GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2022

Tamisha Turner
The Chateau Group of Michigan LLC
PO Box 81
Walled Lake, MI 48390

RE: License #: AS630391762
Investigation #: 2022A0602009
Chateau Of Bloomfield

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.
- 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) 975-5053.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630391762
Investigation #:	2022A0602009
Complaint Receipt Date:	11/24/2021
Investigation Initiation Date:	11/29/2021
Report Due Date:	01/23/2022
Licensee Name:	The Chateau Group of Michigan LLC
Licensee Address:	P.O. Box 81 Walled Lake, MI 48390
Licensee Telephone #:	(248) 252-8888
Administrator:	Tamisha Turner
Licensee Designee:	Tamisha Turner
Name of Facility:	Chateau Of Bloomfield
Facility Address:	2660 Vhay Lane Bloomfield, MI 48304
Facility Telephone #:	(248) 792-6607
Original Issuance Date:	08/01/2018
License Status:	REGULAR
Effective Date:	02/01/2021
Expiration Date:	01/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS; AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff blocked Resident D from going outside to walk around the house and walk to the island on Vhay Lane and Lennox Road and return to the home.	No
Staff member Ashli McNeal showed Resident A pornography and other inappropriate videos on her cellphone while on shift. Ms. McNeal also asked Resident A to rub her feet and he complied. Ms. McNeal was observed shaking her butt in front of residents and saying, "I have a big butt."	Yes

III. METHODOLOGY

11/24/2021	Special Investigation Intake 2022A0602009
11/29/2021	Special Investigation Initiated - Telephone Call made to the complainant
12/02/2021	Comment Received additional allegations.
12/07/2021	Inspection completed on-site Interviewed Resident D and the area manager, Nancy Turner.
12/20/2021	Contact – Document sent Email sent to the licensee designee, Tamisha Turner.
01/12/2022	Contact – Telephone call made Call made to Ms. Turner, unable to leave a message.
02/08/2022	Contact – Telephone call made Message left at office of recipient rights, ORR.
03/04/2022	Inspection completed on-site Interviewed Resident A, Resident B, Resident D, staff member Steven Oleary, staff member Dominiqwa Hatter, and the home manager, Iesha Johnson.
03/07/2022	Exit conference Message left for the licensee designee, Tamisha Turner.

ALLEGATION:

Staff blocked Resident D from going outside to walk around the house and walk to the island on Vhay Lane and Lennox Road and return to the home.

INVESTIGATION:

On 11/24/2021, a complaint was received and assigned for investigation alleging that staff blocked Resident D from going outside the home to walk to the island on Vhay Lane and Lennox Road and return home.

On 12/07/2021, I conducted and unannounced on-site investigation at which time I interviewed the area manager, Nancy Turner and Resident D. Ms. Turner asked Resident D to get dressed and come out of her room. As I was waiting for Resident D, Ms. Turner stated there were active COVID cases in the home. I immediately stepped out of the home and onto the front porch. I was able to interview Resident D and Ms. Turner through the front door. Resident D stated she was angry because her court date was cancelled, and she needed to go for a walk to calm down. As she walked towards the door, Ms. Turner stepped in front of the door, grabbed both of her hands, and told her she could not leave. She said she did not want her to get hurt. Resident D said after the incident occurred and she calmed down, she realized that Ms. Turner did not want her walk to the island on Vhay and Lennox because she wanted to keep her safe. She stated that Ms. Turner did not hurt her in any way.

Ms. Turner stated Resident D became upset when she was told that her court hearing had been cancelled. She called her guardian but there was no answer, and this upset her even more. She said, “I’m leaving this place.” It was raining the day the incident occurred and Resident D was told staff would go with her for a walk once it stopped raining, but she could not go alone. Ms. Turner stated she was holding Resident D’s hand as she was walking towards the door but never grabbed her. After about 30 minutes, Resident D calmed down and apologized to staff for being so angry.

On 11/24/2021, I received and reviewed a copy of Resident D’s Individual Plan of Service (IPOS). According to the plan, Resident D must always be with staff while in the community.

