GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2025

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

RE: License #: AS630015466
Investigation #: 2025A0602012
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) 972-9136.

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 #:	2025A0602012
Complaint Receipt Date:	03/27/2025
Investigation Initiation Date:	03/28/2025
Report Due Date:	05/26/2025
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 03/16/25, staff member Margo Alexander locked Resident A outside naked because he urinated on the floor.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/27/2025	Special Investigation Intake 2025A0602012
03/28/2025	Special Investigation Initiated - Telephone Message left for assigned Recipient Rights worker, Katie Garcia.
03/31/2025	Contact – Telephone call received Spoke with Katie Garcia.
04/03/2025	Inspection Completed On-site Interviewed staff
04/03/2025	Contact - Face to Face Observed Resident A at the Lahser Pre-Vocational Center in Clarkston.
04/16/2025	Aps Referral Adult Protective Services referral denied.
04/16/2025	Contact – Document received Received an email with a video of Resident A in the backyard.
05/22/2025	Contact – Telephone call made Interviewed staff member Margo Alexander
05/22/2025	Exit conference Held with the licensee designee, Pamela Hurley by telephone.

ALLEGATION:

On 03/16/25, staff member Margo Alexander locked Resident A outside naked because he urinated on the floor.

INVESTIGATION:

On 3/27/2025 a complaint was received and assigned for investigation alleging that on 3/16/2025 staff member Margo Alexander locked Resident A outside naked because he urinated on the floor.

On 4/03/2025 I conducted an unannounced on-site investigation at which time, Office of Recipient Rights worker, Katie Garcia participated. I interviewed the home manager, Shanean Butler, area supervisor, Michelle Bailey, assistant manager, Melissa Clark, and staff member, Malika Jones. I was unable to interview any of the residents as they are all non-verbal. Ms. Butler stated she has worked for the company for 10 years and as the home manager for the past 6 years. She said she was not working the day the incident occurred and Ms. Alexander covered her shift. Ms. Jones informed her that on 3/16/2025 Resident A urinated on the hallway floor and Ms. Alexander put him outside naked and locked the door while she cleaned the floor. Ms. Butler went on to state that Ms. Alexander reported to her that Resident A was fully dressed when he went outside. She never said that she locked the door.

Ms. Bailey stated Ms. Alexander is not a full-time employee at the Cuthbert home. She covers open shifts from time to time. She said she has no firsthand knowledge of the incident but received an email at the main office from Resident A's supports coordinator regarding the incident. Ms. Bailey said she immediately informed the licensee designee, Pamela Hurley of the incident then called the group home and informed Ms. Butler to suspend Ms. Alexander. According to Ms. Bailey, Ms. Alexander has not returned to the home. This is all the information Ms. Bailey had regarding the incident.

Ms. Clark stated that she has worked for the company since 8/2024 and began working as the assistant home manager in 2/2025. Ms. Clark said on 3/17/2025 when she arrived for her shift, Ms. Jones informed her that on 3/16/2025 Resident A urinated on the floor a few times and Ms. Alexander became angry because she had to keep mopping the floor. Around 6 pm she put Resident A outside naked and locked the door. Ms. Jones said she asked Ms. Alexander if she wanted her to let Resident A back into the home and she was told not to as she would let him back in.

Ms. Jones stated she has only worked in the home for about 2 months. She said on 3/16/2025 around 6 pm the residents had just finished dinner when Resident A urinated in the hallway. Ms. Alexander shoved Resident A out the back door and onto the patio and locked the door. Resident A was completely naked while outside. Resident A knocked on the patio door and the window but Ms. Alexander did not allow him back into the home. Resident A then walked to the side of the home an began messing with the gate. About 10 minutes later Ms. Alexander brought Resident A back into the home through the garage door. Resident A then went into his bedroom and there were no other incidents for the remainder of the shift. Ms. Jones said she informed the assistant manager when she arrived for her shift the same evening and informed the home manager the next day. Ms. Jones stated she did not allow Resident A back into the home because she was new and afraid.

On 4/03/2025 I attempted to interview Resident A at the Lahser Pre-Vocational Center in Clarkton. Resident A is non-verbal and was unable to provide any information regarding the incident.

