GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2023

Tamisha Turner
The Chateau Group Of Michigan LLC
P.O. Box 81
Walled Lake, MI 48390

RE: License #: AS630391762
Investigation #: 2023A0993016
Chateau Of Bloomfield

Dear Ms. Turner:

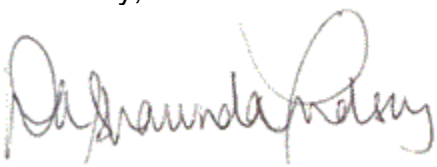
Attached is the Special Investigation Report for the above referenced facility. *A previous recommendation for provisional license was made in the Renewal Licensing Study report dated 03/06/2023, which remains in effect.* Due to the violations identified in the report, a written corrective action plan 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630391762
Investigation #:	2023A0993016
Complaint Receipt Date:	01/30/2023
Investigation Initiation Date:	01/30/2023
Report Due Date:	03/31/2023
Licensee Name:	The Chateau Group Of Michigan LLC
Licensee Address:	P.O. Box 81 Walled Lake, MI 48390
Licensee Telephone #:	(248) 380-4663
Administrator:	Tamisha Turner
Licensee Designee:	Tamisha Turner
Name of Facility:	Chateau Of Bloomfield
Facility Address:	2660 Vhay Lane Bloomfield, MI 48304
Facility Telephone #:	(248) 792-6607
Original Issuance Date:	08/01/2018
License Status:	1ST PROVISIONAL
Effective Date:	03/07/2023
Expiration Date:	09/06/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Chantia Coleman took Resident A's radio. Ms. Coleman threw water in Resident A's face. Ms. Coleman grabbed his wheelchair, shook him back and forth and slammed him into the wall. Ms. Coleman hit Resident A in the arm with a spatula. Resident A has a bruise on his arm and scratches on his chest.	No
Additional Findings	Yes

III. METHODOLOGY

01/30/2023	Special Investigation Intake 2023A0993016
01/30/2023	APS Referral Allegations received from adult protective services (APS)
01/30/2023	Referral - Recipient Rights Allegations forwarded to recipient rights advocate Aaron Winston
01/30/2023	Special Investigation Initiated - Telephone Telephone call made to APS specialist Heather Stickel
01/30/2023	Contact - Document Sent Emailed APS specialist Heather Stickel
01/30/2023	Contact - Telephone call made Telephone call made to Resident A's guardian. Left a message.
01/30/2023	Contact - Document Sent Emailed Resident A's guardian
02/01/2023	Inspection Completed On-site Conducted an onsite investigation
02/15/2023	Contact - Telephone call made Telephone call made to staff Chantia Coleman
02/15/2023	Contact - Telephone call made Telephone call made to staff Steven O'Leary. Left a message.

02/15/2023	Contact - Telephone call made Telephone call made to staff Marcell Williams. Left a message.
02/15/2023	Contact - Telephone call made Telephone call made to staff Lakia Ealy
02/15/2023	Contact - Telephone call made Telephone call made to staff Christin Douglas. Mailbox full. Sent a text message.
02/15/2023	Contact - Telephone call made Telephone call made to staff Jasmine Boykin. Mailbox full. Sent a text message.
02/16/2023	Contact - Telephone call made Telephone call made to staff Jasmine Boykin. Mailbox full. Sent a text message.
02/21/2023	Contact - Telephone call made Telephone call made to staff Marcell Williams
02/23/2023	Contact - Telephone call made Telephone call made to staff Christina Douglas
02/23/2023	Contact - Telephone call made Telephone call made to home manager Thomas Bates. Left a message.
02/23/2023	Contact - Telephone call made Telephone call made to staff Steven O'Leary
03/01/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
03/01/2023	Contact - Face to Face Interviewed Resident A at Pontiac General Hospital
03/09/2023	Comment Reviewed facility’s file in Sharepoint
03/09/2023	Exit Conference Attempted to hold with licensee designee Tamisha Turner. Left a message.

ALLEGATION:

Staff Chantia Coleman took Resident A's radio. Ms. Coleman threw water in Resident A's face. Ms. Coleman grabbed his wheelchair, shook him back and forth and slammed him into the wall. Ms. Coleman hit Resident A in the arm with a spatula. Resident A has a bruise on his arm and scratches on his chest.

