GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 1, 2025

Kristina Yates
H N P H Inc
852 W. Elm
Monroe, MI 48161

RE: License #: AL580007271
Investigation #: 2025A0116044
Elm House

Dear Ms. Yates:

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 (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL580007271
Investigation #:	2025A0116044
Complaint Receipt Date:	08/28/2025
Investigation Initiation Date:	08/29/2025
Report Due Date:	10/27/2025
Licensee Name:	H N P H Inc
Licensee Address:	852 W. Elm Monroe, MI 48161
Licensee Telephone #:	(734) 242-2177
Administrator:	Kristina Yates
Licensee Designee:	Kristina Yates
Name of Facility:	Elm House
Facility Address:	852 W Elm Monroe, MI 48161
Facility Telephone #:	(734) 242-2177
Original Issuance Date:	10/01/1980
License Status:	REGULAR
Effective Date:	04/30/2024
Expiration Date:	04/29/2026
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff, Ashley Cheatham, missed giving Resident A her required bedtime insulin because she was on a smoke break, then refused to administer it because it was past 9:00 p.m.	Yes

III. METHODOLOGY

08/28/2025	Special Investigation Intake 2025A0116044
08/29/2025	Special Investigation Initiated - On Site Licensee designee, Khristina Yates, reviewed Resident A's medication administration record (MAR).
09/02/2025	Contact - Face to Face Residents A-D, staff Roberta Hatfield.
09/05/2025	Contact - Telephone call made Staff Ashley Cheatham.
09/05/2025	Contact - Telephone call made Resident A's case manager, Sergio Walker.
09/05/2025	Inspection Completed-BCAL Sub. Compliance
09/29/2025	Exit Conference Licensee designee, Kristina Yates.
09/30/2025	APS Referral Made

ALLEGATION:

Staff, Ashley Cheatham, missed giving Resident A her required bedtime insulin because she was on a smoke break, then refused to administer it because it was past 9:00 p.m.

INVESTIGATION:

On 08/29/25, I conducted an unscheduled onsite inspection and interviewed licensee designee, Kristina Yates, and reviewed Resident A's August 2025 medication administration record. At the time of my inspection all of the residents were out of the home at their workshop programs.

Ms. Yates reported that she was not at the home when the incident occurred. On Monday 08/25/25, when she arrived at work, she reviewed the incident reports and progress notes from the weekend and that is how she found out about what occurred. On Monday 08/25/25, Ms. Cheatham was on shift and asked about the incident. Ms. Cheatham reported that Resident A returned home from an outing at around 8:45 p.m. on 08/22/25 and she asked her to shower so that she could come back downstairs and take her bedtime medications. Resident A came back downstairs 30 minutes later and started doing her chore. Once she completed her chore, she went outside to smoke instead of coming to the medication room to take her medications. Ms. Cheatham waited until 10:00 p.m. for Resident A to come back inside and when she didn't, she documented medication refusals on her MARs. Ms. Yates addressed the matter and reiterated the importance of prioritizing medication administration. Ms. Yates reported that Ms. Cheatham should have administered the medication immediately upon Resident A's return to the home. Ms. Yates reported Resident A can be difficult at times and does not always tell the truth, however, recognized Ms. Cheatham's error of not immediately passing the medication. Ms. Yates was not informed or aware that staff, Ashley Cheatham, was alleged to be outside the home on a smoke break or refused to administer the medications as alleged. Ms. Yates does not believe this to be true.

I reviewed the incident report and progress note completed by staff, Ms. Cheatham, on 08/22/25. The incident report documents that Resident A refused her medication because after completing her chores she went outside to smoke and did not come back inside until 10:00 p.m. The progress note documents the following:

> "Resident A returned back home from an outing 08/22/25 at about 8:45 p.m., I told her to go shower so she can get her meds, came down 30 mins later. She started doing her chores-no problem. Came by the med room told me she was almost finished. I started getting her things ready (meds) she finished her chore and went right outside. I waited until almost 10:00 p.m. IR written, medication refusal".

I reviewed Resident A's August 2025 MAR and observed that she was not given/applied the following 8:00 p.m. medications:

- Symbicort Inhaler
- Omeprazole 40mg
- Metoprolol Tartrate 25mg
- Nystatin Ointment
- Lantus Sollostar pen

On 09/02/25, I conducted a scheduled onsite inspection and interviewed Residents A-D and staff, Roberta Hatfield. Resident A reported that on 08/22/25, she returned from a dance a little after 8:30 p.m. and staff Ashley Cheatham and an off-duty staff, Roberta Hatfield, were outside talking and smoking. Ms. Hatfield told her to do her chore, which is cleaning her bathroom. Ms. Cheatham and Ms. Hatfield were on a smoke break in the front of the home. After she completed her chore, she went to the back of the home and took a smoke break and chilled out for a while. She was never called back in the home to take her medication. When she went back into the home, sometime after 9:00 p.m., staff, Ms. Cheatham told her she needed to prioritize her time and informed her that she had her medications ready to pass but since she did not come back inside in a timely manner the window to give her the medications had passed. Resident A asked Ms. Cheatham to give her the medication, and she said no. Resident A reported that she requires insulin and could have died because she did not get it as prescribed. She reported she had to wait until the following morning and this upset her. Resident A has lived in the home for about four months and she is no longer happy living there. She is her own guardian and plans to speak with her case manager about finding another home for her.

