GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2022

Andre Lately
ASPGM LLC
41830 Carousel
Novi, MI 48377

RE: License #: AS820385859
Investigation #: 2022A0992019
All Love Home

Dear Mr. Lately:

Attached is the Special Investigation Report for the above referenced facility. The violations identified in the report have been corrected, a written corrective action plan is not required

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820385859
Investigation #:	2022A0992019
Complaint Receipt Date:	03/16/2022
Investigation Initiation Date:	03/17/2022
Report Due Date:	05/15/2022
Licensee Name:	ASPGM LLC
Licensee Address:	41830 Carousel Novi, MI 48377
Licensee Telephone #:	(313) 633-6645
Administrator:	Andre Lately
Licensee Designee:	Andre Lately
Name of Facility:	All Love Home
Facility Address:	28529 PARKWOOD ST INKSTER, MI 48141
Facility Telephone #:	(734) 855-6841
Original Issuance Date:	07/12/2017
License Status:	REGULAR
Effective Date:	07/12/2020
Expiration Date:	07/11/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has been exhibiting aggression and sexual behaviors beyond the control of the facility. Although the facility is giving a 24-hr. emergency discharge. There are concerns that there's inadequate staffing.	No
Additional Findings	Yes

III. METHODOLOGY

03/16/2022	Special Investigation Intake 2022A0992019
03/17/2022	Special Investigation Initiated - Telephone Andre Lately, licensee designee
03/18/2022	Inspection Completed On-site Christina Carter, direct care staff; Crystal Baldwin, direct care staff, Resident A and B.
03/21/2022	Contact - Telephone call made Tami Scharr, Resident A's Supports Coordinator with Community Living Services
03/21/2022	Contact - Telephone call made Latoria Thomas, home manager
03/22/2022	Contact - Telephone call made Ms. Scharr
03/22/2022	Referral - Recipient Rights
03/22/2022	APS Referral
03/22/2022	Contact - Telephone call received Ms. Schaar
03/23/2022	Contact - Telephone call received Ms. Thomas
03/25/2022	Contact - Telephone call made Damon Watkins, Resident A's guardian with Faith Connections.
03/25/2022	Contact - Telephone call made

	Mr. Lately
04/05/2022	Contact - Telephone call received Ms. Schaar
04/08/2022	Inspection Completed On-site Resident A and Whitney Patterson, administrative assistant
04/20/2022	Inspection Completed On-site Latoria Thomas, home manager; Christina Carter, direct care staff and Resident A
05/16/2022	Exit Conference Mr. Lately
05/19/2022	Contact - Telephone call made Tamiko Smith, Resident B's guardian with Kemp Klein Law Firm

ALLEGATION: Resident A has been exhibiting aggression and sexual behaviors beyond the control of the facility. Although the facility is giving a 24-hr. emergency discharge. There are concerns that there's inadequate staffing.

INVESTIGATION:

On 03/17/2022, I contacted Andre Lately, licensee designee regarding the allegations. Mr. Lately stated he issued an emergency discharge to Resident A due to a violent altercation with another Resident. However, he said in addition to that Resident A was involved in another incident involving Resident B. He said Resident B reported to Crystal Baldwin, direct care staff, that Resident A asked him to perform oral sex on him and he would allow him to use his cell phone. After Resident B performed oral sex, Resident A refused to allow him to use his cell phone. Mr. Lately said allegedly this incident occurred in the resident's bathroom while Latoria Thomas, home manager, was administering medications. Mr. Lately said he wants all the resident to feel safe and he can't tolerate such predatory behaviors.

On 03/18/2022 I completed an unannounced on-site inspection and interviewed Christina Carter, direct care staff, and Crystal Baldwin, direct care staff, regarding the allegations. Ms. Carter and Ms. Baldwin made me aware that Resident B confided in them about what happened between him and Resident A. Ms. Carter said in addition to Resident B performing oral sex on Resident A, he stated that Resident A also penetrated his rectum with his penis and although Resident B told him to stop, he didn't. Ms. Baldwin stated Resident B told her the same thing. Ms.