On 4/04/2025 I received and reviewed the staff schedule dated 3/01/2025 – 3/28/2025. According to the schedule, on 3/16/2025, Ms. Clark worked between the hours of 7 am - 3 pm and 9 pm – 9 am, Ms. Butler worked between the hours of 9 am – 1 pm, Ms. Alexander worked between the hours of 9 am – 9 pm, Ms. Jones worked between the hours of 1 pm – 9 am, and Ms. Dixon worked between the hours of 9 pm – 9 am.

On 4/16/2025 I received and reviewed a short video of Resident A outside in the backyard looking in the dining room window. The video shows Resident A from the waist up with no shirt or coat on.

On 4/18/2025 I received and reviewed a copy of Resident A's Individual Plan of Service (IPOS). According to the plan, Resident A is deaf, non-verbal, does not know sign language and has severe intellectual disabilities. When outdoors, staff should be outdoors with him and within eyesight.

On 5/22/2025 I interviewed staff member Margo Alexander by telephone. Ms. Alexander stated on 3/16/2025 she worked between the hours of 9 am – 9 pm and staff member Malika Jones worked between 1 pm - 9 pm. The residents were fed dinner around 4:30 pm or 5:00 pm. After dinner Ms. Alexander said she cleaned the kitchen and began cleaning Resident A's room because he had a bowel movement and there were feces on the wall and around the doorframe in his room. During this time, Ms. Jones was on her phone with her boyfriend and on her computer in the living area. According to Ms. Alexander, Resident A was fully dressed in black pants, a red shirt and white socks. Resident A went outside into the backyard and Ms. Alexander asked Ms. Jones to keep an eye on him while she cleaned his room. She told her he would not go anywhere. After cleaning Resident A's room, she asked Ms. Jones where Resident A was. Ms. Jones informed her that she did not know. Ms. Alexander found Resident A sitting in a pile of wood chips in the yard. He had removed one of his socks and one of his arms from his shirt. She said at no time was he naked while outdoors. Resident A was brought back into the home and showered. Ms. Alexander denied that Resident A urinated on the hallway floor and stated the floor was wet from the shower he had taken. She went on to state that she never locked Resident A out of the home.

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 the investigation, there is sufficient information to determine that Resident A was not treated with dignity. On 3/16/2025 Ms. Jones stated Resident A urinated on the hallway floor and Ms. Alexander put him outside while naked while she cleaned the floor. He was left outside naked for about 10 minutes. On 4/16/2025 I received and reviewed a short video of Resident A in the backyard with no shirt or coat on looking in the window. On 5/22/2025 Ms. Alexander stated she never locked Resident A out of the home naked. Furthermore, Ms. Jones failed to protect Resident A as she did not allow Resident A into the home because she was a new employee and was afraid.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
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: (a) Use any form of punishment. (g) Refuse the resident entrance to the home.

ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that Resident A was locked out of the home naked as punishment for urinating on the hallway floor. According to Ms. Jones on 3/16/2025 Resident A urinated on the hallway floor. Ms. Alexander became angry, put his outside and locked the door. Resident A was naked. On 4/16/2025 I received and reviewed a short video of Resident A in the backyard with no shirt or coat on looking in the window. On 5/22/2025 Ms. Alexander denied punishing Resident A for urinating on the floor by locking him out of the home naked.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 4/03/2025 I requested to review a copy of Resident A's assessment plan. There was no current assessment plan in Resident A's resident file. The most recent plan observed in his file was dated 1/4/2024.

On 5/22/2025 I conducted an exit conference with the licensee designee, Pamela Hurley by telephone. I informed Ms. Hurley of the investigative findings and recommendation documented in this report. Ms. Hurley stated Ms. Alexander was suspended pending the outcome of the investigation and will be terminated as of this date. Ms. Hurley agreed to submit a corrective action plan upon receipt of this report.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the residents' written assessment plan on file in the home.

ANALYSIS:	On 4/03/2025 I reviewed Resident A's resident file and did not observe a current assessment plan. The most recent plan observed was dated 1/4/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

5/22/2025

Cindy Berry Date
Licensing Consultant

Approved By:

For 06/05/2025

Denise Y. Nunn Date
Area Manager