GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 31, 2025

Pamela Hurley
Innovative Lifestyles, Inc.
P.O. Box 1258
Clarkston, MI 48347

RE: License #: AS630015466
Investigation #: 2025A0602003
Cuthbert AIS/MR

Dear Mrs. Hurley:

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630015466
Investigation #:	2025A0602003
Complaint Receipt Date:	11/25/2024
Investigation Initiation Date:	12/09/2024
Report Due Date:	01/24/2025
Licensee Name:	Innovative Lifestyles, Inc.
Licensee Address:	Suite 1 5490 Dixie Hwy Waterford, MI 48329
Licensee Telephone #:	(248) 931-2061
Administrator:	Pamela Hurley
Licensee Designee:	Pamela Hurley
Name of Facility:	Cuthbert AIS/MR
Facility Address:	6720 Cuthbert White Lake, MI 48386
Facility Telephone #:	(248) 922-7119
Original Issuance Date:	10/25/1994
License Status:	REGULAR
Effective Date:	08/03/2023
Expiration Date:	08/02/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 11/21/2024, Resident A was in the AFC home unsupervised due to the caregivers being asleep in the home.	Yes

III. METHODOLOGY

11/25/2024	Special Investigation Intake 2025A0602003
11/25/2024	APS Referral Adult Protective Services (APS) referral - denied.
11/26/2024	Contact – Telephone call made Call made to the home.
12/09/2024	Inspection Completed on-site Interviewed staff member Margo Alexander, and observed Resident A, Resident B, Resident C, and Resident D.
01/08/2024	Contact – Telephone call made Call made to staff member, Ashley Neilson – Message left.
01/08/2025	Contact – Telephone call made Spoke with Resident A and Resident B's behavioralist, Ann Leisen.
01/24/2024	Contact – Telephone call made Message left for the home manager Shanean Butler.
01/24/2025	Exit Conference Held with the licensee designee, Pamela Hurley by telephone.

ALLEGATION:

On 11/21/2024, Resident A was in the AFC home unsupervised due to the caregivers being asleep in the home.

INVESTIGATION:

On 11/25/2024, a complaint was received and assigned for investigation alleging that on 11/21/2024 Resident A was in the AFC home unsupervised due to the caregivers being asleep in the home.

On 12/09/2024, I conducted an unannounced on-site investigation at which time I interviewed staff member Margo Alexander, and observed Resident A, Resident B, Resident C and Resident D. Ms. Alexander stated she has worked for the company about 9 years. In July 2024, she began working at another home full time and only work at the Cuthbert Home to pick up extra hours. Ms. Alexander said she has no firsthand knowledge of the alleged incident but does know that there were staff members who were caught sleeping during their shift and now no longer work at the home. Ms. Alexander went on to state that staff must always remain awake during their shift. This is all the information Ms. Alexander had regarding the incident.

On 12/09/2024 I observed Resident A, Resident B, Resident C, and Resident D. All four residents are non-verbal and were unable to provide any information regarding the alleged incident. Resident A and Resident C were sitting on the couch in the living room, Resident B was walking back and forth between his bedroom, the bathroom and the family room and Resident D was walking back and forth between his bedroom and the family room.

On 12/09/2024, I reviewed Resident A, Resident B, Resident C and Resident D's individual plans of service (IPOS). According to the plans, each resident must be visually checked every 15 minutes when out of the sight of staff and cannot be left alone.

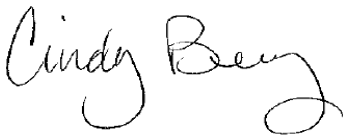
On 1/08/2025, I spoke with Resident A and Resident B's behavioralist, Ann Leisen who works for Easterseals/MORC. Ms. Leisen stated on 11/21/2024 she made a call to the home to let staff know she would be stopping by to see Resident A and Resident B but there was no answer. Ms. Leisen made the visit to the home around 5 pm and when she arrived, there was no response to her knocking on the front door. She said she could hear the residents moving around inside the home. The garage door was open, so she decided to knock on the door inside the garage. Again, there was no response. The door was unlocked so she entered the home while calling out for staff but there was no response. Once inside the home she observed two staff members, Dajanea Hicks and Chariah Matthews on the couch in the family room sound asleep. Resident A was watching the news in the living room while Resident B was in bed naked with a puddle of urine in the middle of his bedroom floor. Ms. Leisen said she had to tap one of the direct care workers (could not recall which one) before she woke up. She informed the direct care workers that they needed to get up and take care of the residents. The direct care worker became angry with her and said, "You're not here to see me" and began yelling and cursing at her. Ms. Leisen left the home and called the provider immediately. Ms. Hicks and Ms. Matthews were both terminated. Ms. Leisen has since made visits to the home and have not had any other issues. The residents are neat, clean and appear to be well taken care of.

On 1/24/2025 I conducted an exit conference with the licensee designee, Pamela Hurley by telephone. I informed Ms. Hurley of the allegations, investigative findings, and recommendation documented in this report. Ms. Hurley stated she was aware of the incident and Ms. Hicks and Ms. Matthews were terminated on 11/22/2024. She went on to state that she trusts Ms. Leisen and believes what she reported. She agreed to submit a corrective action plan along with documentation of compliance upon receipt of this report.

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:	Based on the information obtained during my investigation, there is sufficient information to determine that Ms. Hicks and Ms. Matthews were sleeping during their shift leaving the residents unsupervised. Ms. Leisen stated on 11/21/2024 she made an unannounced visit to the home, observed Ms. Hicks and Ms. Matthews asleep on the couch in the family room while the residents were unattended. According to each resident's IPOS, they require visual checks every 15 minutes by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

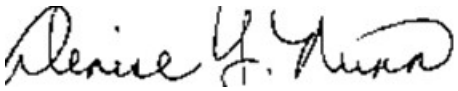
Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



1/24/2025

Cindy Berry — Date
Licensing Consultant

Approved By:



01/31/2025

Denise Y. Nunn — Date
Area Manager