GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2025

Alicia Sain
Pal's Place, LLC
5336 E Court St S
Burton, MI 48509

RE: License #:	AS250385628
Investigation #:	2025A1039035
	Pal's Place

Dear Alicia Sain:

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) 643-7960.

Sincerely,

Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250385628
Investigation #:	2025A1039035
Complaint Receipt Date:	07/16/2025
Investigation Initiation Date:	07/16/2025
Report Due Date:	09/14/2025
Licensee Name:	Pal's Place, LLC
Licensee Address:	5336 E Court St S Burton, MI 48509
Licensee Telephone #:	(810) 938-0018
Administrator:	Alicia Sain
Licensee Designee:	Alicia Sain
Name of Facility:	Pal's Place
Facility Address:	5336 E Court St S Burton, MI 48509
Facility Telephone #:	(810) 938-0018
Original Issuance Date:	07/06/2018
License Status:	REGULAR
Effective Date:	01/06/2025
Expiration Date:	01/05/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Pals Place AFC issued an improper verbal 24-hour eviction after police were called for a patient's behavior, leaving the family uninformed and unsupported at the hospital.	Yes

III. METHODOLOGY

07/16/2025	Special Investigation Intake 2025A1039035
07/16/2025	Special Investigation Initiated - Telephone Completed APS referral.
07/16/2025	APS Referral Completed via telephone.
07/30/2025	Inspection Completed On-site Interviewed Licensee Designee and Direct Care Worker. Resident A no longer lived in the home.
08/01/2025	Contact - Document Received Email from Hurley Social Worker Brianna Neely.
08/21/2025	Contact - Telephone call made Phone interview with Guardian A1.
08/25/2025	Exit Conference Completed with LD.
08/25/2025	Inspection Completed-BCAL Sub. Compliance
08/29/2025	Contact - Telephone call made Phone interview with Genesee Health Systems Case Manager (CM) Jaquanna Andrews.
08/29/2025	Contact – document received Email from GHR ORR Matt Potts.

ALLEGATION:

Pals Place AFC issued an improper verbal 24-hour eviction after police were called for a patient's behavior, leaving the family uninformed and unsupported at the hospital.

INVESTIGATION:

On 07/16/2025, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Pals Place AFC issued an improper verbal 24-hour eviction after police were called for a patient's behavior, leaving the family uninformed and unsupported at the hospital.

On 07/30/2025, I completed an unannounced investigation at Pal's Place.

On 07/30/2025, I interviewed Licensee Designee (LD) Alicia Sain concerning the allegations regarding Resident A. LD Sain stated that she was aware of the allegations but did not believe they were true as she gave verbal and written notification of the emergency discharge withing the same 24 hours. LD Sain stated that she received a call from her staffing team concerning Resident A and they informed her that his behavior was out of control. LD Sain stated that the staff called 911 and informed the police that Resident A was being verbally abusive and he was would not take his medication. LD Sain stated that they contacted Resident A's guardian on a 3-way call with Resident A and tried to de-escalate the situation and convince him to take his medication. LD Sain stated that Resident A's behaviors got worse and worse and he ended up going to the emergency room at Hurley Medical Center. LD Sain stated that Resident A stated on many occasions that he did not want to be in the home and wanted to go back home to be with his family. LD Sain stated that she had been communicating with Resident A's guardian concerning the situation but that it did not get any better. LD Sain stated that she gave Resident A's guardian a verbal notice that Resident A would be discharged due to safety concerns for the staff and other residents in the home. LD Sain stated that she forgot to physically give Resident A's guardian the emergency discharge paper initially, but she did have it sent to her at the hospital within the same 24-hour period. LD Sain stated that Resident A was still at Hurley Medical Center being evaluated when the guardian received the emergency discharge paperwork. LD Sain stated that Resident A's guardian did not sign the emergency discharge paperwork. LD Sain stated there was no way she could keep Resident A in the home as he was threatening to kill people until they let him leave. LD Sain stated that she did not help secure a placement for Resident A prior to giving her emergency discharge notice. LD Said stated that she did inform the Genesee Health Systems worker about the situation and thought that they would secure another placement for Resident A.

