GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2025

Sherri Turner
Adult Learning Systems-Lower Michigan
Suite F
8170 Jackson Road
Ann Arbor, MI 48103

RE: License #: AS500416792
Investigation #: 2025A0990004
Romeo

Dear Ms. Turner:

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.
- 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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

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 #:	AS500416792
Investigation #:	2025A0990004
Complaint Receipt Date:	11/20/2024
Investigation Initiation Date:	11/20/2024
Report Due Date:	01/19/2025
Licensee Name:	Adult Learning Systems-Lower Michigan
Licensee Address:	Suite F - 8170 Jackson Road Ann Arbor, MI 48103
Licensee Telephone #:	(734) 408-0112
Administrator:	Tracie Shier
Licensee Designee:	Sherri Turner
Name of Facility:	Romeo
Facility Address:	17623 21 Mile Rd. Macomb Township, MI 48044
Facility Telephone #:	(734) 408-0112
Original Issuance Date:	08/25/2023
License Status:	REGULAR
Effective Date:	02/25/2024
Expiration Date:	02/24/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The staff has called 911 for services 58 times so far during the current year, 2024. 0n at least 27 of the 58 calls were regarding Resident A and numerous times, he was taken into custody for assault as well as larceny from another residence.	Yes

III. METHODOLOGY

11/20/2024	Special Investigation Intake 2025A0990004
11/20/2024	Special Investigation Initiated - Letter I emailed the Reporting Person.
11/20/2024	Contact - Document Sent I requested Resident A's resident record with Traci Shier, administrator.
12/04/2024	Contact - Face to Face I conducted an unannounced onsite investigation. I interviewed Resident B, Resident C, Resident D, Resident E, Resident F, direct care staff Lyric Ross and home manager Janice Cooper.
01/03/2025	Contact - Document Received I reviewed Resident A's resident record.
01/03/2025	Contact - Document Sent I left a detailed message with Larania Reweerts, Supports Coordinator.
01/03/2025	Contact - Telephone call made I called direct care staff Erykah Kouyara. Ms. Kouyara's voice mail box was full. I sent her test and an email. No response to date.
01/03/2025	Contact - Document Sent I emailed Nuha Shamoon, Adult Protective Services (APS) investigator. Ms., Nuha responded via email.
01/03/2025	Contact - Telephone call made I left a detailed message with Guardian A.

01/03/2025	Contact - Telephone call received I conducted a phone interview with Ms. Reweerts.
01/03/2025	Contact - Document Sent I emailed Ms. Shier, follow-up questions.
01/05/2025	Contact - Document Received I received a reply email from Ms. Shier.
01/07/2025	Contact - Document Received I received reply from Ms. Shamoon.
01/10/2025	Exit Conference I conducted an exit conference with Sheri Turner, licensee designee.

ALLEGATION:

The staff has called 911 for services 58 times so far during the current year, 2024. 0n at least 27 of the 58 calls were regarding Resident A and numerous times, he was taken into custody for assault as well as larceny from another residence.

INVESTIGATION:

On 11/20/2024, I received the complaint via email. No additional information was reported.

On 11/20/2024, I emailed the Reporting Person (RP). The RP responded via email. The RP said Resident A is incarcerated at the Macomb County Jail. The concern is that the Macomb County Sheriff's Department has received over 50 calls to this home this year. The calls range from residents arguing over marijuana vape pens to assault and larceny. Most of the calls have been regarding Resident A. The RP attached 16 police reports that involve Resident A.

On 12/04/2024, I conducted an unannounced onsite investigation. I interviewed Resident B. Resident B is aware of Resident A. Resident B said, "I stayed away from him." Resident B said that he had never witnessed any altercations with Resident A but heard them. Resident B described hearing arguments that Resident A had with other residents and staff. Resident B denied ever having an altercation with Resident A. Resident B said, "Resident A picked on weaker people." Resident B did not express any concerns about the home or his safety.

On 12/04/2024, I interviewed Resident C. Resident C has lived in the home for one year. Resident C said that he had witnessed Resident A's temper. Resident C described witnessing Resident A punch" Ms. Candace," a staff person, in her face. Resident C

said he witnessed Resident A flinch at Ms. Lyric (staff). Resident C said he heard that Resident A got into a physical altercation with Erykah (direct care staff). Resident C said that Resident A was drinking beer and smoking at home. Resident C said that Resident A has never physically assaulted him, but he once yelled at him, "Shut the fuck up." Resident C said he would rather Resident A live elsewhere because he's 22 years old and very aggressive.

On 12/04/2024, I interviewed Resident D. Resident D said he and Resident A were roommates. Resident D said that Resident A is at the Macomb County Jail. Resident D said, "Resident A is crazy." Resident D said that Resident A threatened to harm the home with explosives. He also pulled the strings on his hoodie, tightened it around his neck, and witnessed Resident A kick a staff person named Angela. Resident D said he did not witness the most recent altercation involving Resident A. Still, he saw the police on the scene through the window. Resident D said that Resident A never stole anything from him. Resident D said that he felt so and had no other concerns.

