GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 27, 2022

Jason Schmidt
New Life Services Inc
36022 Five Mile Road
Livonia, MI 48154

RE: License #: AS630012619
Investigation #: 2022A0991038
Alta Vista

Dear Mr. Schmidt:

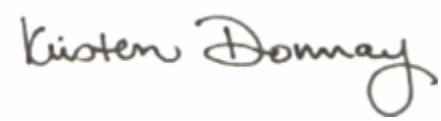
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012619
Investigation #:	2022A0991038
Complaint Receipt Date:	08/19/2022
Investigation Initiation Date:	08/19/2022
Report Due Date:	10/18/2022
Licensee Name:	New Life Services Inc
Licensee Address:	36022 Five Mile Road Livonia, MI 48154
Licensee Telephone #:	(734) 744-7334
Licensee Designee:	Jason Schmidt
Name of Facility:	Alta Vista
Facility Address:	3361 Alta Vista Milford, MI 48380
Facility Telephone #:	(248) 685-8216
Original Issuance Date:	02/21/1990
License Status:	REGULAR
Effective Date:	06/25/2021
Expiration Date:	06/24/2023
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Keara Jones, punished Resident A by refusing to take him on an outing to an air show, because Resident A ate her food that she left in the refrigerator.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/19/2022	Special Investigation Intake 2022A0991038
08/19/2022	Referral - Recipient Rights Received from Office of Recipient Rights (ORR)
08/19/2022	Special Investigation Initiated - Telephone Call to assigned ORR worker, Katie Garcia
08/19/2022	Contact - Document Received Resident A's plan of service and incident report
08/19/2022	Contact - Telephone call made Interviewed home manager, Shurlean Blount-Douglas
08/19/2022	Contact - Telephone call made Interviewed direct care worker, Keara Jones
08/22/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed Resident A, Resident A's guardian, and home manager
09/02/2022	Contact - Document Received Email from ORR worker- substantiating allegations
10/11/2022	Exit Conference Via telephone with Vice President of New Life Services, Sheryl Schmidt

ALLEGATION:

Direct care worker, Keara Jones, punished Resident A by refusing to take him on an outing to an air show, because Resident A ate her food that she left in the refrigerator.

INVESTIGATION:

On 8/19/22, I received a complaint alleging that staff, Keara Jones, punished Resident A by refusing to take him on an outing to an air show, because Resident A ate her food that she left in the refrigerator. I initiated my investigation on 8/19/22 by contacting the assigned Office of Recipient Rights (ORR) worker, Katie Garcia.

On 08/19/22, I interviewed the home manager, Shurlean Blount-Douglas, via telephone. Ms. Blount-Douglas stated that she has worked in the home for 25 years. She was aware of the incident that occurred between Resident A and direct care worker, Keara Jones. Ms. Blount-Douglas stated that last Wednesday, 08/10/22, Ms. Jones opened a bag of cheese that she brought to the home for herself. She gave Resident A some of the cheese. Resident A went back later and ate more of the cheese. When Ms. Jones went to get her food later, she saw that quite a bit of her cheese was gone. Ms. Jones had honey barbecue chicken wings in the freezer, which were also gone. When Ms. Jones asked Resident A about the missing food, he stated that he did not take the food. Ms. Blount-Douglas stated that Resident A is the only resident who goes into the kitchen. He is much higher functioning than the other residents in the home. None of the other staff in the home would have taken food that belonged to someone else, so they knew Resident A took the food. Ms. Blount-Douglas stated that Ms. Jones previously agreed to take Resident A on an outing to an air show. Ms. Jones decided not to take Resident A to the air show because Resident A ate her food and was not truthful about it. Ms. Jones contacted Ms. Blount-Douglas and stated that she was not taking Resident A to the airshow. Ms. Blount-Douglas stated that she was “not getting involved in it either way,” even though the conflict involved staff and a resident. Ms. Blount-Douglas stated that there have been too many instances recently of people trying to get others in trouble, and she did not want to be involved. Ms. Blount-Douglas stated that she was not aware of the home having any policies in place regarding punishing residents. She stated that Resident A has the right to access the refrigerator. There is not a separate refrigerator for staff to use, but “everybody knows if food is yours or not.” Ms. Blount-Douglas stated that Ms. Jones was removed from the schedule pending the investigation. She stated that Ms. Jones’s actions were probably out of anger and “the icing on the cake” was when Resident A said he did not take the food. Resident A has a history of lying and stealing.

