GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2022

Sherri Turner
Adult Learning Systems-Lower Michigan
Suite F
8170 Jackson Road
Ann Arbor, MI 48103

RE: License #: AS810409240
Investigation #: 2022A0122038
Michael's House

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 (517) 284-9720.

Sincerely,

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

License #:	AS810409240
Investigation #:	2022A0122038
Complaint Receipt Date:	08/18/2022
Investigation Initiation Date:	08/18/2022
Report Due Date:	10/17/2022
Licensee Name:	Adult Learning Systems-Lower Michigan
Licensee Address:	Suite F 8170 Jackson Road Ann Arbor, MI 48103
Licensee Telephone #:	(734) 408-0112
Administrator:	Sherri Turner
Licensee Designee:	Sherri Turner
Name of Facility:	Michael's House
Facility Address:	6175 Carpenter Ypsilanti, MI 48197
Facility Telephone #:	(734) 340-4662
Original Issuance Date:	10/06/2021
License **Status:**	REGULAR
Effective Date:	04/06/2022
Expiration Date:	04/05/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 08/11/2022, staff member, Alexis Scott, used physical force with Resident A.	Yes

III. METHODOLOGY

08/18/2022	Special Investigation Intake 2022A0122038
08/18/2022	Special Investigation Initiated - On Site Observed Resident A. Completed interview with Carmen Moore, Case Manager.
08/22/2022	Contact - Telephone call made Completed interview with LaToya Rogers, Direct Care Staff.
08/23/2022	Contact – Telephone call made Completed interview with Alexis Scott, Direct Care Staff.
08/24/2022	Exit Conference Discussed findings with Sherri Turner, Licensee Designee.
08/23/2022	APS Referral
08/24/2022	ORR Referral

ALLEGATION: On 08/11/2022, staff member, Alexis Scott, used physical force with Resident A.

INVESTIGATION: On 08/18/2022, I completed an onsite inspection. I observed Resident A sitting in the living room, comfortably watching television. I asked Resident A about the stuffed animal he held to which he responded with a smile. I asked Resident A several other questions, however, he refused to respond; therefore, I was unable to complete an interview with Resident A.

On 08/18/2022, I completed an interview with Carmen Moore, Case Manager to Resident A. Ms. Moore was made aware of alleged incident involving Ms. Scott. Ms. Moore stated Resident A did not report any details of the alleged incident to her. Ms. Moore stated she has no issues or concerns with the care provided by staff members of Michael's House adult foster care facility.

On 08/22/2022, I completed an interview with staff member, LaToya Rogers. Ms. Rogers stated on 08/11/2022 she observed co-worker, Alexis Scott pull and drag Resident A out of the garage. Ms. Scott stated she was not certain why Resident A was in the garage but stated she initially observed him sitting quietly in the garage. Per Ms. Rogers, she overheard Ms. Scott ask Resident A to take his 8:00 p.m. medications to which he yelled, "No."

According to Ms. Rogers, Ms. Scott asked her to open the garage door, to which Ms. Rogers complied. Ms. Rogers stated Resident A was on the garage floor when Ms. Scott went over to him and pulled, grabbed him by the arm to get him out of the garage. Ms. Scott asked Ms. Rogers for assistance, Ms. Rogers then asked Resident A for his hands to which he complied, he hugged her, and they were able to get Resident A out of the garage and eventually back into the facility.

Ms. Roger stated she observed scratches on Resident A's arms and legs with minor bleeding. Ms. Scott asked Resident A if she could clean his wounds to which he complied. Ms. Roger stated she heard Ms. Scott apologize to Resident A. Ms. Roger reported the incident and completed an incident report.

On 08/18/2022, I received and reviewed the incident report documenting the incident between Resident A and Alexis Scott. A special investigation was opened based upon the alleged incident documented on the incident report.

On 08/23/2022, I completed an interview with Alexis Scott, Direct Care Worker. Ms. Scott confirmed that she pulled Resident A's arm while attempting to remove him from the garage. Ms. Scott stated she was not trying to hurt Resident A but attempting to get him back into the facility and take his evening medications. Ms. Scott confirmed that Resident A received two scratches, one on his knee and the other on his elbow, from the incident. Ms. Scott stated she cleansed Resident A's wounds and apologized to him as well.

On 08/24/2022, I completed an exit conference with Sherri Turner, Licensee Designee. Mr. Turner reported that she understood my findings and would submit a corrective action plan to address the rule noncompliance found.

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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**

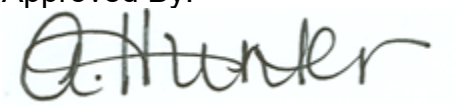
ANALYSIS:	On 08/22/2022, LaToya Rogers reported she observed co-worker, Alexis Scott, pull and drag Resident A to remove him from the facility garage on 08/11/2022. On 08/23/2022, Alexis Scott, confirmed she pulled Resident A by the arm on 08/11/2022 attempting to remove him from the garage. Based upon my investigation I find that direct care staff, Alexis Scott, used physical force with Resident A on 08/11/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Vanita C. Bouldin — Date: 08/24/2022
Licensing Consultant

Approved By:



Ardra Hunter — Date: 09/07/2022
Area Manager