On 12/04/2024, I interviewed Resident E. Resident E has lived in the home for one year. He said that he had witnessed many things involving Resident A. Resident E said that he witnessed Resident A push staff member Lyric and do it near her breasts. Resident A tried to steal his Pepsi. Resident E said that Resident A assaulted many staff members but does not recall each incident. As the interview progressed, I observed that Resident E was becoming manic. I ended the interview.

On 12/04/2024, I interviewed Resident F. Resident F said he moved into the home in September 2024. Resident F said that he witnessed Resident A chase a staff person (name he did not recall), and she ran into the laundry room to protect herself. Resident F said he tried to help and invited Resident A to attend church. Resident F had no concerns regarding his care and safety.

On 12/04/2024, I interviewed Lyric Ross, the direct care staff member. Ms. Ross has worked at the home for almost one year. Ms. Ross said that Resident A is not returning to the house. His bedroom has been cleared out, and his items are gone. Ms. Ross said she was absent for the most recent altercations involving Resident A. However, he assaulted her once. Ms. Ross said that he pushed her very hard, and he was arrested. Ms. Ross said she did not have any injuries.

On 12/04/2024, I interviewed home manager Janice Cooper. Ms. Cooper is the home manager. Ms. Cooper was absent during the most recent incident but witnessed Resident A's behaviors. Ms. Cooper said Resident A was using edible marijuana and was sneaking vape pens into the home. A staff member caught Resident A smoking in the bathroom. Resident A also tends to make false accusations about things. Ms. Cooper said that management had discharged Resident A from home. She said that she was not sure why he was not discharged sooner. Still, many incident reports have been made regarding his behavior. Ms. Cooper noted that Resident A has accumulated several emergency medical (EMS) bills and court fees due to the many police calls to the home. Ms. Cooper said that Resident A never assaulted her, but he told her to go

back to Africa and called her a "nigger” and a "bitch” in front of the police. Ms. Cooper also witnessed one time when Resident A was arrested; he was banging on the windows of the police car. Ms. Cooper said that the staff person, Erykah, who he recently assaulted, is off work due to the incident.

On 01/03/2025, I reviewed Resident A's Resident record, including the Original Licensing Study Report, Healthcare *Appraisal*, Individual Plan of Services (IPOS), Office of Recipient Rights (ORR) investigative report, incident reports, and police reports. I also reviewed the Macomb County Jail inmate search. Resident A was arrested on 11/06/2024 and charged twice for assault and battery and once for Disorderly Conduct. Resident A is diagnosed with unspecified bipolar disorder and intellectual and intellectual disability. Resident A chooses not to work, has a history of assault on his family, and is non-compliant with medication. Resident A has a severe impairment in interpersonal relationships, consistently disruptive with others, and this includes impulsive, aggressive, or abusive behaviors. Resident A was referred to outpatient therapy and psychiatry. An ORR investigation was conducted in September of 2024 in which Resident A accused staff of submerging his cell phone in water. The ORR investigation was not substantiated. In the narrative of the ORR report, it was documented that Resident A admitted to being passed out and sleeping on a cell phone because of eating marijuana gummies. It was documented that staff had to call EMS because he would not wake up.

I reviewed the program statement, and it is as follows: The program is designed for residents who have chronic mental illness and or developmental disabilities who no longer require inpatient psychiatric care but need the structure of a group home setting. The following police reports for Resident A are documented as follows:

- 05/03/2024- Report of self-inflicted injuries. Petitioned into hospital for mental health.
- 05/07/2024- Destruction of property and larceny towards staff. Report taken.
- 08/07/2024- Pulled a knife on staff. Disorderly conduct. Petitioned into hospital for mental health.
- 0828/2024- Injected edibles and causing disturbance; petitioned into hospital for mental health.
- 08/29/2024- Suicide ideation. Petitioned into hospital for mental health.
- 08/30/2024- Suicide ideation and ingesting of marijuana gummies. Petitioned into hospital for mental health.
- 09/15/2024- Barricaded inside the room and altered mental state. Petitioned into hospital for mental health.
- 09/28/2024- Welfare check to lighting a cigarette in the home.
- 10/06/2024- Destruction of property an. Petitioned into hospital for mental health.
- 10/28/2024- Hostile. Petitioned into hospital for mental health.

I reviewed three incident reports regarding Resident A. I observed that there were 16 incidents of “serious display of verbal behavior and hostility and/or police involvement.

There were several incidents of marihuana use in the home and medication refusal. There are incidents where Resident A was unresponsive due to marijuana usage.

Resident A was issued an emergency discharge notice on 10/22/2024. The reason for discharge is as follows:

- The home cannot meet the residents' needs to ensure the safety and well-being of other residents.
- In the past 48 hours, Resident A was arrested for assaulting staff.
- Resident A refuses to quit smoking/ingesting marijuana, which has resulted in several incidents that involve police contact due to verbal/physical aggression.