I interviewed Residents B-D separately, and they all reported not being aware of the incident with Resident A. They reported that at that time of night they are in their bedrooms sleeping or watching television. They all reported that they get their medication as prescribed and medication is not given after 9:00 p.m. They reported that the last medication pass happens at 8:00 p.m.

I interviewed staff, Roberta Hatfield, and she reported that she was not at the facility at all on 08/22/25 and did not work until Saturday 08/23/25. She has been off due to being ill. Ms. Hatfield lives about 25 minutes away and would not drive to her job just to talk to a co-worker. It did not happen and she is not sure why Resident A would make something like this up. Ms. Hatfield is stern with the Residents, and they don't always like that. She believes that Resident A is trying to get her in trouble and may think this would get her fired.

On 09/05/25, I interviewed staff, Ashley Cheatham, and she reported that she was the staff on shift the evening of Friday 08/22/25. She reported that Resident A returned to the home that evening at about 8:45 p.m. When she came, she told her to go ahead and take her shower and then come back downstairs to take her oral medication and have her topical ointment applied. The topical has to be applied after she showers. Resident A took her shower, completed her chore and came to the

med room and told her she was almost done with her chore and would be right back. Ms. Cheatham was in the med room getting everything ready so that she could pass Resident A's medications. Resident A was taking a while, so she went to look for her and found her outside in the back smoking. By this time, it was after 10:00 p.m. which, based on her medication training, is too late to administer. She was trained that medications can be given an hour before or after the scheduled time. Ms. Cheatham reported that licensee designee, Kristina Yates, met with her and informed her that she should have prioritized the medication and administered it immediately upon Resident A's return to the home. I reiterated Ms. Yates position, provided the rule about medication administration and recommended moving forward if a resident is on an outing, and the prescribed medications are not able to be given to the person the resident is going with, the medication should be given immediately upon their return. I also recommended that they follow up with the resident's physician with questions or for clarity. Ms. Hatfield reported that Ms. Yates has already begun doing that for the residents that go on outings or weekends away from the home.

Ms. Cheatham denied that her co-worker Ms. Hatfield was at the home at anytime during her shift on 08/22/25. Ms. Hatfield lives 25-30 minutes away and would not drive all that way on her off day just to talk with her. Ms. Cheatham does not smoke, and for Resident A to say she was on a smoke break is unbelievable.

On 09/05/25, I interviewed Resident A's case manager, Sergio Walker. Mr. Walker reported that Resident A and licensee designee, Ms. Yates, informed him of the incident that occurred on 08/22/25. Mr. Walker reported that the staff overall have done a really good job working with Resident A and maintaining her there. This is her first placement as she was previously living home with her mother. The structure and rules that an AFC setting provides have been a challenge for Resident A and the staff have been patient throughout this transition. Resident A has expressed her desire to move out of the home and he will be assisting her, however, believes that this home is a really good fit for her because of the high functioning residents they provide care for, the structure and programming that prepares residents who plan to transition to independent living, and the compatibility of all the residents.

On 09/29/25, I conducted the exit conference with licensee designee, Kristina Yates, and informed her of the findings of the investigation. Ms. Yates reported an understanding and has had a staff meeting to address medication administration and staff responsibilities. Ms. Yates is also talking to physicians and requesting clarification regarding medication time frames and has spoken with family members about giving them the medication and instructions for use when they are taking the residents out on outings or weekends to ensure no lapse in medication.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the findings of the investigation, which included interviews with Resident A, staff, Ashley Cheatham and Roberta Hatfield, there is a preponderance of evidence to substantiate the allegation. Resident A reported after returning home from a dance on the evening of 08/22/25, staff, Ashley Cheatham, did not administer her bedtime medication as prescribed. Resident A admitted that she showered, completed her chore, went outside to smoke, and Mr. Cheatham did not call for her or come get her to take her medication. Ms. Cheatham admitted that when Resident A returned from the dance on 08/22/25 at around 8:45 p.m. she had her take her shower first, which then led to Resident A completing her chore and then going outside to smoke. Ms. Cheatham admitted that due to the time being past 9:00 p.m. she did not administer Resident A's bedtime medication. Ms. Hatfield denied being at the facility on 08/22/25 and was not involved in what occurred. This violation is established as staff, Ms. Cheatham did not give and apply Resident A medications as prescribed by her physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

10/01/25

Pandrea Robinson
Licensing Consultant
Date

Approved By:

10/01/25

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Ardra Hunter
Area Manager
Date