GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 27, 2024

Shannon White-Schellenberger
Angels' Place
Suite 2
29299 Franklin Road
Southfield, MI 48034

RE: License #: AS630307091
Investigation #: 2024A0465010
R.C. Mahon Home

Dear Mrs. White-Schellenberger:

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630307091
Investigation #:	2024A0465010
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/12/2024
Report Due Date:	03/09/2024
Licensee Name:	Angels' Place
Licensee Address:	Suite 2 29299 Franklin Road Southfield, MI 48034
Licensee Telephone #:	(248) 350-2203
Administrator:	Shannon White-Schellenberger
Licensee Designee:	Shannon White-Schellenberger
Name of Facility:	R.C. Mahon Home
Facility Address:	4765 Tullamore Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 594-0264
Original Issuance Date:	08/18/2010
License Status:	REGULAR
Effective Date:	02/09/2023
Expiration Date:	02/08/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 1/4/2024, direct care staff, Jordan Whaley, and Naquille Wales, left Resident A alone at the facility.	Yes

III. METHODOLOGY

01/09/2024	Special Investigation Intake 2024A0465010
01/09/2024	APS Referral Denied Adult Protective Services (APS) referral
01/12/2024	Special Investigation Initiated - Letter Email exchange with Adult Protective Services Intake Supervisor, Tosha Peterson
01/16/2024	Inspection Completed On-site Conducted a walk-through of the facility; Interviewed direct care staff, Naquille Wales, and reviewed facility documents.
01/26/2024	Contact - Document Received Facility documents received via email
01/26/2024	Contact - Telephone call made I called direct care staff, Jordan Whaley, via telephone. Left voice mail requesting return call
02/06/2024	Contact - Telephone call made I spoke to direct care staff, Nyuntae Bray via telephone
02/16/2024	Contact - Telephone call made I spoke to direct care staff, Jordan Whaley, via telephone
02/20/2024	Exit Conference I conducted an exit conference with Licensee Designee, Shannon White-Schellenberger, via telephone

ALLEGATION:

On 1/4/2024, direct care staff, Jordan Whaley, and Naquille Wales, left Resident A alone at the facility.

INVESTIGATION:

On 1/9/2024, a complaint was received, alleging that on 1/4/2024, direct care staff, Jordan Whaley, and Naquille Wales, left Resident A alone at the facility. The complaint indicated that Ms. Whaley and Ms. Wales had a verbal altercation over Ms. Jordan needing to complete chores at the facility. Ms. Whaley and Ms. Wales both threatened to leave the facility. It is unclear which staff left the facility first, but both staff left the home and Resident A ended up being alone at the facility for an unknown amount of time.

On 1/12/2024, I spoke to Adult Protective Services Intake Supervisor, Tosha Peterson, via email. Ms. Peterson acknowledged that the information contained in the complaint is accurate.

On 1/16/2024, I conducted an onsite investigation at the facility. At the time of my onsite investigation, there were four residents residing at the facility, including Resident A. All of the residents have cognitive and verbal limitations and were unable to be interviewed for this investigation. I completed a walk-through of the facility, interviewed direct care staff, Naquille Wales, and reviewed facility documents.

The *Face Sheet* indicated that Resident A was admitted to the facility on 8/10/2010 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Dementia, Down Syndrome and Bi-Polar Disorder. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has a history of aggressive behavior, needs assistance with personal care tasks and does not use assistive devices. I reviewed the *Incident/Accident Report/ Counseling Action Disciplinary Note*, dated 1/4/2024, signed by both Ms. Whaley and Ms. Bray, which stated the following:

> *Staff, Jordan Whaley, stated she wasn't doing the chore list that was given to her, and she said she was leaving. Ms. Whaley was told by assistant manager (Naquille Wales) that she had to wait for manager (Nyuntae Bray) to get back from transport because she was leaving. Ms. Wales left anyways, leaving {Resident A} home alone. Ms. Whaley's leaving client alone could have resulted in {Resident A} getting hurt or wandering off. Ms. Whaley was interviewed and stated: "I arrived at the home and was given a list to complete, due to being overwhelmed at home and at work, I said I'm not doing this list, I'm going back home. Asst. Manager {Ms. Wales} still proceeded to put on coat. I repeated myself and told her that there was no point in putting on her coat because I'm not doing this list and I'm going home. Ms. Wales response was, "Oh, well I'm still*

about to go. Ms. Bray will be here soon," and then she proceeded to leave with me following 1 -2 minutes after. Ms. Whaley was counseled and made aware if this happens again, she will be terminated.