INVESTIGATION:

On 01/30/2023, I received the allegations from adult protective services (APS).

On 01/30/2023, I forwarded the allegations to recipient rights advocate Aaron Winston.

On 02/01/2023, I conducted an onsite investigation. I interviewed area manager Nancy Turner and home manager Thomas Bates.

Ms. Turner stated she has worked for the company for approximately three years. She denied being present the day staff Chantia Coleman allegedly took Resident A's radio, threw water in Resident A's face, grabbed his wheelchair, shook him back and forth, slammed him into the wall, and hit Resident A in the arm with a spatula. Ms. Turner denied knowledge of Ms. Coleman taking Resident A's radio. Per Ms. Turner, Resident A does not have a radio. Ms. Turner stated she was informed Resident A began displaying behaviors because he wanted a MP3 player. Licensee designee Tamisha Turner told Resident A if he did not have behaviors for one week, she will get him a tablet or MP3 player. A few days ago, Resident A tore up the entire facility. He busted out the window in his bedroom with his walker, broke the fax machine, threw food at the refrigerator, broke the tv in the living room, etc. Police were called and he was taken to St. Joes Hospital in Pontiac. Resident A was assessed, discharged, and returned to the facility the same day. Ms. Turner stated while she was transporting Resident A back to the facility, Resident A stated Ms. Coleman was going to jail. He admitted to lying on her because he wanted to get her fired and she was going to jail as a result. Resident A said to Ms. Turner, "I'm going to get that b*tch fired". When Resident A returned to the facility, his behaviors began again. He threw various items throughout the facility. Police were called and he was taken to the hospital again. Resident A is still in the hospital.

Ms. Turner stated Resident A is highly behavioral. He used to have one to one staffing, but his case manager took it away. Ms. Turner is trying to get one to one staffing for Resident A again. Resident A has been sent for medication reviews, but that does not seem to work for long. It will work for a minute, and then it stops working. Ms. Turner stated staff are doing everything that they can to accommodate Resident A. Staff "tip toe" around Resident A because they do not want him to go into behavior.

Mr. Bates stated he has worked in the facility since 2020. He works day shift from 7am to 7pm. He denied observing Ms. Coleman take Resident A's radio, throw water in Resident A's face, grab his wheelchair, shake him back and forth, slam him into the

wall, and/or hit Resident A in the arm with a spatula. Mr. Bates stated Resident A does not have a radio. Resident A took another resident's radio and hid it under his bed. When Resident A is behavioral, staff and residents are not brave enough to get close to Resident A. Recently, Resident A has been having behaviors one or twice per day. As a result of Resident A's behaviors, there is an order to repair a window. Resident A broke two closet doors. A fax machine and TV had to be replaced after Resident A broke them. Mr. Bates stated Resident A compulsively lies, and he says he is going to keep getting away with his behaviors. Mr. Bates confirmed Resident A is still in the hospital. He is awaiting psychiatric placement. He has been denied by four hospitals due to his behaviors.

On 02/15/2023, I conducted a telephone interview with staff Chantia Coleman. Ms. Coleman stated she began working back in the facility on 01/01/2023. She works the day shift from 7am to 7pm. She verified she worked on 01/27/2023 when Resident A went into behavior and was transported to the hospital. Per Ms. Coleman, when she arrived at the facility, Resident A was okay. He asked Mr. Bates about a tablet. He went into behavior after Mr. Bates responded. He threw milk at the wall. Later, he threw a bucket of water. He threw things and broke things. Resident B heard Resident A and called the police. The police came to the facility and talked to Resident A. The police were unable calm him down. Resident A stated he was going to kill himself and Resident B stated she did not want Resident A in the facility. Resident A was taken to the hospital via EMS. About two hours later, EMS returned him to the facility. Ms. Coleman stated she observed that Resident A had a cigarette lit inside the facility. She asked Resident A to go outside to smoke. Resident A told her that was his house, and he could smoke wherever he wanted. He then threw the cigarette, threw his walker into the window, hit walls, and slammed doors. He also took Resident A's radio. The police were called. The police came to facility and calmed Resident A. The police left. Resident A went into behavior again. The police came back to the facility and Resident A was transported to the hospital. Ms. Coleman stated Resident A is still hospitalized. Ms. Coleman denied taking Resident A's radio, throwing water in his face, grabbing his wheelchair, shaking him back and forth, slamming him into the wall, and/or hitting Resident A in the arm with a spatula.