On 08/19/22, I interviewed direct care worker, Keara Jones, via telephone. Ms. Jones stated that she has worked in the home for six months. She stated that she brought some cheese and buffalo wings to work for herself. She opened the cheese and gave some to Resident A. Resident A later “took it upon himself to go and eat the rest of it.”

Ms. Jones stated that her buffalo wings were also missing. She stated that Resident A knows it is not right to take her food. She asked Resident A about the missing food and Resident A “chuckled and said sorry.” She stated that Resident A did not seem apologetic about it. Ms. Jones stated that she never agreed to take Resident A to the air show. She was asked to take him, and she stated, “I’ll see.” When the situation with the food happened, Ms. Jones decided not to take Resident A to the air show. She stated that not taking Resident A to the air show was a consequence of his actions. She was upset that he ate her food, as she did not have any other food in the home. She was not aware that it would be viewed as a punishment.

On 08/22/22, I conducted an unannounced onsite inspection at Alta Vista and attempted to interview Resident A. Resident A became upset and stated that he was not able to answer any questions, as he is not his own guardian. Resident A contacted his guardian via telephone during my onsite inspection. I interviewed Resident A’s guardian via speakerphone, and Resident A also participated in the interview. Resident A’s guardian stated that staff, Keara Jones, was supposed to take Resident A to the air show on the weekend. Resident A was excited to be going on an outing and everyone was on the same page. When Ms. Jones was working earlier that week, she gave Resident A some cheese to put on his eggs. Resident A went back later and ate more of the cheese. Ms. Jones noticed that her cheese and some chicken wings were missing, and she got upset. Ms. Jones contacted the home manager and was complaining about her missing food. She decided that she was not going to take Resident A to the air show. Resident A stated that he thought he could eat more of the cheese even when Ms. Jones was not there. He stated that she scolded him for eating the food. She did not really yell at him, but she asked who ate the food. Resident A’s guardian stated that Resident A apologized to Ms. Jones and told her that he would replace the food. Resident A’s guardian contacted the home manager to get clarification about the incident. She asked the home manager if it was true that the staff decided not to take Resident A to the air show because he ate her food. The home manager stated that was accurate. Resident A’s guardian stated that Resident A was looking forward to going to the air show, as he does not get to go on any outings. He is supposed to go into the community four times a week, per his individual plan of service (IPOS). Resident A’s parents are the only ones who take him on outings. The home manager is still scared of COVID, so they do not leave the home. Resident A sits on the couch and watches television or plays video games all day. They have not been on an outing for two or three years.

On 08/22/22, I interviewed the home manager, Shurlean Blount-Douglas. Ms. Blount-Douglas stated that they have not been on any outings due to COVID. She does not feel comfortable taking the residents out in the community. They have not been anywhere since March 2022. They only go to medical appointments or on transport to workshop. Ms. Blount-Douglas stated that Resident A goes out with his parents, but he does not go anywhere with staff.

I reviewed a copy of Resident A’s individual plan of service (IPOS) dated 05/01/22. The IPOS notes that one of Resident A’s goals is to access the community and participate in physical activities responsibly. It notes that Resident A likes to be active in his

community. Due to his legal status and community needs, close monitoring is required while in the community. Resident A should remain within eyesight and hearing distance while in the community. The IPOS lists an objective that Resident A will attend a community outing with his home staff and peers at least once per week 100% of the time.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(4) A licensee shall provide all of the following: (c) An opportunity for community-based recreational activities.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A was not provided an opportunity for community-based recreational activities. Direct care worker, Keara Jones, refused to take Resident A on an outing to the air show as a result of Resident A eating her food without permission. Resident A's individual plan of service dated 05/01/22 indicates that Resident A should attend a community outing with his home staff and peers at least once per week. The home manager and Resident A's guardian both stated that Resident A does not go on outings with staff, as the home manager is afraid of COVID. Resident A only accesses the community with his parents.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (a) Use any form of punishment.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, Keara Jones, punished Resident A by refusing to take him on an outing to the air show after Resident A ate her food without permission. Ms. Jones stated that she decided not to take Resident A on the outing as a consequence of his actions and because he did not seem apologetic about taking her food.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/22/22, I conducted an unannounced onsite inspection at Alta Vista. I interviewed Resident A while his guardian was present via speakerphone. Resident A and his guardian stated that they had concerns about the overall cleanliness of the home. Resident A stated that over the weekend, the bathroom was very dirty. There was stool in the shower and toilet. The toilet is clean now, but staff did not clean the bathroom all weekend. Resident A stated that the shower is slimy and full of mildew. Resident A provided pictures from his phone that showed feces on the toilet bowl and inside rim of the toilet, brown stains in the shower, a used adult brief on the floor of the bathroom next to the garbage can, rust stains on the bathroom sink, and a mattress in the yard. Resident A's guardian stated that the home had issues with bed bugs last year, so they moved a mattress and some furniture into the yard. These items are still in the backyard.

