GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2023

Jason Schmidt
New Life Services Inc
36022 Five Mile Road
Livonia, MI 48154

RE: License #: AS630012619
Investigation #: 2023A0611017
Alta Vista

Dear Mr. Schmidt:

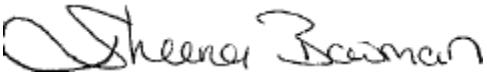
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012619
Investigation #:	2023A0611017
Complaint Receipt Date:	03/30/2023
Investigation Initiation Date:	03/31/2023
Report Due Date:	05/29/2023
Licensee Name:	New Life Services Inc
Licensee Address:	36022 Five Mile Road Livonia, MI 48154
Licensee Telephone #:	(734) 744-7334
Administrator:	Jason Schmidt
Licensee Designee:	Jason Schmidt
Name of Facility:	Alta Vista
Facility Address:	3361 Alta Vista Milford, MI 48380
Facility Telephone #:	(248) 685-8216
Original Issuance Date:	02/21/1990
License Status:	REGULAR
Effective Date:	06/25/2021
Expiration Date:	06/24/2023
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 3/23/23, Resident G found Staff "Keke" asleep on the couch in the living room. Resident G took a picture and sent it to his mother. Resident G went into the medication cabinet and got his own medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/30/2023	Special Investigation Intake 2023A0611017
03/31/2023	Special Investigation Initiated - Letter I made an Adult Protective Services referral via email.
04/03/2023	APS Referral The Adult Protective Services (APS) referral was denied.
04/06/2023	Inspection Completed On-site I completed an unannounced onsite. I interviewed the home manager, Shurlean Douglas, Resident R, and Resident G.
04/11/2023	Contact - Telephone call made I left a voice message for staff member, Chekeyla Waite requesting a call back.
04/11/2023	Contact - Telephone call made I made a return phone call to staff member, Chekeyla Waite. I attempted to discuss the allegations however; Ms. Waite kept over talking me and would not allow me to explain the allegations.
04/11/2023	Contact - Telephone call made I left a voice message for staff member, Justin Ishola requesting a call back.
04/11/2023	Exit Conference I completed an exit conference with Cheryl Schmidt via telephone and an email was sent to the licensee designee, Jason Schmidt.
04/12/2023	Contact - Telephone call made

	I made a return phone call to staff member, Justin Ishola. The allegations were discussed.

ALLEGATION:

On 3/23/23, Resident G found Staff "Keke" asleep on the couch in the living room. Resident G took a picture and sent it to his mother. Resident G went into the medication cabinet and got his own medications.

INVESTIGATION:

On 03/30/23, I received an intake regarding allegations stating Resident G found staff member "Keke" asleep on the couch in the living room. Resident G took a picture and sent it to his mother. Resident G went into the medication cabinet and got his own medications, and the police were called. It is unknown who contacted the police and/or why the police were called. Keke told police that she was able to sleep on duty.

On 04/06/23, I completed an unannounced onsite. I interviewed the home manager, Shurlean Douglas, Resident R, and Resident G.

On 04/06/23, I interviewed the home manager, Shurlean Douglas. Regarding the allegations, Ms. Douglas stated Resident G sent her a picture of staff member, Chekeyla Waite (Keke) sleeping from his cell phone. Ms. Waite was sleeping during her afternoon shift around 7:30pm. Resident G called Ms. Douglas around 8:00pm being demanding and complaining about not getting his medications because Ms. Waite was asleep. Ms. Douglas informed Resident G that if he does not get his medications by 9:00pm then he will have a reason to complain.

Ms. Douglas sent a text message to Ms. Waite about the picture of her sleeping. Ms. Waite stated she was on break. Ms. Douglas stated every staff member is aware that they are not allowed to sleep while on duty. Ms. Waite was the only staff member present in the AFC group home while she was sleeping. Ms. Douglas does not know how long Ms. Waite was asleep but, she was sleeping after dinner was served. Ms. Douglas stated the majority of the residents were in the common living room with Ms. Waite while she was asleep on the couch. Resident G was in the front living room. Ms. Douglas stated this was her first-time hearing about Ms. Waite sleeping on duty. The area supervisor talked to Ms. Waite about her behavior, but she was not disciplined.

Ms. Douglas stated while Ms. Waite was asleep on the couch, Resident G went into the kitchen and broke the medication cabinet and took his medication out and administered his own medications. Ms. Waite woke up and saw Resident G take his medications out of the cabinet. Resident G called the police because he was upset that Ms. Waite did not administer him his medications. The police talked to Resident G and Ms. Waite. Ms. Waite ensured that the rest of the medications were locked up. When the police left,

Resident G grabbed the remote control from Ms. Waite and locked himself into his bedroom.

Ms. Douglas returned to the AFC group home from grocery shopping. She knocked on Resident G bedroom door and asked him to give back the remote control. Resident G eventually gave the remote control back and he stayed in his bedroom. Ms. Douglas stated she checked Resident G's bubble packets and saw he took the right medications.

I observed the medication cabinet and saw that it was locked. The lock on Resident G's bedroom door is non-locking against egress. Ms. Douglas stated that Resident G has lived at the AFC group home for two years. A 30-day discharge notice was submitted for Resident G however; the 30 days have passed, and a placement has not been located for him.

On 04/06/23, I interviewed Resident R. It was hard to understand Resident R. Resident R stated he has lived at the AFC group home for over a year. Resident R likes the staff at the AFC group home. Resident R stated he saw Ms. Waite sleeping this morning and on a different day but he cannot remember which day. Resident R stated Ms. Waite was sleeping on the couch.

