GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2025

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

RE: License #: AS500082431
Investigation #: 2025A0617003
Meadow Lane

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500082431
Investigation #:	2025A0617003
Complaint Receipt Date:	02/05/2025
Investigation Initiation Date:	02/07/2025
Report Due Date:	04/06/2025
Licensee Name:	Adult Learning Systems-Lower Michigan
Licensee Address:	Suite F 8170 Jackson Road Ann Arbor, MI 48103
Licensee Telephone #:	(734) 408-0112
Administrator:	Donna Nickens
Licensee Designee:	Sherri Turner
Name of Facility:	Meadow Lane
Facility Address:	48173 Meadow Lane Chesterfield, MI 48047
Facility Telephone #:	(734) 408-0112
Original Issuance Date:	02/08/1999
License **Status:**	REGULAR
Effective Date:	08/08/2023
Expiration Date:	08/07/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Jimmy Williams punched Resident A in the face (left eye), leaving a bruise.	Yes

III. METHODOLOGY

02/05/2025	Special Investigation Intake 2025A0617003
02/07/2025	Special Investigation Initiated - Telephone Call made to the Complainant
02/11/2025	Inspection Completed On-site I conducted an unannounced onsite investigation at the Meadow Lane facility. I interviewed, day manager Carol Szymczak, Licensee Designee Sheri Turner (via phone), Resident B, and Resident C.
02/11/2025	Contact - Telephone call made TC to Ms. Sultes
02/21/2025	Contact - Telephone call made I interviewed Resident A's guardian
02/21/2025	Contact - Telephone call made TC to Amber Sultes
02/21/2025	Contact - Telephone call made TC to Ms. Logan
02/21/2025	Contact - Telephone call made TC to Mr. Williams
02/24/2025	Contact - Telephone call made I interviewed Resident A.
03/06/2025	Contact - Telephone call made I interviewed manager Ms. Ebony Logan

03/13/2025	Contact - Telephone call made I interviewed staff Jimmy Williams
03/21/2025	Exit Conference I conducted an exit conference with licensee designee Sheri Turner

ALLEGATION:

Staff Jimmy Williams punched Resident A in the face (left eye), leaving a bruise.

INVESTIGATION:

On 02/05/25, I received a complaint on the Meadow Lane facility. According to the complaint, on 1/27/25, Resident A was having behavioral issues regarding not being given cigarettes by staff. Staff Jimmy Williams punched Resident A in the face (left eye), leaving a bruise. Police were called and staff petitioned Resident to the hospital. Staff did not accompany Resident A to the hospital (he is required to have 1:1 staff in the community) and he was left in the ER all night without staff.

On 02/11/25, I conducted an unannounced onsite investigation at the Meadow Lane facility. I interviewed, day manager Carol Szymczak, licensee designee Sheri Turner (via phone), Resident B, and Resident C.

According to Ms. Szymczak, she was not present when the incident occurred, but she was told that Resident A had been good all day. Then around 5pm, Resident A asked the evening manager Ebony for one of her personal cigarettes. Ebony told him no because staff are not allowed to give residents any of their personal items. Ms. Szymczak stated that Resident A got very upset and physically attacked Ebony when she tried to call the police. Staff Jimmy came over and got Resident A off of Ebony until the police came. When the police arrived, Resident A was still having behavioral issues and was eventually handcuffed and transported to McClearn Hospital. According to Ms. Szymczak, Resident A did not sustain any injuries, but staff Jimmy did. Due to his injuries, Jimmy left the facility and went to Urgent Care for treatment. Ms. Szymczak stated that no staff went with Resident A to the hospital, and he was left in emergency alone until he was admitted. Ms. Szymczak stated that she has had no contact with the hospital staff or Resident A. Ms. Szymczak spoke to Resident A's guardian a few days prior and according to the guardian, new placement was obtained for Resident A.

According to Resident B, Resident A was extremely upset that staff Ebony would not give him one of her cigarettes. Resident B stated that Resident A and Jimmy got into a fight where they were punching each other and both sustained injuries.

According to Resident C, he was in his room and didn't see anything, but he heard a lot of yelling and screaming from staff and residents.

According to Ms. Sheri Turner, Resident A wanted a cigarette and was told no. He got upset and became physical with staff, assaulting both Ebony and Jimmy. Staff called police, and the police took Resident A to the hospital. Ms. Turner was unaware of the whereabouts of Resident A. The facility gave Resident A an emergency discharge and Ms. Turner believes that he is being admitted to a new facility.

While onsite, I reviewed staff schedules and Resident A's file. According to Resident A's file, he has a history of aggressive behaviors in placements. During the onsite investigation, I inspected the facility. The home was clean and there were no concerns to report. During the onsite investigation, I reviewed several resident files, there were no concerns to report.

