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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

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

RE: License #: AS630012681
Investigation #: 2023A0465024
McGinnis

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012681
Investigation #:	2023A0465024
Complaint Receipt Date:	05/17/2023
Investigation Initiation Date:	05/22/2023
Report Due Date:	07/16/2023
Licensee Name:	New Life Services Inc
Licensee Address:	36022 Five Mile Road Livonia, MI 48154
Licensee Telephone #:	(734) 744-7334
Administrator:	Jason Schmidt
Licensee Designee:	Jason Schmidt
Name of Facility:	McGinnis
Facility Address:	4473 McGinnis Holly, MI 48442-0204
Facility Telephone #:	(248) 634-1499
Original Issuance Date:	02/13/1991
License Status:	REGULAR
Effective Date:	01/19/2023
Expiration Date:	01/18/2025
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 5/15/2023, direct care staff, Jason McCauley, did not provide line-of-sight supervision to Resident A.	Yes
On 5/24/2023, direct care staff, Jason McCauley, threatened to withhold dessert from Resident B if she did not eat her dinner.	Yes

III. METHODOLOGY

05/17/2023	Special Investigation Intake 2023A0465024
05/22/2023	Special Investigation Initiated - Telephone I spoke to home manager, Monica Vance, via telephone
06/09/2023	Inspection Completed On-site I conducted an onsite investigation. I conducted a walk-through of the facility, observed residents, and interviewed direct care staff, Jonathan Ramirez and Monica Vance
06/19/2023	Contact - Document Received Facility documents received via email
06/21/2023	Contact - Telephone call made I attempted to contact ex-direct care staff, Jason McCauley; Phone is not in service
06/28/2023	Contact - Telephone call made I attempted to contact ex-direct care staff, Jason McCauley; Number not in service
07/05/2023	Exit Conference I conducted an Exit Conference with licensee via telephone

ALLEGATION:

On 5/15/2023, direct care staff, Jason McCauley, did not provide line-of-sight supervision to Resident A.

INVESTIGATION:

On 5/17/2023, an *Incident/Accident Report* was received from home manager, Monica Vance. The incident report stated the following:

5/15/2023 at 8:20pm; Completed by direct care staff, Jonathan Ramirez: Jason McCauley is not following Resident A's crisis plan of having him in sight at all times. Resident A was found in the bathroom unattended with the door closed for 30 minutes and attempting to get out of his wheelchair. I asked Mr. McCauley where Resident A was, and he said he didn't know and didn't bother to look for him. I found Resident A in the bathroom and brought him into the living room, so he was in the line of sight.

On 5/22/2203, I spoke to home manager, Monica Vance, via telephone. Ms. Vance acknowledged that the information contained in the incident report is accurate.

On 6/9/2023, I conducted an onsite investigation. At the time of my onsite investigation, there were three residents residing in the home, including Resident A. Resident A is non-verbal and was unable to be interviewed. I completed a walk-through of the facility, reviewed resident files, observed residents, and interviewed direct care staff, Jonathan Ramirez and Monica Vance.

The *Face Sheet* stated that Resident A was admitted to the facility on 10/23/2020 and has a legal guardian, Guardian A1. The *Health Care Appraisal* lists Resident A's medical diagnosis as Severe Intellectual Disability and Seizure Disorder. The *Assessment Plan for AFC Residents* and the *Crisis Prevention and Safety Plan* stated that Resident A is wheelchair-bound, requires supervision in the community, is non-verbal, has a history of aggressive behavior, needs assistance with self-care tasks, and requires to be within sight and hearing of staff at all times to monitor for seizure precautions.

I interviewed direct care staff, Jonathan Ramirez, who stated that he has been working at the facility for five months. Mr. Ramirez stated, "I was working on the day of this incident, and I am the person that completed the incident report. Resident A is wheelchair bound and requires line-of-sight by staff at all times and assistance with toileting. Mr. McCauley was trained and knew that Resident A required line of sight. On 6/15/2023, I was working with Mr. McCauley at the facility. I went into the backroom to provide care to another resident. When I came back into the main living room area, I saw Mr. McCauley sitting in the living room area and I asked him where Resident A was. Mr. McCauley said he didn't know and then he continued to sit there. Mr. McCauley did not proceed to get up and look for Resident A. He just continued to sit there. I immediately began walking around the facility to find Resident A. I found Resident A in the bathroom, trying to get himself off of his wheelchair and onto the toilet. I estimate that I was away for 30 minutes before I came back into the living room and found out that Mr. McCauley was not supervising Resident A, and that is how long I think Resident A was alone for and unattended. I was very frustrated with Mr.