Baldwin said no matter how many times he tells the story, he remains consistent, and nothing changes. Ms. Carter and Ms. Baldwin said Resident B has limited speech ability and suggested I asked him to repeat himself if I don't understand. Ms. Carter said Resident B asked to go to the hospital today because he's having issues with being constipated. She said the visiting physician did see him, but she wasn't sure if Resident B made him aware of his problems. As far as staffing, Ms. Carter said there's always adequate staffing in the home.

I proceeded to interview Resident B regarding the allegations. Resident B said he feels safe in the home but he's uncomfortable around Resident A. I asked him more about being uncomfortable around Resident A. Resident B said, "One-time [Resident A] put his dick in my ass." He said, "I told him to stop, but he didn't." I asked him where the staff was when this occurred and Resident B was uncertain. He said there was staff in the home, but he couldn't recall the staff name. I asked him what time of day it was when this occurred, and he said it was dark outside; Resident B was unable to provide additional details pertaining to the day the incident ocurred and/or who was on shift. I asked him if there was an incident involving a cell phone and he said yes. Resident B said, "[Resident A] told me I could use his cell phone, if I sucked his dick." Resident B said he did it, but Resident A wouldn't let him see his cell phone. Resident B said the incident occurred in the bathroom. He said Latoria Thomas, home manager, was on shift. He said he did not tell Ms. Thomas and that he only told Ms. Carter and Ms. Baldwin. Resident B said he needs to go to the doctor because now he's having trouble having a bowel movement. I asked him if he requested to go to the doctor and he said the doctor came to see him but he need to see him again.

Prior to interviewing Resident A, Ms. Carter made me aware that Resident A has explosive behaviors and doesn't like being bothered. Ms. Carter escorted me to Resident A's room, she knocked on the door and Resident A yelled, "I'm sleep." Resident A refused to open his door to be interviewed. Ms. Carter attempted to open Resident A's bedroom door, Resident A barricades himself in his bedroom. Ms. Carter said Resident A tends to move his dresser in front of his door to prevent anyone from entering his room. I made Ms. Carter aware that Resident A cannot barricade himself in his room and if he continues to do that, his dresser must be removed.

While onsite, I reviewed the assessment plans for Residents A through E, to better understand the residents' needs and determine if there was adequate staffing on shift. Residents A through E does not require 1:1 staffing.

On 03/21/2022, I contacted Tami Scharr, Resident A's Supports Coordinator with Community Living Services regarding the allegations. Ms. Scharr said she's familiar with the allegations and she discussed it with Mr. Lately. I asked Ms. Scharr if Resident A has history of acting out sexually and she said not to her knowledge. She said she's aware Mr. Lately has issued a 24-hour discharge due to Resident A's behaviors, but no one has told Resident A in fear of him acting out. Ms. Scharr said

Resident A has a history of felonious assault and she doesn't want to incite him or have him potentially retaliate against Resident B. She said Resident A has bullied Resident B in the past and if she's not mistaken, he also urinated on Resident B's bed before. As far as Resident A's needs, she said he has been diagnosed with autism disorder but that doesn't quite explain his behaviors; Ms. Scharr said there's a possibility he's been misdiagnosed. However, she said he's been scheduled for follow-up exams, but he refuses treatment which makes it hard to service him. She said Resident A also refuses medications regularly. Ms. Scharr denied having any concerns regarding staffing. However, she said there is a possibility 1:1 staffing will soon be authorized for Resident A. She said she intends to visit the home on 3/22/2022 to make Resident A aware he's being discharged; she said she will be accompanied by the local police and Damon Watkins, Resident A's guardian. She agreed to keep me updated.

On 03/21/2022, I contacted Latoria Thomas, home manager, regarding the allegations. Ms. Thomas denied having any knowledge of the allegations until recently. She said based on Resident B's statements, she was on shift when it occurred, but he did not notify her. I asked if Resident B has been seen by a doctor and she said just the visiting physician. I explained that Resident B said he's been having some issues with having a bowel movement and he should be examined, in which she agreed. Ms. Thomas agreed to have Resident B examined hospital emergency room immediately.

On 03/22/2022, I made follow-up contact with Ms. Scharr. She said they did not meet as expected because there's a possibility Resident A might remain in the home and Resident B will relocate. She said if Resident A remains in the home, he will require 1:1 staffing.