On 02/21/25, I interviewed Resident A's guardian. According to Resident A's guardian, the incident occurred because Resident A got upset about something. Resident A told his guardian that staff Ebony doesn't like him. Resident A asked Ebony for a cigarette and she told him no and an altercation ensued in which staff Jimmy punched Resident A. According to Resident A's guardian, Resident A has a history of aggressive behavior and can escalate his aggression very quickly. Resident A's guardian stated that Resident A can be very difficult to reason with and deal with because of his mental health challenges. Resident A has a history of self-harming and breaking property when he's upset. Resident A has already had an incident at his new placement according to his guardian.

On 02/24/25, I interviewed Resident A. According to Resident A, he got into a fight with staff Jimmy and Jimmy punched him in the face. Resident A stated that before the incident he got irritated but he didn't know why. He believes that Jimmy made him mad but he's not sure why or how Jimmy made him mad. Resident A stated that he started breaking things in the house like a table and a vase. He stated that he was mad that he wasn't getting attention from staff. He then asked Ebony for a cigarette so he could go outside and smoke. She told him no and that upset him. Ebony tried to call 911 and Resident A grabbed her to try and take the phone from her. Resident A stated that him and Jimmy started fighting and Jimmy punched him in the eye. The police showed up and handcuffed him, then took him to the Emergency Room. Resident A stated that he was left alone in Emergency without staff. He stated that he has been hearing voices and recently gotten into a fight at his new placement.

On 03/06/25, I interviewed manager Ms. Ebony Logan. According to Ms. Logan, Resident A had a doctor's appointment on 1/27/25 and she took him. He had a good day with no issues until they got back to the facility. They returned to the home around

4pm. Once they returned, Resident A started messing with things around the home, in which staff tried to redirect him. It worked for a while but when Ms. Logan went outside for a smoke break, Resident A demanded she give him one of her personal cigarettes. She told him no because it is against policy for staff to give residents their personal belongings. Resident A had a melt down and grabbed Ms. Logan but eventually he let her go. Staff Jimmy was in the kitchen cooking and Resident A started throwing things at Jimmy and into the food he was preparing. Staff tried to redirect him, but he was not cooperating. Resident A started destroying things around the house. When staff tried to stop him, he started hitting and kicking Jimmy. Ms. Logan, tried to call 911 but when Resident A saw her calling, he attacked her and tried to get the phone from her. Resident A was trying to throw her on the floor while hitting her. Jimmy stepped in and tried to separate them, but Resident A started attacking him again. Ms. Logan ran into the staff office and shut the door so she could finish calling 911. Police showed up and tried to redirect Resident A but he continued breaking things in the house. The police then handcuffed him and transported him to the hospital. Ms. Logan stated that she did not receive any injuries, but Jimmy did and had to go to urgent care. According to Ms. Logan, the police took Resident A to the hospital around 5pm and no staff went with him. Ms. Logan stated that she received a phone call from the hospital around midnight stating that they were going to admit him. Resident A was in the emergency room without staff from approximately 5pm to midnight.

On 03/13/25, I interviewed staff Jimmy Williams. According to Mr. Williams, Resident A and Ebony came back from the doctor around 4pm on 1/27/25. When they returned, Resident A asked her for a cigarette, and she said no. Mr. Williams said he was cooking dinner and Resident A started messing with things around the house trying to cause a disturbance. Resident A started demanding a cigarette from Ebony and when she refused, he attacked her. Mr. Willams stepped in to deescalate the situation. Resident A grabbed Mr. Williams clothes and ripped his shirt off of his body. Resident A went around the house breaking things, including throwing the dinner that Mr. Williams made on the floor. Mr. Williams denied punching Resident A, stated that he just tried to protect himself and redirect Resident A. Police showed up and tried to redirect Resident A but he continued breaking things in the house. The police then handcuffed him and transported him to the hospital. Mr. Williams stated that he sustained multiple injuries and had to go to urgent care. Mr. Williams stated that no staff went with Resident A to the hospital.

On 03/21/25, I conducted an exit conference with licensee designee Sheri Turner to discuss the findings of this report. Ms. Turner was not available, and a message was left for her.

APPLICABLE RULE	
R 400.14308	**Resident behacior 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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	On 1/27/25, Resident A was transported to McClearn Hospital via the local police department after a physical altercation in the home with staff. Resident A was hit in the eye by staff Jimmy Williams during an altercation in the home. Resident A suffered a black eye as a result.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 1/27/25, Resident A was transported to McClearn Hospital via the local police department after a physical altercation in the home with staff. Although Resident A was transported by the police, no staff member accompanied Resident A to emergency or met him there. Resident A was left in the emergency room alone from approximately from 5pm to 12 am before being admitted into the hospital. The facility left a vulnerable adult without anyone to supervise or advocate for him during his time of distress.
CONCLUSION:	**VIOLATION ESTABLISHED**

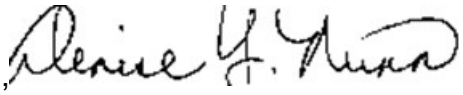
IV. RECOMMENDATION

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

03/21/25

Eric Johnson Date
Licensing Consultant

Approved By:



04/03/2025

Denise Y. Nunn Date
Area Manager