On 08/22/22, I interviewed the home manager, Shurlean Blount-Douglas. Ms. Blount-Douglas stated that staff check the bathroom throughout the day and regularly clean it. She stated that Resident B uses the bathroom on his own and his feces did not go into the water in the toilet bowl. Resident A told her that Resident B did not flush behind him, and Ms. Blount-Douglas cleaned the toilet. Ms. Blount-Douglas stated that she was at the home on Saturday, and the bathroom was not dirty.

I observed Resident B and Resident C sitting in the living room of the home. They were unable to be interviewed due to limited cognitive and verbal abilities.

During the onsite inspection, I conducted a walkthrough of the home and noted the following:

- An extension cord was connected to a power strip (daisy chained) in the front room. Resident A reported that he did this because some of the electrical outlets in the front room were not working. The home manager plugged a vacuum into one of the electrical outlets during the onsite inspection and it did not work.
- There was a hole in the wall in the front room.
- The light fixture in the front room was missing the globe and the bulbs were hanging from a wire.

- The floor in the front room was dirty.
- The blinds in the front room were broken and missing slats.
- The blinds in Resident A's bedroom were broken and missing slats.
- The door handle on the egress door was loose and broken.
- The vent in the bathroom had a thick layer of built-up dust.
- The tile on the bathroom wall was cracked and missing in places.
- The bathroom sinks were rust stained.
- The floor and walls of the shower were dirty, and the grout was mildewy.
- The grout on the bathroom floor was dirty.
- There was an old mattress and an old wooden couch in the backyard.
- The oven door was stained and dirty.

On 10/11/22, I attempted to contact the licensee designee, Jason Schmidt, via telephone to conduct an exit conference. Mr. Schmidt was not available, so I reviewed my findings with his wife, Sherly Schmidt, who is the vice president of New Life Services. Ms. Schmidt stated that they submitted a 30-day discharge notice for Resident A several months ago, as they do not feel he is a good fit for the home; however, a new placement has not been located. I provided technical assistance to Ms. Schmidt regarding training staff so that they have a better understanding of Resident A's diagnosis and behaviors. Ms. Schmidt stated that several of the physical plant repairs have already been addressed. Ms. Schmidt stated that she would share the findings with the licensee designee and they would submit a corrective action plan to address the violations.

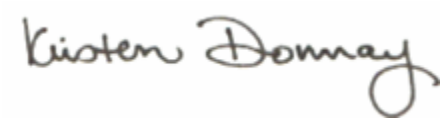
APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the onsite inspection I observed that an extension cord was plugged into a power strip and an electrical outlet in the front room was not working. There was a hole in the wall in the front room. The blinds were broken in the front room and in Resident A's bedroom. The door handle on the egress door was broken. The tile on the bathroom wall was cracked and missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.
ANALYSIS:	During the onsite inspection, I observed an old mattress and an old wooden couch in the yard. Resident A's guardian reported that these items had been in the yard since last year when the home was treated for bedbugs.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report dated: 06/23/21; CAP dated: 06/24/21**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	During the onsite inspection, I observed that the floor in the front room was dirty. The light fixture in the front room did not have a cover. The bathroom sink was rusty. The vent in the bathroom had a thick layer of dust. There was mildew in the shower and the floor and walls of the shower and bathroom were dirty. The oven door was dirty and stained. Resident A stated that the bathroom had not been cleaned over the weekend and shared pictures of a dirty toilet and shower.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report dated: 06/23/21; CAP dated: 06/24/21**

IV. RECOMMENDATION

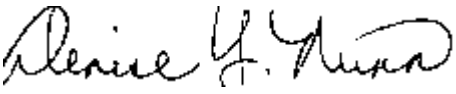
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



10/11/2022

Kristen Donnay Date
Licensing Consultant

Approved By:



10/27/2022

Denise Y. Nunn Date
Area Manager