GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2022

Joseph Bates
CHS Group LLC
115 East Front
Monroe, MI 48161

RE: License #: AS580403346
Investigation #: 2023A0116012
Vineyard Home

Dear Mr. Bates:

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) 456-0380.

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 #:	AS580403346
Investigation #:	2023A0116012
Complaint Receipt Date:	11/28/2022
Investigation Initiation Date:	11/29/2022
Report Due Date:	01/27/2023
Licensee Name:	CHS Group LLC
Licensee Address:	115 East Front Monroe, MI 48161
Licensee Telephone #:	(734) 240-0185
Administrator:	Joseph Bates
Licensee Designee:	Joseph Bates
Name of Facility:	Vineyard Home
Facility Address:	15127 S Dixie Monroe, MI 48161
Facility Telephone #:	(734) 636-9140
Original Issuance Date:	09/07/2022
License Status:	TEMPORARY
Effective Date:	09/07/2022
Expiration Date:	03/06/2023
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/25/22, I received an incident report that documented that on 11/22/22, staff, Ebony Walker and Mackenzie Slinker left the home, leaving the 6 residents alone for about 30 minutes.	Yes

III. METHODOLOGY

11/28/2022	Special Investigation Intake 2023A0116012
11/28/2022	Contact - Telephone call received Spoke with Laura Reinhardt, Chief Operating Officer(COO) of CHS Group, on 11/23/22 regarding the incident.
11/28/2022	Referral - Recipient Rights Made by Shilo Wood, program coordinator.
11/29/2022	Special Investigation Initiated - On Site Interviewed Resident's A-D, reviewed Resident A's Individualized Plan of Service (IPOS), and interviewed Program Coordinator Shilo Wood.
11/29/2022	Inspection Completed-BCAL Sub. Compliance
11/30/2022	APS Referral Made.
12/13/2022	Contact - Telephone call made Attempted to interview staff, Ebony Walker.
12/13/2022	Contact - Telephone call made Spoke with Ms. Reinhardt.
12/13/2022	Exit Conference With licensee designee, Joseph Bates.

ALLEGATION:

On 11/25/22, I received an incident report that documented that on 11/22/22, staff, Ebony Walker and Mackenzie Slinker left the home, leaving the six residents alone for about 30 minutes.

INVESTIGATION:

On 11/23/22, I received a telephone call from Laura Reinhardt, COO of CHS group, informing me that she would be completing an incident report regarding the six residents who reside at the home. Ms. Reinhardt reported that they were left home alone for about a half hour. She reported that the incident report would provide all of the details.

On 11/29/22, I conducted an unscheduled onsite inspection and interviewed Shilo Woods, program coordinator, spoke with Ms. Reinhardt, interviewed Residents A-D and reviewed resident records.

Ms. Woods reported that on Tuesday 11/22/22, at around 5:00 p.m. she received a telephone call from Christy Munson, who was the home manager at the time, stating that staff, Ebony Walker, had contacted her telling her that she would be leaving the home and not finishing her shift, due to a family emergency. Ms. Woods reported that Mackenzie Slinker was on shift with Ms. Walker, and that Ms. Munson told her that she was heading to the home to cover the remaining hours of Ms. Walker's 4:00 p.m. to 12:00 a.m. shift. Ms. Woods reported that Ms. Munson never went to the home, turned off her cell phone and quit. Ms. Woods reported that at about 6:30 p.m. she started receiving text messages from Ms. Slinker stating that she was going to leave the home at 7:00 p.m. Ms. Woods reported that when she saw the message, she texted Ms. Slinker back and asked her not to leave until she was able to get dressed and drive over to the home. Ms. Woods reported on her way to the home she called Ms. Reinhardt to inform her of what was going on. Ms. Woods reported that while enroute to the home her car over heated and Ms. Reinhardt had to come pick her up, and the two of them made it to the home at around 7:30 p.m. Ms. Woods reported when they arrived at the home Ms. Slinker was not there and the six residents were alone. Ms. Woods reported that they were all fine and no one was harmed. Ms. Woods added that Resident A is a 1:1 during waking hours so there must be two staff working during day and afternoon shift. Ms. Woods reported that Resident A was in his bedroom and unaware that the staff had left them alone.

