GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 3, 2023

Nicolette Cheff
Mill Street AFC Home, Inc.
P.O. Box 235
Atlas, MI 48411

RE: License #: AM630289045
Investigation #: 2023A0465036
Mill Street AFC Home

Dear Mrs. Cheff:

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
Fax: 517-763-0204
gonzalezs3@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630289045
Investigation #:	2023A0465036
Complaint Receipt Date:	09/07/2023
Investigation Initiation Date:	09/11/2023
Report Due Date:	11/06/2023
Licensee Name:	Mill Street AFC Home, Inc.
Licensee Address:	307 Mill St. Ortonville, MI 48462
Licensee Telephone #:	(248) 627-3067
Administrator:	Nicolette Cheff
Licensee Designee:	Nicolette Cheff
Name of Facility:	Mill Street AFC Home
Facility Address:	307 Mill St. Ortonville, MI 48462
Facility Telephone #:	(248) 627-3067
Original Issuance Date:	11/20/2007
License Status:	REGULAR
Effective Date:	03/12/2023
Expiration Date:	03/11/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 8/31/2023, the facility refused to allow Resident A to return to the home.	Yes

III. METHODOLOGY

09/07/2023	Special Investigation Intake 2023A0465036
09/07/2023	APS Referral Adult Protective Services (APS) referral, denied for investigation
09/07/2023	Special Investigation Initiated – Telephone I spoke to Complainant via telephone
09/11/2023	Contact – Telephone call made AFC Licensing Consultant, Johnna Cade, spoke to licensee designee/administrator, Nicolette Cheff, via telephone
09/18/2023	Inspection Completed On-site I completed a walk-through of the facility, reviewed resident files, and interviewed direct care staff, Sharon Hernandez
09/27/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone
10/05/2023	Contact - Telephone call made I spoke to licensee designee via telephone
10/11/2023	Contact - Document Received Facility documents received via email
10/18/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone
10/20/2023	Exit Conference I conducted an exit conference with licensee designee via telephone, Nicolette Cheff

ALLEGATION:

On 8/31/2023, the facility refused to allow Resident A to return to the home.

INVESTIGATION:

On 9/7/2023, a complaint was received, alleging that on 8/31/2023, the facility refused to allow Resident A to return to the home. The complaint indicated that Resident A has a medical diagnosis of Schizophrenia and requires adult foster care services. On 8/31/2023, the facility staff packed up all of Resident A's belongings and dropped him off at a day crisis center for mental health evaluation. Once the evaluation was completed, the facility was asked to pick Resident A up, and they refused. Due to Resident A having no where to go, he was transported to the local hospital as a temporary solution while placement is located.

On 9/7/2023, I spoke to Complainant via telephone. Complainant confirmed that the information contained in this complaint is accurate.

On 9/11/2023, Adult Foster Care Licensing Consultant, Johnna Cade, spoke to licensee designee/administrator, Nicolette Cheff, via telephone. Ms. Cheff informed Ms. Cade that she did discharge Resident A from the facility and was refusing to allow him to return to the home. Ms. Cheff acknowledged her refusal to allow Resident A to return to the facility is an AFC licensing rule violation.

On 9/18/2023, I completed a walk-through of the facility, reviewed resident files, and interviewed direct care staff, Sharon Hernandez.

The *Face Sheet* stated that Resident A resided at the facility from 10/23/2010 – 8/31/2023. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia and Bi-Polar. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, requires assistance with personal hygiene tasks but has a history of refusing to shower, history of refusal to eat food, incontinent and refusal to change clothes or bathe, and does not require use of assistive devices. I reviewed the *30-Day Discharge Statement*, dated 8/31/2023, which stated, in part, the following:

> *Resident A is hereby notified we reserve the right to terminate your residency due to the following violations in the home rules. You have 30 days to vacate but if there are extreme changes in behaviors after this notice is served, then the facility reserves the right to call for immediate removal and/or petition the county for immediate hospitalization. Resident A has on more than one occasion refused his medication, bath or meals; Resident A is a consistent disruption to the stability and routine of the home environment; Resident A is a danger to himself*

or others (this is cause for immediate removal from the home); Resident A is repeatedly disrespectful to the staff; Resident A displays inappropriate verbal or physical interactions with others in the home; Resident A has repeatedly ignored the warnings from staff to cease behaviors. Demand is hereby made that Resident A vacate via immediate eviction.

I interviewed direct care staff, Sharon Hernandez, who stated she has worked at the facility for seven years. Ms. Hernandez stated, "I provided care to Resident A while he lived here. He was having a lot of issues with refusing to comply with his treatment plan, refusing to bathe or shower. He was also becoming very aggressive and would sometimes refuse medications or meals. I was working the day that we evicted Resident A from the facility. I was told by the licensee to pack all of Resident A's belongings and call the police and hospital to have him undergo a psychological evaluation. He was taken to Common Ground for evaluation and then to the hospital after that. I was told by management that we would not allow Resident A to come back here." Ms. Hernandez acknowledged that this complaint is true.

On 9/27/2023 and 10/18/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "This complaint is true. When the facility kicked out Resident A on 8/31/2023, they had him transported to Common Ground, which is a mental health clinic, and does not have housing or shelter services. Within a few hours of being taken to Common Ground, Resident A was ready to be picked up, but the facility refused to pick him up. Subsequently, the staff at Common Ground had Resident A transported to the local hospital that same day because he had no where to go. Resident A was discharged from the hospital on 9/1/2023 and was discharged to the streets. He resided at my home for three weeks while a new placement was located. Resident A is now living in a new adult foster care facility and is doing well."

On 10/5/2023, I spoke to licensee designee/administrator, Nicolete Cheff, via telephone. Ms. Cheff stated, "I issued an immediate discharge for Resident A on 8/31/2023 and did not allow him to return to the home. This was a very difficult decision to make. I did not make this decision lightly. Resident A was refusing all personal care, medication, and meals. He was also destroying property and was getting really out of control. I have never done something like this before as far as refusing to allow a resident to return to the home, but it became too much and an unsafe situation. After we had Resident A transported to Common Ground, he did call the facility and ask to return but we told him no." Ms. Cheff acknowledged that she issued the discharge notice on 8/31/2023, with no prior discharge notice issued before this date.

On 10/20/2023, I conducted an exit conference with Ms. Cheff via telephone. Ms. Cheff is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	According to the *30-Day Discharge Statement*, dated 8/31/2023, the facility issued the discharge notice the same day that they had Resident A transported to an outpatient clinic. The discharge notice indicated that the facility issued an immediate removal and eviction of Resident A from the home, in direct contradiction to adult foster care licensing rules. According to Ms. Hernandez and Ms. Cheff, Resident A was discharged from the home on 8/31/2023, without prior notice issued. Ms. Hernandez and Ms. Cheff stated that Resident A was not allowed to return to the home, despite being aware that he had nowhere to go. Ms. Hernandez and Ms. Cheff acknowledged that this complaint is true. Based on the information above, there is sufficient information to confirm that the facility improperly discharged Resident A from the home on 8/31/2023, prior to an appropriate alternate placement being located.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend this investigation be closed with no change to the status of the license.

10/26/2023

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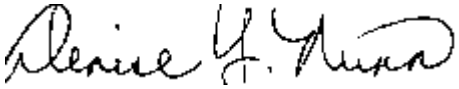
Stephanie Gonzalez Date
Licensing Consultant

Approved By:



11/03/2023

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Denise Y. Nunn Date
Area Manager