff were directly present and did not intervene. See video notes above.

Director 1 confirmed via email, on 06/04/20, that the individual who is seen separating the other youth from Resident A in the video is another resident and not a staff.
Video of this incident was received by the agency and reviewed. The video was not time stamped but is 36 minutes and 9 seconds long. The video shows the following: Resident A goes after a peer, who appears to be saying something to Resident A. Staff 8 immediately jumps up and grabs Resident A's arm. The two youth continue to go after each other, and several staff and residents jump up and try to separate the two. They move across the room, and staff stop Resident A from going after the peer. Two residents restrain Resident B on the couch while two staff stand over them and watch, but do not redirect them off of him. The residents then get off of the peer and they all leave the area with staff.

Staffs 8 and 9 restrain Resident A; Staff 9 with Resident A's hands pulled behind his back. He breaks loose and Staff 8 and 9 hold his left arm and Staff 11 holds on to his right. A resident is in the mix the entire time, facing Resident A and has hands on Resident A, but exited when the restraint went to the floor. Resident A falls backwards onto the couch while struggling and Staff 12 joins the restraint and they pull/push Resident A to the ground. Staff 13 pulls on Resident A's legs to straighten them out while Staff 8, 9 and 12 are securing the mid and upper body. Their positioning is not able to be seen, as their backs are blocking the camera view of the resident. Staff 9 and 12 are on their knees pushing down on Resident A's mid/upper body while Staff 13 is laying over his upper legs and lower abdomen. Resident A appears to be struggling and his legs are in the air. Staff 12 is pulling on his legs and then lays across him again. Staff 8 is at Resident A's head, but his actions are not visible. Staff 11, a very large man, enters and drops his body onto Resident A's legs, laying across them. He then gets into what resembles a push up position with his arm on Resident A's leg. Staff 12 remains laying on his mid-section.

The Case Manager enters the room and is observing the restraint. Staff 10 enters and they both crouch down near Resident A's head, on either side of Staff 8. Staff 11 lays on Resident A again. The staff on the upper body appear to be struggling and as Staff 9 is leaning on Resident A, the Case Manager pushes on Staff 9's back. The Case Manager appears to be laying over the chest area of Resident A. Staff 12 remains laying across the mid-section and Staff 11 gets up and again drops his body onto Resident A's legs. The Case Manager then bridges over his chest, but it cannot be seen what he is holding onto or if he is laying on Resident A.

After 4 minutes Resident A is not seen moving, despite this the staff continue the restraint. After 5 minutes some staff begin to release their hold, get up and there is no sign of struggle. The restraint, however, is not ended for 32 minutes, when the remaining staff release his arms and sit him up. Resident A appears unsteady when he stands, and staff escort him by both arms out of camera view.

The DCWL Consultant interviewed Director 3 via phone, on 06/04/20, and she reported no knowledge of this incident. Director 3 reported that all restraints are to be not longer than 10 minutes in duration and a half hour restraint would be "flagged" for review. Director 3 reported that staff have to report the duration of restraints. Director 3 stated that disciplinary action could occur for restraints over 10 minutes. Director 3 reported that she thought all restraints on video were reviewed by the quality team and documented in a log.

The DCWL Consultant emailed Director 1 regarding this video and the accompanying incident reports for clarification. When asked if all restraint videos are reviewed, Director 1 replied, "We do not have a policy that specifically addresses the camera review of incidents. We review all of the incident reports and we try to review all restraints on video, but at times that wasn't always feasible." Director 1 also stated, "From the documentation that I have looked at, it does not appear that this

restraint video had been reviewed or brought to management's attention, and therefore staff were not disciplined for it." Director 1 confirmed that the individual who is seen separating and restraining a peer in the video is another resident and not a staff. Director 1 additionally emailed the following clarification regarding the documentation on the incident reports for this restraint.

> You are correct on the incident reports- all of the staff inappropriately documented that the restraint lasted 10 minutes. The actual start time on the video is 8:19pm….
> All staff that are involved in the restraint are expected to do a supplemental incident report. We do not have a policy specifically on incident reports, but below is a blurb from the ESPI policy:
>
> A. All staff involved with an Emergency Safety Physical Intervention may not leave campus until the initial and all supplemental incident reports have been completed. Incident reports will be filed electronically unless for some reason the electronic system is inoperable.