On 04/06/23, I interviewed Resident G. Regarding the allegations, Resident G stated he has lived at the AFC group home for one and a half years. Resident G stated it is horrible living at the AFC group home. Resident G stated Ms. Waite and staff member Justin Ishola treat him like he is a nobody. Ms. Waite is argumentative and petty. Resident G stated Mr. Ishola does not talk to him. Resident G stated he does not feel safe around these staff members, but he would not provide a straight answer as to why. Resident G stated that Mr. Ishola has yelled at him and snatched an ice tray out of his hands before. Resident G denied any physical contact between him and staff.

During the onsite, Resident G showed me a picture of Ms. Waite sleeping on the couch on March 23, 2023. I observed a video on Resident G's cell phone of him recording Ms. Waite in the bathroom. Ms. Waite said something about Resident G standing there with his underwear on like a "pedophile". Ms. Waite then walked out of the bathroom. Resident G stated he was trying to take a shower while Ms. Waite was cleaning the bathroom. The video was recorded on March 2, 2023.

Resident G stated he broke into the medication cabinet because Ms. Waite was sleeping on the couch. Ms. Waite was asleep four a half hour while the resident were in the living room and one resident was in their bedroom. Resident G stated he was having problems with his mood and needed his medications. Resident G stated he took his medications and Ms. Waite became upset. Resident G called the police. Resident G talked to the police and then went to bed.

On 04/11/23, I return a phone call from staff member, Chekeyla Waite. I attempted to discuss the allegations with Ms. Waite however; she kept over talking me and would not allow me to discuss the allegations. Ms. Waite stated she receives an hour break and

during that time she is allowed to do what she chooses to. Ms. Waite stated she likes to pray and mediate during her break. Ms. Waite denied sleeping as she refers to it as mediating. Ms. Waite stated she does not remember if another staff was present on the day Resident G took a picture of her sleeping on her break. Ms. Waite became extremely defensive and uneasy. I ended the phone call as Ms. Waite did not want to answer any questions.

On 04/12/23, I made a return phone call to staff member, Justin Ishola. Regarding the allegations, Mr. Ishola stated he works the days and afternoon shift. Mr. Ishola stated sometimes he works with Ms. Waite. However, Mr. Ishola and Ms. Waite normally see each other during shift change. Mr. Ishola denies ever witnessing Ms. Waite sleeping while on duty. Mr. Ishola has never heard of Ms. Waite sleeping while on duty. Mr. Ishola stated typically Ms. Waite works with another staff member. Mr. Ishola stated the employees are not allowed to sleep while on duty. Mr. Ishola has no knowledge of a picture being taken of Ms. Waite while she was sleeping on duty. Mr. Ishola is not aware of any video being taking of Ms. Waite.

Mr. Ishola stated that he does not have casual conversations or interaction with Resident G. Mr. Ishola stated he only discusses food and medications with Resident G and he makes sure his needs are met. Mr. Ishola stated sometimes he has to re-direct Resident G. Mr. Ishola denied ever snatching anything out of Resident G hands or having any type of altercation with him.

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:	On 04/06/23, Resident G sent the home manager Shurlean Douglas, a picture of staff member, Chekeyla Waite (Keke) sleeping from his cell phone. Ms. Waite was sleeping during her afternoon shift around 7:30pm. When Ms. Douglas asked Ms. Waite about the picture of her sleeping, Ms. Waite stated she was on break. Ms. Douglas confirmed that Ms. Waite was the only staff member present in the AFC group home while she was sleeping. Although, Ms. Waite denied sleeping while on duty, I observed the picture of Ms. Waite sleeping on Resident G's cell phone. Therefore, the residents were not being supervised during the time Ms. Waite was asleep on duty.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Resident G admitted to breaking the medication cabinet and administering his own medications while Ms. Waite was asleep on the couch. Ms. Waite was unable to administer Resident G's medication and/or supervise him while he took his medications because she was asleep and; there was no other staff member present.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/06/23, I observed a video on Resident G's cell phone of him recording Ms. Waite in the bathroom. Ms. Waite said something about Resident G standing there with his underwear on like a "pedophile". Ms. Waite then walked out of the bathroom. Resident G stated he was trying to take a shower while Ms. Waite was cleaning the bathroom. The video was recorded on March 2, 2023.

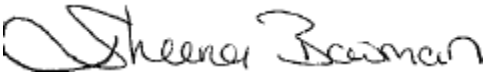
On 04/11/23, I completed an exit conference with the licensee designee, Jason Schmidt via email. I also spoke to Cheryl Schmidt regarding the allegations. Mrs. Schmidt stated Ms. Waite admitted to sleeping on duty. I discussed the video I saw on Resident G's cell phone with Ms. Waite. Mrs. Schmidt stated Resident G is a sex offender and he has a history of walking up to staff and residents and pulling his pants down. Mrs. Schmidt agreed that Ms. Waite should not be calling Resident G names specifically a pedophile. Mrs. Schmidt stated Ms. Waite is a good staff member. Mrs. Schmidt stated she completed a 30-day discharge letter a year ago however; she is actively working with MORC to find another placement for Resident G.

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:** **(ii) Verbal abuse.**

ANALYSIS:	Based on the information gathered and observed, Ms. Waite did subject Resident G to verbal abuse as she called him a pedophile.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

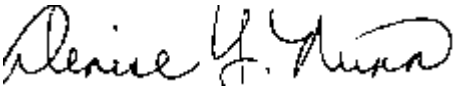
Contingent upon an acceptable corrective action plan, I recommend no change in the license status.



Sheena Bowman
Licensing Consultant

04/14/23
Date

Approved By:



04/19/2023

Denise Y. Nunn
Area Manager

Date