



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

June 9, 2025

Deana Fisher  
St. Louis Center for Exceptional Children & Adults  
16195 Old US-12  
Chelsea, MI 48118

RE: License #: AS810409201  
Investigation #: 2025A0122030  
Uncle Mike's House

Dear Ms. Fisher:

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 (517) 284-9720.

Sincerely,

A handwritten signature in dark ink, reading "Vanita Bouldin". The script is cursive and fluid, with the first name "Vanita" and last name "Bouldin" clearly distinguishable.

Vanita C. Bouldin, Licensing Consultant  
Bureau of Community and Health Systems  
22 Center Street  
Ypsilanti, MI 48198  
(734) 395-4037

Enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS810409201
<b>Investigation #:</b>	2025A0122030
<b>Complaint Receipt Date:</b>	05/09/2025
<b>Investigation Initiation Date:</b>	05/09/2025
<b>Report Due Date:</b>	06/08/2025
<b>Licensee Name:</b>	St. Louis Center for Exceptional Children & Adults
<b>Licensee Address:</b>	16195 Old US-12 Chelsea, MI 48118
<b>Licensee Telephone #:</b>	(734) 475-8430
<b>Administrator:</b>	Deana Fisher
<b>Licensee Designee:</b>	Deana Fisher
<b>Name of Facility:</b>	Uncle Mike's House
<b>Facility Address:</b>	1669 Hayes Rd Chelsea, MI 48118
<b>Facility Telephone #:</b>	(734) 475-8430
<b>Original Issuance Date:</b>	08/16/2021
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	02/16/2024
<b>Expiration Date:</b>	02/15/2026
<b>Capacity:</b>	5
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

## II. ALLEGATION(S)

	Violation Established?
On 05/09/2025, staff member Terra Teall, was found asleep and therefore did not attend to Resident A's needs.	Yes

## III. METHODOLOGY

05/09/2025	Special Investigation Intake 2025A0122030
05/09/2025	APS Referral
05/09/2025	Special Investigation Initiated - Telephone Guardian A1. Unavailable, left voice message requesting return phone call.
05/12/2025	Contact – Telephone call made- Completed an interview with Resident A.
05/19/2025	Contact – Telephone calls made- Completed interview with staff member, Amy Wamsley and Terra Teall.
05/20/2025	Contact – Telephone call made- Completed interview with supports coordinator, Carolyn Fillman.
05/21/2025	Exit Conference- Discussed findings with licensee designee, Deana Fisher.

**ALLEGATION:** On 05/09/2025, staff member Terra Teall, was found asleep and therefore did not attend to Resident A's needs.

**INVESTIGATION:** On 05/09/2025, licensee designee, Deana Fisher, stated she received the following report: On 05/09/2025, Resident A woke up at 3:00 a.m. in pain from a shoulder injury she experienced earlier in the week. Resident A called for staff, Terra Teall, to obtain an ice pack. Ms. Teall was sleeping and did not respond, therefore Resident A was up all night in pain.

On 05/12/2025, I completed an interview with Resident A. Resident A reported on 05/09/2025 she woke up in pain, her shoulder was hurting, and she wanted some Tylenol. Resident A stated she found staff member, Terra Teall, asleep on the couch and she was unable to wake her for assistance. Resident A stated she went back to

bed, in pain, and received assistance from staff member, Amy Wamsley who came in the next morning. Resident A stated Amy gave her the Tylenol she requested.

On 05/19/2025, I conducted separate interviews with staff members Amy Wamsley and Terra Teall. Ms. Wamsley stated that on 05/10/2025, Resident A reported to her that staff member, Terra Teall was sleeping when she went to request an ice pack for her shoulder. Ms. Teall confirmed that she fell asleep on 05/09/2025, from 3:10 a.m. until approximately 3:40 a.m. Ms. Teall stated she was unaware that Resident A attempted to request assistance from her.

05/20/2025, I conducted an interview with supports coordinator for Resident A, Carolyn Fillman. Ms. Fillman confirmed that she had been notified about the incident between Resident A and staff member, Terra Teall. Ms. Fillman reported that she has no issue of concern with the care Resident A receives from the staff members of Uncle Mike's adult foster care facility and she believes that the administration of the facility will appropriately address the incident.

05/21/2025, I completed an exit conference with licensee designee, Deana Fisher, and discussed my findings with her. Ms. Fisher agreed with my findings.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of multiple interviews with licensee designee, Deana Fisher, Resident A, supports coordinator, Carolyn Fillman and staff members, Amy Wamsley and Terra Teall there is enough evidence to substantiate the allegation that on 05/09/2025, staff member Terra Teall, was found asleep and therefore did not attend to Resident A's needs.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan, I recommend no change to the status of the license.

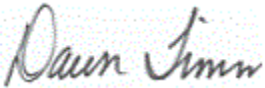


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Vanita C. Bouldin  
Licensing Consultant

Date: 05/21/2025

Approved By:



06/09/2025

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Ardra Hunter  
Area Manager

Date