On 02/15/2023, I conducted a telephone interview with staff Lakia Ealy. Ms. Ealy stated she has worked in the facility since September 2022. She works midnights from 7pm to 7am. Ms. Ealy stated she does not work with Ms. Coleman. She denied ever seeing any staff abuse, neglect, or mistreat the residents. Per Ms. Ealy, she has heard Resident A has behaviors quite often during day shift.

On 02/16/2023, I conducted a telephone interview with staff Jasmine Boykin stated she has worked in the facility for a couple of months. She works day shift from 7am to 7pm. Ms. Boykin stated she does not work with Ms. Coleman. She denied ever seeing any staff abuse, neglect, or mistreat the residents. Per Ms. Boykin, Resident A has behaviors when he does not get his way or when he does not receive attention.

On 02/21/2023, I conducted a telephone interview with staff Marcel Williams. Ms. Williams stated she has worked in the facility off and on for one year. She works the midnight shift from 7pm to 7am. Ms. Williams stated she has never worked with Ms. Colemen. She denied ever seeing any staff abuse, neglect, or mistreat the residents. Per Ms. Williams, Resident A has behaviors a lot. He throws things and call people names.

On 02/23/2023, I conducted a telephone interview with staff Christina Douglas. Ms. Douglas stated she has worked in the facility for about 90 days. She works day shift from 7am and 7pm. Ms. Douglas stated she has never worked with Ms. Coleman. She has only worked with Mr. Bates. She denied ever seeing any staff abuse, neglect, or mistreat the residents. Per Ms. Douglas, Resident A socks windows and tvs as well as get violent.

On 02/23/2023, I conducted a telephone interview with staff Steven O'Leary. Mr. O'Leary stated he has worked in the facility for two years and two months. He mainly works day shift from 7am to 7pm. He sometimes works midnight shift from 7pm and 7am. Mr. O'Leary stated he worked with Ms. Coleman twice. He denied observing her or other staff abusing, neglecting, or mistreating the residents. Per Mr. O'Leary, if Resident A does not get what he wants, he goes into behavior. His behaviors include cursing and yelling as well as property damage.

On 03/01/2023, I conducted an unannounced onsite investigation. I spoke with Mr. Bates. He stated that Resident A was still hospitalized. Resident A was at Pontiac General Hospital. I also interviewed Resident B, Resident C, Resident D, Resident E, and Resident F.

Resident B denied ever observing any staff abuse, neglect, or mistreat Resident A. She stated Resident A attacks staff and other residents.

Resident C denied ever observing any staff abuse, neglect, or mistreat Resident A. He stated Resident A beats and abuse people all the time. He also masturbates in public. Per Resident C, the police are always called to the facility due to his behaviors.

Resident D denied ever observing any staff abuse, neglect, or mistreat Resident A. He stated he could not recall an incident between Ms. Coleman and Resident A. He stated Resident A has episodes. He has broken windows.

Resident E denied ever observing any staff abuse, neglect, or mistreat Resident A. He stated he was present during the incident between Ms. Coleman and Resident A. He heard Resident A say that "b*tch" put water on me, but he denied seeing it. Resident A was yelling and destroying the kitchen. He broke the window and the tv. Resident A was taken to the hospital.

Resident F denied ever observing any staff abuse, neglect, or mistreat Resident A. He described Resident A has "a filthy animal", "a domestic disturbance", and "a public

hazardous". He stated Resident A scratched his butt and does not wash his hands. He steals food. He has not respect for other people's property. He beats on women. He beats on staff. Police comes to the facility due to his behaviors. He masturbates in public. He urinates in his bedroom as well as on the porch.

On 03/01/2023, I interviewed Resident A at Pontiac General Hospital. Resident A stated Ms. Coleman put water on the radio as well as him. Ms. Coleman touched his wheelchair and pushed it to the wall. He stated he got mad due to that. Resident A denied hitting Ms. Coleman. He stated he called the police.