McCauley's lack of follow-through on doing his job. I completed an incident report, and I informed management of the incident. Mr. McCauley no longer works here. I have never observed any other staff leave Resident A unattended. I have not had any issues since this one incident."

I interviewed direct care staff, Monica Vance, who stated that she has been working at the facility for 12 years. Ms. Vance stated, "I was not working that day, but I am aware of the incident when Mr. McCauley left Resident A unattended. Mr. McCauley no longer works here. This is the only time I am aware of something like this happening. I think we do a good job of caring for all residents, including Resident A. There have not been any further issues regarding staff supervision of Resident A."

On 6/21/2023 and 6/28/2023, I attempted to contact Mr. McCauley, and have been unable to reach him as of the date of this report.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	According to the *Incident/Accident Report* and Mr. Ramirez, on 5/15/2023, he observed Resident A was unsupervised in the bathroom for an unknown length of time, without line of sight provided by Mr. McCauley. According to Mr. Ramirez and Ms. Vance, Mr. McCauley was trained and fully aware that Resident A requires line of sight at all supervision at all times. Based on the information above, there is sufficient information to confirm that on 5/15/2023, Mr. McCauley did not adhere to, and adequately provide supervision to Resident A, as specified in his written assessment and safety plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 5/24/2023, direct care staff, Jason McCauley, threatened to withhold dessert from Resident B if she did not eat her dinner.

INVESTIGATION:

On 5/26/2023, a complaint was received, alleging that on 5/24/2023, Mr. McCauley threatened to withhold dessert from Resident B if she did not eat her dinner.

During my onsite investigation on 6/9/2023, I interviewed Resident B, Mr. Ramirez, and Ms. Vance. I was unable to interview the other two residents living in the home due their non-verbal communication limitations.

I interviewed Resident B, who stated that she likes living at the facility. Resident B stated, “I like living here. Staff are good to me. But Mr. McCauley was not nice. He told me I could not have dessert if I didn’t eat dinner.” Resident B stated that she was able to receive ice cream but was upset that Mr. McCauley had threatened to withhold ice cream from her. Resident B stated that she has not had any issues with any other staff.”

I spoke to Mr. Ramirez, who stated, “I was working when this incident happened. I overheard Mr. McCauley tell Resident A that if she did not eat all of her dinner, that he was not going to give her dessert. Resident B did eat all of her food and was provided ice cream for dessert but what Mr. McCauley said was not okay. I did hear Mr. McCauley make this threat to Resident B and this allegation is true. He is no longer working here, and we have not had any other issues.”

I interviewed Ms. Vance, who stated, “I was not working that day, but I am aware of the incident when Mr. McCauley left Resident A unattended. Mr. McCauley no longer works here. This is the only time I am aware of something like this happening. I think we do a good job of caring for all residents, including Resident A. There have not been any further issues regarding staff supervision of Resident A.”

On 6/21/2023 and 6/28/2023, I attempted to contact Mr. McCauley, and have been unable to reach him as of the date of this report.

On 7/5/2023, I conducted an exit conference with licensee designee/administrator, Jason Schmidt, via telephone. Mr. Schmidt is in agreement with the findings of this report.

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: **(f) Subject a resident to any of the following:** **(iv) Threats.**

ANALYSIS:	According to Resident B, on 5/24/2023, Mr. McCauley threatened to withhold dessert from her if she did not eat her dinner. According to Mr. Ramirez, on 5/24/2023, he witnessed Mr. McCauley verbally threaten to withhold food from Resident B if she did not finish eating her dinner. Based on the information above, there is sufficient information to confirm that on 5/24/2023, Mr. McCauley made a verbal threat to Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Stephanie Gonzalez 7/6/2023

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn 07/31/2023

Denise Y. Nunn Date
Area Manager