GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 29, 2022

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

RE: License #: AS630012619
Investigation #: 2023A0991001
Alta Vista

Dear Mr. Schmidt:

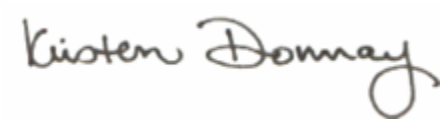
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2023A0991001
Complaint Receipt Date:	10/10/2022
Investigation Initiation Date:	10/11/2022
Report Due Date:	12/09/2022
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?
On 10/05/22, direct care worker, Chekelya “Keke” Waite, was video/audio recording Resident A when she picked him up from his day program. She told Resident A she was recording him because he was making threatening comments to staff.	Yes
On 10/06/22, water was backing up in the bathroom and coming up from the drains. Resident A was unable to use the toilet or shower.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/10/2022	Special Investigation Intake 2023A0991001
10/11/2022	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker, Katie Garcia
10/11/2022	Referral - Recipient Rights Received from recipient rights
10/11/2022	Contact - Telephone call made To Sheryl Schmidt, vice president of New Life Services
10/12/2022	Inspection Completed On-site Unannounced onsite inspection, interviewed home manager, Resident A, and Resident B
10/12/2022	Contact - Telephone call made To area manager, Lori Mitchell
10/12/2022	Contact - Telephone call made Left message for direct care worker, Si'Ani Price
10/12/2022	Contact - Telephone call made Left message for direct care worker, Chekeyla Waite
10/14/2022	Contact - Document Received Invoices for septic services and hotel
10/20/2022	Contact - Telephone call made

	Left message for direct care worker, Si'Ani Price
10/20/2022	Contact - Telephone call made Left message for direct care worker, Chekeyla Waite
10/20/2022	Contact - Telephone call received From direct care worker, Si'Ani Price
10/22/2022	Contact - Document Received Text message and pictures from Resident A
11/09/2022	Contact - Telephone call made Left message for direct care worker, Chekeyla Waite
11/10/2022	Contact - Telephone call received From staff, Chekeyla Waite
11/29/2022	Contact - Telephone call made To Lori Mitchell, area supervisor
11/29/2022	Exit Conference Via telephone with vice president, Sheryl Schmidt

ALLEGATION:

On 10/05/22, direct care worker, Chekelya "Keke" Waite, was video/audio recording Resident A when she picked him up from his day program. She told Resident A she was recording him because he was making threatening comments to staff.

INVESTIGATION:

On 10/10/22, I received a complaint from the Office of Recipient Rights (ORR), alleging that on 10/05/22, direct care worker, Chekelya "Keke" Waite, was video/audio recording Resident A when she picked him up from his day program. She told Resident A that she was recording him because he was making threatening comments to staff. Resident A's guardian did not give permission for any staff to video or audio record him. The complaint also alleged that on 10/06/22, water was backing up in the bathroom and coming up from the drains. Resident A was unable to use the toilet and shower because there was standing water on the bathroom floor. I initiated my investigation on 10/11/22 by contacting the assigned ORR worker, Katie Garcia.

On 10/11/22, I interviewed Sheryl Schmidt the vice president of New Life Services. Ms. Schmidt stated that she was aware of an incident that occurred when Chekeyla Waite was transporting Resident A to his day program. Resident A grabbed the keys from the

van and was making threats towards Ms. Waite. Ms. Schmidt stated that she was not aware of the incident being recorded. Nobody showed her a video. The area supervisor did not see a video. She stated that she felt staff was scared of Resident A, as he knows how to manipulate the system and staff.

On 10/12/22, Ms. Garcia and I conducted an unannounced onsite inspection at Alta Vista, and interviewed the home manager, Shurlean Blount-Douglas. Ms. Blount-Douglas stated that direct care worker, Chekeyla Waite, contacted her on 10/05/22 because Resident A was having a behavior and was making threats towards her. Resident A took the keys from the van when Ms. Waite was dropping him of at his program. Ms. Waite contacted the home manager and called the police. Ms. Waite informed Ms. Blount-Douglas that she told Resident A she was recording him, because he was making threats towards her. She pushed the button to record on her phone and laid it down. Ms. Blount-Douglas stated that she was not aware of any policy that indicates whether or not staff can record residents. She stated that Resident A frequently records staff and takes pictures.