Ms. Woods reported that Ms. Slinker has been terminated and that internal investigation was underway regarding Ms. Walker, leaving prior to ensuring that another staff was there to cover her.

Ms. Woods also reported that she made a referral to the Office of Recipient Rights (ORR) and has spoken with Coy Hernandez, the assigned rights investigator.

I spoke with Ms. Reinhardt who reported that she was glad that the residents were safe and unharmed and reported that they had hired a new home manager and are still actively trying to hire additional staff.

I interviewed Resident A, and he reported that he was not aware that staff had left them home alone on 11/22/22. Resident A reported that he just found out about it

today. Resident A did recall that staff, Ebony Walker, left the home shortly after arriving. Resident A reported that he thought Ms. Slinker was still in the home.

I interviewed Resident B, and he reported that one day last week staff, Ms. Walker and Ms. Slinker left him and his housemates home alone. Resident B reported that Ms. Walker left first and then Ms. Slinker left. Resident B reported that Ms. Slinker said, “I’m not putting up with this [s#%@],” and walked out.

I interviewed Resident C, and he reported that staff, Ms. Walker, just got up and left her shift, then a little while later Ms. Slinker walked out and quit. Resident C reported that he called the Monroe County mental health after hours hotline and informed them that him and his five housemates were home alone. Resident C reported shortly after he made the call Ms. Woods and Ms. Reinhardt arrived at the home. Resident C reported that Ms. Woods stayed the remainder of the shift until the midnight staff arrived.

I interviewed Resident D, and he reported that he did not recall ever being left alone in the home and was not aware that the staff had left him and his housemates alone.

I reviewed Resident’s A-F Individual Plans of Service (IPOS) and confirmed that Resident A requires 1:1 staffing during waking hours. Resident A is the only resident that requires 1:1 staffing.

On 12/13/22, I attempted to interview staff, Ebony Walker. Ms. Walker reported that she has not worked in the home since the incident and is no longer employed there. Ms. Walker refused to answer any questions.

On 12/13/22, I spoke with Ms. Reinhardt, and she reported that Ms. Walker has not worked since 11/23/22, after 4 no calls, no shows so they consider that a voluntarily quit.

On 12/13/22, I conducted the exit conference with licensee designee, Joseph Bates, and informed him of the findings of the investigation and the specific rule violations. Mr. Bates reported an understanding and reported he would submit an acceptable corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Woods and Residents B and C, I am able to corroborate the allegation. Ms. Woods and Residents B and C confirmed that former staff, Ebony Walker and Mackenzie Slinker left the home during their 4:00 p.m. to 12:00 a.m. shift on 11/22/22, without finding appropriate coverage. This resulted in Residents A-F being left home alone for approximately 30 minutes. This violation is established as Ms. Walker and Ms. Slinker are not suitable to assure the welfare of the residents, as evidenced on their poor choice to leave the residents home alone.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Woods, Residents B and C, and review of the Resident's A-F IPOSs, I am able to corroborate the allegation. Ms. Woods reported that due to Resident A requiring 1:1 staffing during waking hours, there must be two staff working day and afternoon shift. Ms. Woods confirmed that did not happen on 11/22/22, after both staff on shift left the home. Residents B and C confirmed that both staff left the home during their assigned shifts, leaving them home alone. I reviewed the IPOSs for Resident's A-F and confirmed that Resident A requires 1:1 staffing during waking hours. Additionally, the remaining five residents require 24-hour supervision, personal care and protection. This violation is established because during a period of at least 30 minutes, there was no staff on duty for the supervision, personal care, and protection of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Pandrea Robinson 12/14/22
Pandrea Robinson Date
Licensing Consultant

Approved By:

A. Hunter 12/15/22
Ardra Hunter Date
Area Manager