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 from Resident D and Ms. Turner, there is insufficient information to determine that Resident D was not treated with dignity and her needs were not met. Resident D admitted that she was angry and wanted to leave the home without staff but later realized staff was only trying to keep her safe.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS:

Staff member Ashli McNeal showed Resident A pornography and other inappropriate videos on her cellphone while on shift. Ms. McNeal also asked Resident A to rub her feet and he complied. Ms. McNeal was observed shaking her butt in front of residents and saying, "I have a big butt."

INVESTIGATION:

On 12/02/2021, additional allegations were received alleging that staff member Ashli McNeal showed Resident A pornography and other inappropriate videos on her cellphone while on shift. Ms. McNeal also asked Resident A to rub her feet and he complied. Ms. McNeal was observed shaking her butt in front of residents and saying, "I have a big butt."

On 12/07/2021, I conducted an unannounced on-site investigation but was unable to interview the residents and staff regarding these allegations as I was informed there were active COVID cases in the home.

On 3/4/2022, I conducted another unannounced on-site investigation at which time I interviewed the home manger, Iesha Johnson, staff members Steven Oleary, and Dominiqwa Hatter, Resident A, Resident B, Resident D and Resident E. Ms. Johnson stated she became the manager of the home in June 2021. She had no information regarding the alleged incident but reported that staff member Ashli McNeal was removed from the schedule for reasons unknown to her. Ms. McNeal never returned to the home as she quit while on suspension.

Mr. Oleary stated he has worked in the home for a little over a year and usually works the night shift between the hours of 7 pm and 7 am but works day shifts when needed. He said he only worked one time with Ms. McNeal and there were no issues or concerns involving her during that shift.

Ms. Hatter stated she was not working the day the incident occurred and had no firsthand knowledge of what exactly happened. When she returned to work (exact date unknown), the residents were talking about Ms. McNeal and Resident A. She heard them saying that Resident A was rubbing Ms. McNeal’s feet and had masturbated while

doing it. They were also talking about videos Resident A had seen on Ms. McNeal's phone.

Resident A stated he asked Ms. McNeal if he could watch some pornographic videos on her cell phone and she said yes. Resident A said Ms. McNeal had very pretty toes so when she told him to rub her feet he did. While rubbing her feet he started masturbating and she recorded him with her cell phone. This occurred in the living room with other people around. Resident A refused to provide the names of those who witnessed the incident.

Resident B refused to answer any questions and said there was nothing to report.

Resident C also refused to answer any questions.

Resident D stated she was dancing (twerking) with Ms. McNeal and did not see any issue with it. I asked Resident D if she witnessed Resident D rubbing Ms. McNeal's feet and masturbating. She said she will only speak about her interactions with Ms. McNeal and nothing more. Resident D then ended the interview and said she had nothing further to report.

Resident E stated Ms. McNeal was dancing like you would dance in a club. She was shaking her buttocks (twerking), but it was all in good fun. Resident E said he did not see anything wrong with what she was doing because they were having fun. He had no information about Resident D watching pornographic videos on Ms. McNeal's cell phone or him rubbing her feet and masturbating.

Resident F stated he had no knowledge of Ms. McNeal being inappropriate in any way or showing Resident D any pornographic videos.

On 12/20/2021, I sent the licensee designee, Tamisha Turner an email and on 3/07/2022 I left her a voicemail message to discuss the allegations and conduct an exit conference. As of this date, I have not received a response.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based on the information obtained from Ms. Hatter, Resident A, Resident D, Resident E, there is sufficient information to determine that Ms. McNeal mistreated the residents. She acted inappropriately with Resident A by showing him pornographic videos and allowing him to rub her feet while masturbating. I also determined that Ms. McNeal danced inappropriately in the presence of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

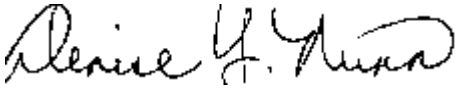
IV. RECOMMENDATION

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

03/08/2022

Cindy Berry Date
Licensing Consultant

Approved By:



03/10/2022

Denise Y. Nunn Date
Area Manager