On 03/23/2022, I received a follow-up call from Ms. Thomas. She said she took Resident B to the Beaumont Wayne Hospital and explained what happened. She said due to the lapse in time a rape kit was not performed, but Resident B was examined and discharged. She said a police report was filed 22-4160 with Inkster Police Department.

On 03/25/2022, I contacted Damon Watkins, Resident A's guardian with Faith Connections regarding the allegations. Mr. Watkins said he is fully aware of the allegations. He said he was contacted by the Detroit Wayne Integrated Health Network (DWIHN) and apparently Resident A is going to remain in the home and Resident B is going to relocate. Mr. Watkins said all arrangements are being facilitated by Mr. Lately, DWIHN and Resident B's guardian. He said he is aware that one of the conditions for Resident A to remain in the home is to have 1:1 staffing, which is going to be authorized by DWIHN.

On 03/25/2022, I contacted Mr. Lately and made him aware that I attempted to interview Resident A. However, he barricaded himself in his bedroom by moving his dresser in front of his door to prevent anyone from entering his room; Mr. Lately

confirmed he's aware Resident A barricades himself in his bedroom. I informed Mr. Lately that Resident A cannot continue to barricade himself in his room and if he does, his dresser must be removed from his bedroom. I also inquired about Mr. Lately' s actions to safeguard Resident B from Resident A, considering there was a staff on shift when the alleged incident occurred. Mr. Lately said he received a call from DWIHN, and Resident B is relocating, and Resident A will remain in the home with 1:1 staffing. He said he intends to contact Resident A and B's guardian to make sure everyone is on the same accord.

On 04/05/2022, I received a telephone call from Ms. Schaar, regarding Resident A. Ms. Scharr said 1:1 staffing has been approved for Resident A, effective 3/31/2022. She said the psychologist will be completing a functional analyst assessment on 4/5/2022 and an emergency behavioral meeting will be held on 4/6/2022 to address Resident A's behaviors. She said she took a deeper look at Resident A's file, and it appears as though Resident A exhibited sexual and predatory behaviors in 2017 but it was never documented in his individual plan of study (IPOS). She said Resident A is originally from Ohio and somehow his file was not complete. However, she said she intends to amend his current assessment to reflect his past behaviors so that moving forward he can be assessed properly.

On 04/08/2022, I completed an unannounced onsite and I interviewed Resident A regarding the allegations in which he denied. Resident A said he did not ask Resident B to perform oral sex on him, nor did he receive oral sex. He said that's all rumors. Resident A was adamant that nothing sexual occurred between him and Resident B. He began to raise his voice and become agitated.

While onsite, Ms. Carter made me aware that placement was secured at a different location for Resident B.

On 05/16/2022, I conducted an exit conference with Mr. Lately. I explained that based on the investigative findings, there is insufficient evidence to support the allegations. However, I made Mr. Lately aware that 1:1 staffing has been authorized for Resident A as of 3/31/2022, so he needs to make sure the home is properly staffed; in which Mr. Lately said he has increased staffing as required. Mr. Lately denied having any additional questions.

On 05/19/2022, I contacted Tamiko Smith, Resident B's guardian with Kemp Klein Law Firm regarding the allegations. Ms. Smith said she was notified about the allegations early-on and was able to relocate Resident B to a safe and comfortable home. She said he's doing well and there are no concerns.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	During this investigation I interviewed Andre Lately, licensee designee; Latoria Thomas, home manager; Christina Carter, direct care staff; Crystal Baldwin, direct care staff; Tami Scharr, Resident A's Supports Coordinator with Community Living Services; Damon Watkins, Resident A's guardian with Faith Connections; Tamiko Smith, Resident B's guardian with Kemp Klein Law Firm; Residents A and B. All of which were unable to determine if the incident occurred, with the exception of Resident A. Resident A stated the incident occurred on two occasions and staff was present. However, he denied reporting the incident to staff when it occurred. I reviewed Residents A through E's, assessment plans; none of which required 1:1 staffing at the time the allegations were reported. Based on the investigative findings, there is insufficient evidence to support the allegation. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/18/2022, I completed an unannounced onsite inspection. When I arrived the smoke detector in the living room area was beeping due to the battery needing to be changed, I notified Ms. Carter. While onsite I attempted to interview Resident A. Ms. Carter escorted me to Resident A's bedroom, I discovered that Resident A barricades himself in his bedroom by moving his dresser in front of his door to prevent anyone from entering his room. I made Ms. Carter aware that Resident A cannot barricade himself in his room and if he continues to do that, his dresser must be removed.