I interviewed direct care staff, Naquille Wales, who stated that she has worked at the facility for six years. Ms. Wales stated, "I did work on 1/4/2024, and Resident A was left alone at the facility for about 30 minutes because staff, Jordan Whaley, left her shift and left Resident A alone. On that day, I came into work at 7:00am. The other three residents were not home at the time of this incident. Only Resident A was home. Ms. Whaley arrived at the facility around 1:15pm. When she arrived, I gave her a list of duties for her to do. She was given a list of duties to do because the prior week she told me that she didn't have enough work to do. After I gave her the list, I told her that I planned to leave and go to Walmart to buy stuff for the house. At that time, Ms. Whaley told me that she was not going to do the list. I told her she needed to follow up with the manager and then I left. I left the home at 1:27pm. Once I go into my car, I called the manager, Nyuntae Bray, and told her what happened. As I was driving to Walmart, I received a call back from Ms. Bray at 2:00pm. She told me that she had arrived at the home and Ms. Whaley was gone, and that Resident A was at the facility alone. Ms. Bray told me to turn around and head back to the facility, so I did. I don't know what time Ms. Whaley left, but I know that when I left the home, she was still inside the facility. If I had known that Ms. Whaley was going to leave, I would not have left." Ms. Wales acknowledged that Resident A was at the facility alone, without staff on duty, for approximately 30 minutes on 1/4/2024.

On 2/6/2024, I spoke to direct care staff, Nyuntae Bray via telephone. Ms. Bray stated that she has worked at the facility for two years. Ms. Bray stated, "I was working on 1/4/2024, the day of the incident. On that day, I was working with Ms. Wales. I left the facility to transport a resident somewhere. So, I was not at the home at the time that the incident occurred. At 1:30pm, I was heading back to the facility, and I received a call from Ms. Wales. She stated that she gave Ms. Whaley a list of duties to complete, and that Ms. Whaley stated she was not going to do them. Ms. Wales stated that Ms. Whaley said she was going to leave the facility and walk-off the job. When Ms. Wales called me, she had already left the facility and was in the car driving to Walmart. Ms. Wales told me that Ms. Whaley threatened to leave work, but she didn't think Ms. Whaley would really leave the facility and leave Resident A alone. When I arrived at the facility, at 2:00pm, I observed Resident A sitting in his bedroom, looking out the window. Resident A appeared to be fine. I then walked through the rest of the home and determined that there was no staff at the house. I was unable to locate Ms. Whaley inside the home. I made several attempts to contact Ms. Whaley and I finally got a hold of her via phone around 5pm. When I spoke to Ms. Whaley about the incident, she told me told she was upset with Ms. Wales and told Ms. Wales that she was going to leave the home and not complete her shift. Ms. Whaley did apologize for leaving her shift. Resident A was alone at the facility from 1:30pm – 2:00pm." Ms. Bray acknowledged that this complaint is true.

On 2/16/2024, I spoke to direct care staff, Jordan Whaley, via telephone. Ms. Whaley stated that she worked at the facility for six months prior to this incident occurring. Ms. Whaley stated, “I arrived at work at 1pm. My shift was supposed to be from 1pm – 9pm. When I arrived at work, Ms. Wales gave me a list of additional duties to do, and I became upset. I told Ms. Wales that I was not going to do the list. I then told her that I was going to leave and not complete my shift. Then Ms. Whaley began to put her coat on and told me that she was going to leave to the store, and I again told her not to leave because I was about to leave work. I then ordered a Lyft ride. Despite me telling Ms. Whaley that I was planning to leave work, she still left the home too. Ms. Whaley got in her car and then I walked to get in my Lyft ride. We both left the home around the same time and we both left Resident A alone without staff supervision. I was upset and overwhelmed that day and I have never done anything like this before. I am suspended indefinitely from work because of my actions.” Ms. Whaley acknowledged that this complaint is true.

On 2/20/2024, I conducted an exit conference with licensee designee/administrator, Shannon White-Schellenberger. Ms. White-Schellenberger is in agreement with the findings of this report.

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:	According to the *Incident/Accident Report/Counseling Action Disciplinary Note* and Ms. Wales, Ms. Whaley, and Ms. Bray, on 1/4/2024, Resident A was left alone at the facility without sufficient staff on duty from 1:30pm – 2:00pm. According to Ms. Whaley, on 1/4/2024, she intentionally left Resident A alone in the facility, knowing that there were no other staff on duty to provide care to Resident A. Ms. Wales, Ms. Whaley and Ms. Bray acknowledged that this complaint is true. Based on the information above, there is sufficient information to confirm that the facility did not have sufficient staff on duty on 1/4/2024 from 1:30pm – 2:00pm, to provide supervision, personal care and protection to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

2/22/2024

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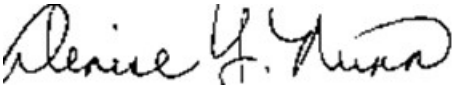
Stephanie Gonzalez Date
Licensing Consultant

Approved By:



02/27/2024

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Denise Y. Nunn Date
Area Manager