Documentation reviewed as part of this investigation:
Safe Crisis Management Participant Workbook and Safe Crisis Management Instructors Manual: Requirements outlined under the investigation of the 04/29/20 incident above.

Agency policy for Emergency Safety Physical Intervention: Requirements outlined under the investigation of the 04/29/20 incident above.

Agency policy for Use of physical holds with children and youth: Requirements outlined under the investigation of the 04/29/20 incident above.

Agency policy on Behavioral Intervention Approaches: Requirements outlined under the investigation of the 04/29/20 incident above.

Incident Report, 20-01-04-009, dated 01/04/20, authored by Staff 9. The time of the incident notes 8:15pm – 8:25pm. The report notes that Nurse 2 evaluated Resident A at 8:20pm, which was before Resident A was released from the restraint. The report notes that Staff 12, the program director, was notified at 8:25pm and Director 4 was notified at 8:25pm. There was no documentation for approvals of restraints over 10 minutes as this was recorded as a 10-minute restraint.

Debriefing Report, dated 01/07/20, authored by Staff 12 who is the program director. Notes this as a 10-minute incident.

Supplemental Incident Report, dated 01/05/20, authored by Staff 11. The report notes, "I was on Resident A's legs." Notes this as a 10-minute incident.

Supplemental Incident Report, dated 01/05/20, authored by Staff 8. The report notes, "I secured the student's hand so he would not be able to hurt himself or staff." Notes this as a 10-minute incident.

Supplemental Incident Report, dated 01/04/20, authored by Staff 13. The report notes, “I was on Resident A’s legs and switched out with a staff and held his arms.”

Investigation Notes 1i:
During the course of this investigation, as outlined above, it was determined that Director 3, the chief administrator, lacked administrative capability, sufficient to ensure the day to day operation of the institution and compliance with licensing rules.

Investigation Notes 1j:
During the course of this investigation, it was learned on 5/8/20 that the agency did not have 22 medical consents as required.

On 05/11/20, Director 2 reported the following via email:

> We have recovered 19 of the 22 consents/ROIs that we needed. The 3 that are still missing are from California, which we have communicated to the individual youth’s workers as well as to California out-of-state licensing to get help recovering them. Additionally, Lakeside’s Director of Student Services (who also oversees the Director of Case Management) is doing a look-behind audit today of the consents, to see if they were misfiled or if they were there but systemic issues resulted in them being difficult or unable to be located when needed. We will correct any faulty systems identified.

The DCWL Consultant interviewed Director 5 on 05/20/20. Director 5 stated that there were not 22 missing medical consents. He stated that there was only one missing. Director 5 said that the agency staff had not recovered the consents at the time they were requested, but the agency did have them.

The DCWL Consultant received an email from Director 1, on 05/21/20, that noted the following in regarding to the missing consents; “We were able to locate all but 1 student's consents. Some were stored in a separate binder together that some staff were not all aware of, which is what caused the original confusion.”

On 06/01/20, Director 1 emailed a link to the consents. The following was noted after a review:

- 99 youth consents were included
- 2 of the noted 22 missing consents were not found
- 7 were not dated
- 6 were dated 05/08/20
- 1 was not dated by the parent/guardian but was by the witness. This same youth had another consent dated 05/08/20 (included in the total of 6 noted above)
- 1 was dated 10/20/20 by the parent/guardian with a witness signature date of 10/16/20

ALLEGATION 2:

On 05/06/20 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.

Investigation Notes:

The DCWL Consultant called the complainant on 05/06/20, and a message was left to call back. I called again, and interviewed the complainant, on 05/19/20 and 05/20/20, via phone. The complainant identified themself as an employee at the facility who was laid off. The complainant advised of the allegations and reported that Director 4 directed the staff across campus not to allow the youth to make calls that night. The complainant reported not knowing what was going on and felt there was secrecy and a lack of sharing information. The complainant reported that after that initial night, the youth were again permitted to make phone calls. The complainant clarified that the night the youth were not permitted to make calls was the night of the restraint, 04/29/20, and that they were able to start making calls again the following day.

The DCWL Consultant spoke with Director 5 regarding this allegation, on 05/20/20, via phone. Director 5 indicated that I would need to speak with Director 4, but Director 5 attested that youth were getting phone calls to workers and families throughout this situation.