On 10/12/22, I interviewed Resident A. Resident A stated that he took the keys out of the van because staff, Chekeyla Waite, was bickering with him. He was trying to give her directions to get to his program, but she did not want to follow his directions and continued to use her GPS. Resident A told her she was going the wrong way, but she did not listen. Resident A got upset and took the keys. Ms. Waite asked for the keys back, but Resident A did not respond appropriately, so she called the police. Resident A stated that Ms. Waite told him she was recording him during this incident. She told him that she had been recording him since he moved into the home.

On 10/12/22, I interviewed the area manager, Lori Mitchell, via telephone. Ms. Mitchell stated that on 10/05/22, direct care worker, Chekeyla Waite, called her. She was transporting Resident A to his day program, and Resident A was threatening to kill her. Resident A grabbed the keys from the van and ran into the building. Ms. Mitchell stated that Ms. Waite was scared. Ms. Waite told Ms. Mitchell that she video recorded Resident A's voice making threats to her. Ms. Mitchell told Ms. Waite to delete the recordings. Ms. Waite reported that she erased them. Ms. Mitchell stated that it is common sense that staff cannot record the residents, and they should all know that, as it is a HIPAA (Health Insurance Portability and Accountability Act) violation. She stated that she will hold a meeting with staff to review HIPAA rules.

On 11/10/22, I interviewed direct care worker, Chekeyla Waite, via telephone. Ms. Waite stated that she has worked in the home for 90 days. She stated that Resident A is verbally and physically aggressive towards staff. On her first day, Resident A pushed her, bumped her into the wall, and cussed her out in front of the home manager. She stated that Resident A has threatened to kill her, staff, and the other residents in the home. On 10/05/22, Resident A was already upset when she arrived at the home because he did not want to get up. She stated that she was there to transport him to his program. Resident A threatened to kill her because she used her GPS directions instead of following his directions. He tried to grab her phone to throw it out the window

and he punched Ms. Waite. Ms. Waite stated that she put the phone down by the door where Resident A could not reach it. Resident A yelled at Ms. Waite, cussed, and used racial slurs. He stated that he was going to kill her and told her that she would be the sixth person he has killed. Resident A then took the keys out of the ignition and took off running. Ms. Waite called the home manager and the police. The police came and got the keys back from Resident A. He told them he was upset because she would not follow his directions. Ms. Waite stated that she had to transport Resident A home following this incident. She was fearful of him, as he is a large individual who is angry and violent. Ms. Waite stated that she never video recorded Resident A during this incident or at any other time. She stated that she is allowed to voice record him in order to document his threats towards her under the "stand your ground" laws. She stated that she spoke to the police, and they informed her that she could record Resident A.

On 10/20/22, I interviewed direct care worker, Si'Ani Price via telephone. Mr. Price stated that he has worked for the company for 22 years and has worked at Alta Vista for 12 years. Mr. Price stated that he was not aware of any staff person recording or taking video of Resident A. He denied ever recording Resident A. Mr. Price did not have any concerns about the home or any of the staff in the home.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A was not treated with consideration and respect with regards to his privacy when staff, Chekeyla Waite, recorded Resident A's voice as he was having a behavioral episode. Ms. Waite stated that she only recorded Resident A's voice to protect herself; however, this is a violation of his rights. The home manager also stated that she was not aware of any policy as to whether or not staff can record residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 10/06/22, water was backing up in the bathroom and coming up from the drains. Resident A was unable to use the toilet or shower.