On 03/25/2022, I contacted Mr. Lately regarding my findings while onsite. I made him aware that Resident A barricades himself in his bedroom by moving his dresser in

front of his door to prevent anyone from entering his room, which Mr. Lately confirmed. I made Mr. Lately aware that Resident A cannot barricade himself in his room and if he continues to do that, his assessment plan must be updated to reflect his behaviors and the dresser must be removed. I also made Mr. Lately aware that the smoke detector in the living room area is beeping due to the battery needing to be changed, in which Mr. Lately agreed to change the battery.

On 04/08/2022, I completed an unannounced onsite inspection to interview Resident A regarding allegations. I requested to interview him privately in his bedroom. Resident A had to move the dresser from blocking his door prior to being interviewed. I explained to Resident A that he cannot keep moving his dresser to block his door or barricade himself in his room. I explained that if he continues to do that, the dresser is going to be removed from the room. He explained that he moves the dresser because the door does not lock, and he can't have any privacy. Although Resident A's bedroom (bedroom #2) door is equipped with non-locking against egress hardware, the door does not positive-latching. Resident A does not have a lightbulb in his lamp, he said he's been without a light for days. Also, I observed the door of bedroom #5 off the hinges and propped against the wall, which is a safety hazard. The mattress in bedroom #5 was severely bowed inward and in poor condition. The smoke detector in the living room area was still beeping due to the battery needing to be changed.

It should be noted while onsite, Whitney Patterson, administrative assistance removed the door from bedroom #5 and placed it outside. She also showed me that a work order has been submitted to replace the bedroom door. She also agreed to make sure all the physical plant repairs are completed immediately.

On 04/20/2022, I completed an unannounced onsite inspection, Ms. Thomas and Ms. Carter were present. Resident A's bedroom door was positive-latching, and his light bulb was replaced and working. The mattress was replaced in bedroom #5.

On 05/16/2022, I conducted an exit conference with Mr. Lately. I explained that throughout this investigation, I observed several physical plant deficiencies including (bedroom #2) door was not positive-latching; no lightbulb in bedroom #2; #5 bedroom door off the hinges and propped against the wall, which posed a safety hazard; the mattress in bedroom #5 was severely bowed inward and in poor condition; and the smoke detector in the living room area was beeping for weeks due to the battery needing to be changed. I further stated that as of 4/20/2022, the repairs had been completed, so although he will be cited a corrective action plan is not required. Mr. Lately inquired about sufficient time frames to complete repairs considering his home is a high behavior home. I explained to Mr. Lately that the timeframe for repairs depends on the nature of the repair. For example, replacing a battery in the smoke detector shouldn't take weeks to replace. However, replacing a bedroom door might take longer depending on if the door is available in store or if it must be ordered, the size of the door all of which are determining factors, but he is responsible to demonstrate efforts to rectify the problem. Mr. Lately denied having any additional questions.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(6) Occupied room door hardware shall be equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	On 04/08/2022, I completed an unannounced onsite inspection and observed the door to bedroom #2 was not positive-latching. As of 04/20/2022, the door has been repaired and is equipped with positive-latching**.** No CAP required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 04/08/2022, I completed an unannounced onsite inspection and observed the door to bedroom #5 was not side hinged and observed propped against the wall. As of 04/08/2022, the door was removed from the home, and I observed a work order to replace the bedroom door. No CAP required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic

	materials. The use of a waterbed is not prohibited by this rule.
ANALYSIS:	On 04/08/2022, I completed an unannounced onsite inspection and observed the mattress in bedroom #5 was severely bowed inward and in poor condition As of 04/20/2022, the mattress has been replaced**.** No CAP required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

5/23/2022

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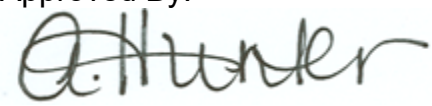
Denasha Walker Date
Licensing Consultant

Approved By:



6/1/2022

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Ardra Hunter Date
Area Manager