The DCWL Consultant interviewed Director 4 via phone, on 06/02/20. Attorney 2 was present on the call as well. Director 4 acknowledged that he had directed staff not to allow youth to make phone calls the night of the restraint. Director 4 reported that the management team made this decision in order to gather information and get a communication out to advise workers and families of the incident. Director 4 noted that youth were allowed to make phone calls the following day.

Director 1 was asked for the agency's policy on communication between workers/family and residents. Director 1 responded via email on 6/10/20, indicating that telephone calls are allowed weekly however residents are permitted additional call opportunities on weekends, one or both days to their approved contacts. The facility's program statement indicates that youth are permitted contacts with their workers and families.

ALLEGATION 3:

Resident U reported that Resident A took a drug or was given a drug that made his breathing heavy.

Investigation Notes:

This complaint was forwarded for investigation by Centralized Intake. Log ID 69655706. The complainant reported the following:

> Resident U (13) was placed at Lakeside Academy in Kalamazoo, Michigan on 12/12/19 and left the facility yesterday (5/7/20). Resident U is currently on his way back to Oregon after leaving Kalamazoo, MI yesterday. On 04/29/2020, Resident U witnessed his peer (who passed away) resisting in the cafeteria and reportedly the peer took some kind of drug that made him breathe heavy. There is rumor that a staff member drugged Resident U's deceased peer. It is unknown why the residents at the facility believe this.

Attempts were made to contact the complainant with no response received.

The DCWL Consultant interviewed Resident U's worker, on 05/28/20 via phone. Resident U's worker reported that she was aware of Resident U's report but noted that he had not said anything to her directly.

The DCWL Consultant interviewed Resident U on 06/01/20 via phone. Resident U reported that he had been at Lakeside for about five to six months. When asked about the allegations, Resident U reported that he had only heard that Resident A took a drug, "like a Percocet or something," but he did not have firsthand knowledge. Resident U reported that he heard this from other residents.

The DCWL Consultant interviewed the Medical Examiner (ME) on 06/09/20, jointly with the MDHHS Specialist via phone, in follow up to his report. [redacted]

Documentation reviewed as part of this investigation:
MiSACWIS and facility medical records, including last two well child exams and current medications. [redacted]

Medical Examiner and Forensic Services report: completed 05/01/20 and signed 05/29/20 by the Medical Examiner.

ALLEGATION 4:

On 05/15/20, the DCWL Consultant received information that indicated Resident T's mother reported at court, that he had not started therapy even though he had been at the facility since September of 2019.

Investigation Notes:

The DCWL Consultant interviewed Resident T at the facility on 05/18/20. Resident T reported that he sees his therapist weekly and has group therapy sessions multiple times per week. Resident T did note that he has not participated in regular therapy over the last couple of weeks, since he was quarantined as a result of testing positive for a communicable virus.

The DCWL Consultant interviewed Resident T's mother via phone on 06/01/20. Resident T's mother reported that she was not pleased with the services her son received while in Lakeside's care and reported being dissatisfied with staff responsiveness, follow up, and turnover, along with other non-rule related complaints. When asked about the allegations regarding Resident T's therapy, Resident T's mother said that he was not getting therapy since the pandemic, or for about the last two months, as the therapist was not coming in for sessions. The mother reported that Resident T told her this.
I interviewed the complainant on 06/08/20, via phone, who indicated that there was no more information to add to the complaint. The court advised her of this report by the mother so that the matter could be investigated.

The DCWL Consultant interviewed Resident T's worker on 06/09/20. She reported that, although she is no longer Resident T's worker, she had not heard any reports that Resident T was not receiving therapy. The worker reported that she had many conversations with the Director of Case Management who never mentioned this either.

Documentation reviewed as part of this investigation:
Therapy notes for Resident T from 03/01-05/14/20 inclusive of individual and group sessions. Documentation from these notes revealed the following:

- Individual therapy was documented for every week except for the week of 05/04/20.
- No group therapy was documented to have occurred during the weeks 03/23/20, 04/06/20, 04/13/20, 05/04/20, or 05/11/20 as those sessions were cancelled for various reasons.

The Updated Treatment Plans completed 04/2020, 01/2020, and 10/2019 were reviewed and all noted therapy being provided.

Testing results for Resident T noted him to be positive for a communicable virus and those notes were provided to DCWL via email from Director 2, on 05/06/20.