I reviewed an Incident Report (IR) dated 07/15/2025. The IR was consistent with what LD Sain stated. Resident A would not take his medications. Resident A's guardian was contacted to help de-escalate him and convince him to take his medications. Resident

A would not take is medication and began threatening to kill staff and residents in the home. 911 was contacted and an ambulance transported Resident A to Hurley Medical Center emergency room. LD Sain informed Genesee Health Systems Case Manager and the guardian they were completing an emergency discharge of Resident A. Resident A's guardian did not sign an emergency discharge notice.

I reviewed a Notification of Emergency Discharge dated for 07/14/2025. The discharge paperwork is not signed as Guardian A1 refused to sign per GHS social worker Brianna Neely.

On 08/01/2025, Hurley Medical Center Social Worker Brianna Neely informed me that she did not remember Resident A's name and had no updated information as the Resident is no longer in the emergency department.

On 08/21/2025, I completed a phone interview with Resident A's guardian, Guardian A1, concerning the allegations regarding Resident A. Guardian A1 stated that she was aware of the allegations and believed that they were true. Guardian A1 stated that she felt that LD Sain was trying to get Resident A out of the home for a while before this incident happened. Guardian A1 stated that from what she understands about the situation is that Resident A was having some behavioral issues and the staff sent him to Hurley Medical Center to be examined. Guardian A1 stated that after Resident A went to the hospital she did not hear from the staff or anyone for a few hours and then when she did hear back from LD Sain, she was informed that they would not be taking him back and he was being discharged due to his behaviors. Guardian A1 stated that she did not receive any paperwork concerning the emergency discharge until later on in the evening after it was faxed over to Hurley Medical Center. Guardian A1 stated that she did not sign the discharge paperwork and that she did not feel that LD Sain was honest with her about the situation. Guardian A1 stated that once Resident A was discharged from Hurley Medical Center that she took him home and that she had to quit her job so that she could care for him until a new placement was found. Guardian A1 stated that she has been working with Genesee Health Systems Case Manager (CM) Jaquanna Andrews to help find Resident A a new home that can meet his needs.

On 08/29/2025, I completed a phone interview with Genesee Health Systems Case Manager (CM) Jaquanna Andrews concerning the allegations regarding Resident A. CM Andrews stated that she was familiar with the allegations and believed that they were true. CM Andrews stated that she is familiar with what happened and that she was communicating with LD Sain as Resident A went to Hurley Medical Center. CM Andrews stated that she is aware that LD Sain gave Guardian A1 a verbal emergency discharge notice but did not provide her with a paper emergency discharge notice until after Resident A was admitted to Hurley Medical Center. CM Andrews stated that LD Sain did a good job of communicating with her and Guardian A1 while Resident A was at Pal's Place, but she did not help locate a placement for Resident A prior to his emergency discharge. CM Andrews stated that she spoke with LD Sain and asked if she would take him back in the home until a placement was found for Resident A and

she said no. CM Andrews stated that Resident A currently resides at home with Guardian A1, but there is a perspective home they are looking at next week.

On 08/29/2025, Genesee Health Systems Office of Recipient Rights (ORR) Director Matt Potts informed me that ORR has no rules about discharge notices or time frames.

On 08/25/2025, I completed an exit conference with Licensee Designee (LD) Alicia Sain. I informed LD Sain of the results of my investigation. LD Sain stated that she did not agree with the findings but understands why the findings were made and will complete corrective action plan.

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.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	It was alleged that Pals Place AFC issued an improper verbal 24-hour eviction after police were called for a patient's behavior, leaving the family uninformed and unsupported at the hospital. I interviewed the Licensee Designee, GHS case manager and Guardian A1. The Licensee Designee acknowledged that she did not help locate placement prior to giving Guardian A1

	emergency discharge notice for Resident A. The GHS case manager and Guardian A1 believe the allegations are true. I reviewed the Incident Report and Notification of Emergency Discharge for Resident A. The facility did not obtain an appropriate placement for Resident A before enacting the 24-hour discharge notice. Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

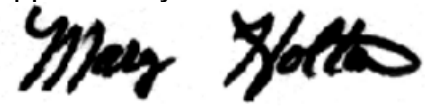
IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in licensure status.

09/03/2025

Martin Gonzales Licensing Consultant	Date

Approved By:



09/03/2025

Mary E Holton Area Manager	Date