RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 12, 2018

Andre Lately
ADL Estate
PO Box 04388
Detroit, MI 48204

RE: License #: AS820266993
Investigation #: **2018A0782022**
ADL Estate Foster

Dear Mr. Lately:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

Andrea Green, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 236-0832

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS820266993
Investigation #:	2018A0782022
Complaint Receipt Date:	04/09/2018
Investigation Initiation Date:	04/11/2018
Report Due Date:	06/08/2018
Licensee Name:	ADL Estate
Licensee Address:	PO Box 04388 Detroit, MI 48204
Licensee Telephone #:	(313) 865-1428
Administrator:	Andre Lately
Licensee Designee:	Andre Lately
Name of Facility:	ADL Estate Foster
Facility Address:	1730 Longfellow Street Detroit, MI 48206
Facility Telephone #:	(313) 865-1428
Original Issuance Date:	07/30/2004
LicenseLicense **Status:**	REGULAR
Effective Date:	04/22/2018
Expiration Date:	04/21/2020
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
Resident A alleged that staff person, Tierra Peeples grabbed him by the collar.	No
Resident A alleged that staff person, Tierra made derogatory remarks about him on Instagram.	Yes

II. METHODOLOGY

04/09/2018	Special Investigation Intake 2018A0782022
04/11/2018	Special Investigation Initiated - Telephone Telephone call to licensee designee, Andre Lately.
04/17/2018	Inspection Completed On-site Interviewed Resident A, staff person, staff person, Jessica Smith, staff person, Danielle Jones, and licensee designee, Andre Lately.
04/19/2018	Contact - Telephone call made Telephone call to staff person, Tiera Peeples.
06/06/2018	Exit Conference Exit conference call to licensee designee, Andre Lately.

ALLEGATION:

Resident A alleged that staff person, Tierra Peeples grabbed him by the collar.

INVESTIGTION:

I conducted an on-site investigation at the home on 4/17/2018. During the on-site investigation I interviewed Resident A regarding this allegation. Resident A stated that staff person, Tierra Peeples was angry at him because he had made several phone calls to her. Resident A stated that Ms. Peeples came to confront him and when he attempted to walk away from her she grabbed him by the collar and pulled

him toward her. Resident A stated that he was able to pull away from her and walked away to an area where she was not able to get to him. I asked Resident A if there was anyone who had witnessed this incident. He stated that there was, but he was not comfortable giving out that person's name and phone number. Resident A stated that after the incident he contacted the licensee designee, Andre Lately. Resident A stated that Mr. Lately had fired Ms. Peeples and she has not returned to work since the incident.

During the on-site I also interviewed staff persons, Jessica Smith and Danielle Jones. They both stated that they had never seen Ms. Peeples grabbing Resident A or physically harming him in any way. They both stated that Resident A and Ms. Peeples had gotten along very well before this alleged incident. They both stated that Resident A has a tendency to lie about things when he does not get his way. Ms. Smith stated that Resident A seeks a lot of attention and he may have gotten upset because Ms. Peeples was not spending as much time interacting with him.

I also interviewed the licensee designee, Andre Lately regarding this allegation. Mr. Lately stated that Resident a has a history of making complaints that are not true. Mr. Lately stated that he was told by another staff person that Resident A stated that he had made the complaint because he was mad at Ms. Peeples. Mr. Lately stated that he had interviewed Ms. Peeples and she denied the allegation. Ms. Lately stated that he suspended Ms. Peeples for something unrelated to this allegation. He stated that he had not determined whether he is going to terminate Ms. Peeples' employment at the time of the on-site investigation.

I interviewed Ms. Peeples by telephone on 4/19/2018. Ms. Peeples stated that Resident A had been making prank phone calls to her, so she did confront him about it. Ms. Peeples denied that she had grabbed Resident A by the collar. Ms. Peeples stated that she had never physically assaulted Resident A in any way.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Although Resident A stated that staff person, Ms. Peeples grabbed him by the collar in a public place there was no one who was able to corroborate this allegation and the other staff interviewed denied ever seeing Ms. Peeples physically assault Resident A, therefore, there is insufficient evidence to substantiate this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A alleged that staff person, Tierra Peeples made derogatory remarks about him on Instagram.

INVESTIGATION:

During my on-site investigation I interviewed Resident A regarding the allegation he made that Ms. Peeples made derogatory remarks about him on Instagram. Resident A stated that he was angry with Ms. Peeples after the incident when she grabbed his collar and he had posted some negative things about her on Instagram. Resident A stated that Ms. Peeples responded on Instagram by saying rude things about him.

I interviewed staff person, Danielle Jones regarding this allegation. Ms. Jones stated that she does know that Ms. Peeples had responded to the negative comments Resident A made about her on Instagram by saying negative things about him.

I interviewed Ms. Peeples regarding the allegation that she had made derogatory remarks about Resident A on Instagram. Peeples stated that she feels that Resident A had become to close to her and when she tried to have less contact with him when she was not working he became angry with her and started making these allegations. Ms. Peeples stated that Resident A had made some negative statements about her on Instagram. Ms. Peeples admitted that she had responded to Resident A's negative comments by making negative comments about him in response.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	Staff person, Tierra Peeples admitted that she had made derogatory remarks about Resident A on Instagram in response to negative comments he had made about her therefore violation of this rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend that the status of the license remains unchanged.

6/6/2018

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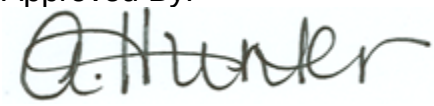
Andrea Green Date
Licensing Consultant

Approved By:



6/12/2018

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Ardra Hunter Date
Area Manager