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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

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

RE: License #: AS810266894
Investigation #: 2023A0575028
Cherrywood

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,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS810266894
Investigation #:	2023A0575028
Complaint Receipt Date:	05/02/2023
Investigation Initiation Date:	05/02/2023
Report Due Date:	06/01/2023
Licensee Name:	Adult Learning Systems-Lower Michigan
Licensee Address:	8170 Jackson Road, Suite F Ann Arbor, MI 48103
Licensee Telephone #:	(734) 408-0112
Administrator:	Sherri Turner, Designee
Licensee Designee:	Sherri Turner, Designee
Name of Facility:	Cherrywood
Facility Address:	3600 Cherrywood Ann Arbor, MI 48104
Facility Telephone #:	(734) 332-0968
Original Issuance Date:	04/18/2005
License **Status:**	REGULAR
Effective Date:	03/20/2022
Expiration Date:	03/19/2024
Capacity:	6
Program Type:	PH; DD; MI

II. ALLEGATION(S)

	Violation Established?
Staff Christina Cooper mistreated Resident A.	Yes

III. METHODOLOGY

05/02/2023	Special Investigation Intake-2023A0575028
05/02/2023	APS Referral
05/02/2023	Referral - Recipient Rights
05/02/2023	Special Investigation Initiated - Telephone
05/02/2023	Contact - Telephone call made- (1) staff: (a) Christina Cooper; (b) Rosalyn Gains-Baker. (2) Resident A's guardian
05/03/2023	Inspection Completed On-site- interviews with (a) Resident A, (b) Christy Minor-home manager
05/03/2023	Contact - Telephone call made- (a) Resident B; (b) Christy Minor-home manager
05/10/2023	Contact - Telephone call made-(a) Christy Minor-home manager; (b) staff Christina Cooper
05/10/2023	Corrective Action Plan Requested and Due on 05/31/2023
05/10/2023	Exit Conference-with licensee designee and administrator

ALLEGATION:

Staff Christina Cooper mistreated Resident A.

INVESTIGATION:

An APS referral was received, and an ORR referral was made on 5/2/2023.

On 5/2/2023, I interviewed staff Christina Cooper. She stated that Resident A became irate when she discovered that Resident A was trying to take her cell phone to school, which she is not allowed to do. She stated Resident A did not fall on the floor or hit her head during the incident.

On 5/2/2023, I interviewed staff Rosalyn Gains-Baker. She stated she did not witness the incident but could hear loud talking from where she was in the facility. On 5/2/2023, I interviewed Resident A's guardian. She stated she was satisfied with Resident A's placement and has not heard of any other problems in the facility. Finally, she stated Resident A does not have permission to take her cell phone to school.

On 5/3/2023, I interviewed Resident A. She stated staff Christina Cooper pushed her down scrapping her knee and hitting her head on a TV set. She showed me her knee and head where she claimed the injuries took place. I could not see any bruises and/or abrasions that would have supported her claim. Also, she stated the incident took place yesterday (5/2/2023), when it took place on 4/28/2023, per the APS referral. Finally, she stated Resident B witnessed the incident, but she would not answer my question about why the incident took place. She said she knows she's not allowed to take her cell phone to school.

On 5/3/2023, I interviewed Resident B. He stated staff Christina Cooper did not push Resident A to the floor. He stated staff Christina Cooper physically re-directed/escorted Resident A to her room.

On 5/3/2023, I interviewed home manager, Christy Minor. She stated that per Resident A's behavior plan, when Resident A gets verbally aggressive, staff can re-direct her to her bedroom.

On 5/10/2023, I re-interviewed home manager, Christy Minor based on a question from APS. She looked up Resident A's current behavior plan and found it does not allow staff to physically re-direct Resident A when she becomes verbally/physically aggressive.

On 5/10/2023, I re-interviewed Christina Cooper. She admitted she physically re-directed Resident A to her bedroom when Resident A became verbally aggressive.

On 5/10/2023, I conducted an exit conference with the licensee designee and administrator.

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:	While there are inconsistencies in Resident A's version of the incident, staff Christina Cooper admitted she physically escorted Resident A to her bedroom which was corroborated by Resident B. Therefore, the preponderance of credible evidence is that staff Christina Cooper mistreated Resident A by physically escorting her to her bedroom and thus exposing her to the risk of physical harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable plan of correction; I recommend no changes in the status of the license.

Jeffrey J. Bozsik
Licensing Consultant

Date: 5/10/2023

Approved By:

Ardra Hunter
Area Manager

Date: 05/11/2023