INVESTIGATION:

On 10/11/22, I interviewed the vice president of New Life Services, Sheryl Schmidt. Ms. Schmidt stated that she was aware of an issue with the plumbing at Alta Vista. Water was coming up from the drains in the bathroom floors. She stated that they contacted community housing, but the plumber could not come out the same day. The residents could still use the toilets. She stated that the water was coming up from the shower drains. If the residents wanted to shower, they could go to Dunham Group Home to use the showers, which is one street away. Ms. Schmidt was not aware of the residents going to a hotel, as they could still use the bathroom.

On 10/12/22, I interviewed the home manager, Shurlean Blount-Douglas. Ms. Blount-Douglas stated that the shower drains began backing up on Thursday, 10/06/22, when staff was running the showers in the morning. Direct care worker, Si'Ani Price, was working that morning. Mr. Price contact the home manager and the area supervisor, Lori Mitchell, regarding the water backing up from the drains. Ms. Mitchell stated that a plumber would be out on Thursday; however, the plumber did not come on Thursday. Mr. Price was working again on Friday and the shower drains backed up again. They contacted the area manager on Friday, and she stated that they would have to go to a hotel. Ms. Blount-Douglas stated that she and Mr. Price took the residents to the Best Western on Friday. The plumber came to the home on Saturday, and they were able to return to the home. Ms. Blount-Douglas stated that the residents could use the toilets, but they could not shower during this time. Nobody told Ms. Blount-Douglas that she could take the residents to Dunham Group Home for showers. Ms. Blount-Douglas stated that she did not have a copy of the invoice from when the plumber came to the home, as the area manager handled that.

On 10/12/22, I interviewed Resident A. Resident A stated that last week, both bathrooms in the home flooded. There was one or two inches of water on the floor. The drains started making a bubbling sound on Wednesday, and then they started to flood on Thursday. Resident A stated that they could use the toilets, but you could not go "number two" because they would not flush properly. Resident A stated that they went to the hotel on Friday. He was able to take a quick shower on Thursday and he showered at the hotel on Friday, so he did not miss any showers. Resident A provided pictures from his phone, which showed several towels spread out on the bathroom floor. The towels were by the shower and toilet areas and appeared to be soaking wet.

On 10/12/22, I attempted to interview Resident B. Resident B stated that he remembered when there was water in the bathroom, and he remembered going to stay at a hotel. He could not provide any additional information about what happened, as he was fixated on the home's van being broken. I observed Resident C sitting in the living room area. Resident C is nonverbal and was unable to be interviewed.

On 10/12/22, I interviewed the area manager, Lori Mitchell, via telephone. Ms. Mitchell stated that on 10/06/22, direct care worker, Si'Ani Price, texted her to let her know that the bathrooms were flooding. Both bathrooms were flooded, and water was coming up from the shower drains. Ms. Mitchell stated that the septic tank was just pumped by AW Septic in August 2022. Ms. Mitchell contacted Christine from Community Housing to report the issue with the plumbing on Thursday. On Friday morning, Mr. Price contacted Ms. Mitchell again to let her know the bathroom was still flooding. Ms. Mitchell was not aware that a plumber had not been to the house until Mr. Price contacted her on Friday. She contacted Community Housing again, and they informed her that they could not get someone to come out until next week. Ms. Mitchell told them that this was not acceptable. She booked rooms at a hotel for staff and the residents for Friday night. The septic company came out to the home on Saturday and the residents were able to return that day. Ms. Mitchell provided a copy of an invoice from J.W. Field Septic Services which shows they came out on 10/08/22 and the septic tanks were pumped. The invoice notes that levels were normal and there was nothing blocking the inlet pipes. It notes "all looks good."