On 01/03/2025, I conducted a phone interview with Ms. Reweerts. Ms. Reweerts said that Resident A is still incarcerated. Resident A will not return to Romeo, and placement will be looked for once he is released from Macomb County Jail. Ms. Reweerts said Romeo issued a 30-day discharge in October, and they were looking for a placement. Ms. Reweerts said a placement was found right after he went to jail. Resident A was to receive outpatient therapy but missed several appointments and would say, "Therapy is a waste of time." Resident A had a behaviorist through Sparks Behavioral Center and was willing to participate; however, it is not known if he ever did.

On 01/03/2025, I emailed Ms. Shier with follow-up questions. Ms. Shier replied via email on 01/06/2025. I asked why a discharge notice was not issued before October 2024. Ms. Shier said they worked with the case manager to meet Resident A's needs. Still, after Ms. Cooper (home manager) and the case manager met with Resident A in October to discuss ways to help meet his goals to decrease his behaviors, it continued. Resident A continued to injure a staff member and is now discharged. Resident A refused outpatient therapy. Ms. Shier did not answer why a discharge notice was not issued before October 2024.

On 01/07/2025, I received a reply from Ms. Shamoon. Ms. Shamoon said her allegations were as follows: Another resident gave Resident A $20 when he got some money. Resident A went to Wild Bills Smoke Shop and purchased synthetic CBD gummies. Resident A began to have behaviors. Staff sent him to the ER at Henry Ford. The hospital would briefly examine him and then immediately discharge him. This happened a few times. Resident A would try to attack staff, and law enforcement would petition him back in the hospital. He was once admitted to McLaren Hospital, where he stayed for over a week. Ms. Shamoon received her complaint because the hospital was concerned about the complaint because there were concerns about repeat ER visits; however, they did nothing for him, not even a blood screen. Ms. Shamoon said it was alleged neglect by AFC staff, but she did not substantiate the investigation. Ms. Shamoon noted that she believed the staff did their best to work with him. Ms. Shamoon said that she spoke with Guardian A, who informed her that she wanted him placed in a more specialized position. Still, they wanted him to be more stable due to his aggressive behaviors.

On 01/10/2025, I conducted an exit conference with Ms. Turner. Ms. Turner said they were following his crisis plan to call 911. We discussed in detail the numerous hospitalizations and assaults on staff. Ms. Turner said that she did not submit a discharge notice before October 2024 because they wanted to help Resident A. Ms. Turner expressed that her program is designed to help residents with mental illness. We discussed that Resident A required a specialized setting due to the number and the gravity of incidents. Ms. Turner expressed that even if she had given a discharge notice sooner, it would have taken a while before the county would find placements. Ms. Turner said that she has had several meetings with Resident A's case manager about Resident A. Resident is difficult to place to his behaviors. Resident A refuses to participate in outpatient therapy. Ms. Turner said that Resident A's first incident was in March 2024, in which he threatened the police. Resident A has spent time in jail and the hospital. Ms. Turner said most times when Resident A was hospitalized, they would send him back, saying that he did not meet the criteria of treatment. We discussed the discharge and emergency discharge policy.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Based on the investigation, there is evidence to support that Resident A was not compatible with the other residents in the home due to multiple verbal, physical, and attempted suicide attempts. Resident A was petitioned into the hospital multiple times from March 2024 to October 2024. Based on interviews with Resident B, Resident C, Resident D, and Resident E, all reported various incidents regarding Resident A's behaviors, including verbal/ physical assaults towards staff and residents, witnessing assault by Resident A toward staff, and smoking marijuana and drinking beer in the home. Direct care staff Lyric Ross said that Resident A pushed her very hard. The home manager, Janice Cooper, noted that

	Resident A called her vulgar names and witnessed his aggressive behaviors. The program statement is designed for residents who have chronic mental illness and or developmental disabilities who no longer require inpatient psychiatric care but need the structure of a group home setting. Resident A has a severe impairment in interpersonal relationships, consistently disruptive with others, and this includes impulsive, aggressive, or abusive behaviors. According to APS specialist Ms. Shamoon, Guardian A believed Resident A belongs in a specialized group home setting. Resident A is incarcerated for two assault and battery charges and disorderly conduct.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.**
ANALYSIS:	Based on the investigation, there is evidence to support that Resident A exhibited self-destructive behavior, serious physical assaults, and destruction of property. Resident A was admitted to the home on 02/19/2024. Resident A's first incident was on 03/23/2024. Resident A has been petitioned in the hospital for mental health eight times. I reviewed 10 police reports which reported that Resident A ingested edible marijuana, altered mental state, hostility, suicide

	ideation, destruction of property, disorderly and assaulted, and battery staff. I reviewed an ORR report in which Resident A resident falsely accused staff of submerging his cell phone in water but later recanted, saying that he was high on marijuana gummies and was sleeping on his phone. There has been a substantial risk of multiple occurrences of self-destructive behavior, serious physical assaults, and destruction of property, and the program could not meet the needs of the Resident. Resident A refuses outpatient therapy. Resident A refuses medications. Lastly, there were 16 incident reports in which Resident A displayed serious hospitality verbal or behavioral behavior that resulted in law enforcement contact.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

L. Reed

01/10/2025

LaShonda Reed — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

02/04/2025

Denise Y. Nunn — Date
Area Manager