On 03/09/2023, I reviewed two incident reports (IRs) for Resident A. Per the first IR, dated 01/27/2023, Resident A threw chocolate milk on the walls, punched the walls, and kicked over a bucket of water. Staff tried to redirect him with no success. Resident A was transported to the hospital. He returned the same day. He broke a window, a TV and dishes. He was sent back to the hospital. Per the other IR, dated 01/31/2023, Resident A went into behavior. Staff was unable to redirect him. He broke a window and attempted to attack another resident. Resident A was transported to hospital.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Mr. Bates and Ms. Coleman denied that Ms. Coleman took Resident A's radio, threw water in Resident A's face, grabbed his wheelchair, shook him back and forth, slammed him into the wall, and hit Resident A in the arm with a spatula. Staff interviewed as well as Resident B, Resident C, Resident D, Resident E, and Resident F denied observing staff abuse, neglect, or mistreat Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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: **(a) Use any form of punishment.**

	(b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Mr. Bates and Ms. Coleman denied that Ms. Coleman took Resident A's radio, threw water in Resident A's face, grabbed his wheelchair, shook him back and forth, slammed him into the wall, and hit Resident A in the arm with a spatula. Staff interviewed as well as Resident B, Resident C, Resident D, Resident E, and Resident F denied observing staff abuse, neglect, or mistreat Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/01/2023, I conducted an onsite investigation. I interviewed area manager Nancy Turner and home manager Thomas Bates. Ms. Turner stated Resident A is highly behavioral. Mr. Bates stated, recently, Resident A has been having behaviors one or twice per day.

On 02/15/2023, I conducted a telephone interview with staff Chantia Coleman. Ms. Coleman stated Resident A displayed behaviors on 01/27/2023 and was transported to the hospital. He returned to the facility and eventually began displaying behaviors again.

On 02/15/2023, I conducted a telephone interview with staff Lakia Ealy. Ms. Ealy stated she has heard Resident A has behaviors quite often during day shift.

On 02/15/2023, I conducted a telephone interview with staff Jasmine Boykin. Ms. Boykin stated Resident A has behaviors when he does not get his way or when he does not receive attention.

On 02/21/2023, I conducted a telephone interview with staff Marcell Williams. Ms. Williams stated Resident A has behaviors a lot. He throws things and call people names.

On 02/23/2023, I conducted a telephone interview with staff Christina Douglas. Ms. Douglas stated Resident A socks windows and TVs as well as get violent.

On 02/23/2023, I conducted a telephone interview with staff Steven O'Leary, Mr. O'Leary stated if Resident A does not get what he wants, he goes into behavior. His behaviors include cursing and yelling as well as property damage.

On 03/01/2023, I conducted an unannounced onsite investigation. I interviewed Resident B, Resident C, Resident D, Resident E, and Resident F.

Resident B Resident A attacks staff and other residents.

Resident C stated Resident A beats and abuse people all the time. He also masturbates in public. Per Resident C, the police are always called to the facility due to his behaviors.

Resident D stated Resident A has episodes. He has broken windows.

Resident E stated Resident A yelled and destroyed the kitchen. He broke the window and the TV. Resident A was taken to the hospital.

Resident F stated Resident A scratched his butt and does not wash his hands. He steals food. He has no respect for other people's property. He beats on women. He beats on staff. Police comes to the facility due to his behaviors. He masturbates in public. He urinates in his bedroom as well as on the porch.

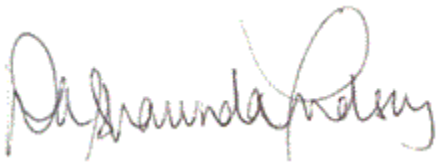
On 03/09/2023, I reviewed the facility's file in Sharepoint. I have only received two incident reports (IRs) for Resident A this year. The IRs were dated 01/27/2023 and 01/31/2023.

On 03/09/2023, I attempted to conduct an exit conference with licensee designee Tamisha Turner with no success. I left a message.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**
ANALYSIS:	Staff and residents stated Resident A has various behaviors. However, I have only received two incident reports for Resident A this year.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

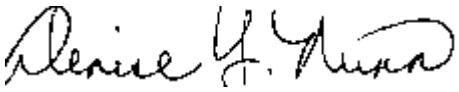
Contingent upon receipt of an acceptable corrective action plan, I recommend that this special investigation is closed. A previous recommendation for a provisional license was made in the Renewal Licensing Study report dated 03/06/2023, which remains in effect.



03/09/2023

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



03/10/2023

Denise Y. Nunn Date
Area Manager