On 10/20/22, I interviewed direct care worker, Si'Ani Price via telephone. Mr. Price stated that on Thursday, 10/06/22, water started coming up from the shower drains in both bathrooms at the home. He stated that you could hear the drains bubbling first, and then water just started coming up. He estimated that there was about two inches of water on the floor. The water went down after a couple of hours. He stated that everyone received a shower Thursday morning, except Resident A. By the time Resident A got up, the bathrooms were flooded. He stated that Resident A washed up with a towel, but he did not take a full shower. Mr. Price stated that one of the toilets was working, but he was not sure if the toilet in the second bathroom was working. He reported the issue to the home manager, Shurlean, and the area manager, Lori. He stated that they tried to contact a plumber, but the plumber could not come out right away, so they went to a hotel on Friday. Mr. Price stated that the managers are usually pretty good about fixing things in the home. It never takes more than a day or two if they have an issue, but it depends on how quickly someone can get out to fix the issue. This was the first time the drains overflowed. They have heard the bubbling noise before, but water never came up. Mr. Price stated that the plumbing is working properly now, and they have not had any issues with flooding since this incident. He heard the drains making the bubbling sound yesterday, so he reported it to the home manager, but no water came up.

On 10/22/22, I received a text message and photographs from Resident A stating that the bathroom was flooding again. The pictures showed water on the floor of the bathroom as well as a toilet that appeared to be overflowing.

On 11/29/22, I interviewed the area manager, Lori Mitchell, via telephone. Ms. Mitchell stated they contacted Community Housing after the bathrooms flooded for the second time. They sent a plumber to home who found numerous paper towels and wipes blocking the pipes. Ms. Mitchell stated that the pipes were cleared and there are currently no issues with the plumbing.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief valve, both of which shall be in good working condition.
ANALYSIS:	Based on the information gathered through my onsite inspection, there is sufficient information to conclude that the plumbing fixtures were not maintained in good working condition, as the bathrooms flooded on 10/06/22 and 10/22/22. Staff and Resident A reported hearing the pipes bubbling and gurgling, prior to the drains backing up in the bathrooms. The septic tanks were pumped on 10/08/22; however, this did not address the issue, as the drains overflowed again on 10/22/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 10/12/22, I requested a copy of the staff schedule from the home manager, Shurlean Blount-Douglas. Ms. Blount-Douglas stated that she did not have a schedule available in the home. She stated that she could write a schedule, as the same people work every shift, but it was not written in advance.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	During my onsite inspection, there was no staff schedule that was written in advance available to review.

CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

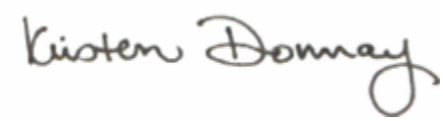
During the onsite inspection, Resident A stated that the home's van has a crack in the windshield that goes all the way across the windshield. He provided a picture of the windshield from his phone, which shows a crack from the passenger side extending horizontally across the windshield to the driver's side of the van. The home manager, Shurlean Blount-Douglas, confirmed that the windshield of the van is cracked. It has been cracked for years. She reported the crack to Sheryl Schmidt, but it has not been repaired. Ms. Blount-Douglas stated that she goes to the office every Monday and gives them a form that states the needed repairs at the home. She stated that she does not keep a copy of these forms. Direct care worker, Si'Ani Price, also confirmed that the van has a couple of cracks in the windshield. It has been cracked since last winter. I was unable to observe the van during my onsite inspection, as it had a flat tire that was being repaired.

On 11/29/22, I conducted an exit conference via telephone with Sheryl Schmidt, the vice president of New Life Services, as her husband who is the licensee designee, Jason Schmidt, was not available. Ms. Schmidt stated that they would submit a corrective action plan to address the violations that were identified during the investigation.

APPLICABLE RULE	
R 400.14319	**Resident transportation.**
	When a home provides transportation for a resident, the licensee shall assure all of the following: (a) That a vehicle is in good operating condition.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home's van was not maintained in good operating condition. Resident A, the home manager, and staff stated that the van has a crack across the windshield. The windshield has been cracked for over a year and has not been repaired.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

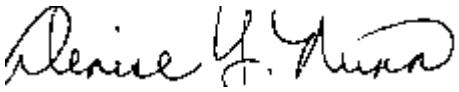
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



11/29/2022

Kristen Donnay Date
Licensing Consultant

Approved By:



11/29/2022

Denise Y. Nunn Date
Area Manager