GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2024

Karen LaFave
Adult Learning Systems - UP, Inc
Suite-4
228 West Washington
Marquette, MI 49855

RE: License #: AS520302805
Investigation #: 2024A0873027
Woodridge

Dear Ms. LaFave:

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 (616) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N. W.
Grand Rapids, MI 49503
(906) 250-9318
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520302805
Investigation #:	2024A0873027
Complaint Receipt Date:	07/26/2024
Investigation Initiation Date:	07/26/2024
Report Due Date:	09/24/2024
Licensee Name:	Adult Learning Systems - UP, Inc
Licensee Address:	Suite-4 228 West Washington Marquette, MI 49855
Licensee Telephone #:	(906) 228-7370
Administrator:	Karen LaFave
Licensee Designee:	Karen LaFave
Name of Facility:	Woodridge
Facility Address:	169 Fairbank Street Marquette, MI 49855
Facility Telephone #:	(906) 273-1100
Original Issuance Date:	10/01/2009
License Status:	REGULAR
Effective Date:	03/21/2024
Expiration Date:	03/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION

	Violation Established?
Staff locked Resident A in her bedroom	Yes
Additional Findings	Yes

III. METHODOLOGY

07/26/2024	Special Investigation Intake 2024A0873027
07/26/2024	Special Investigation Initiated - Telephone Interview with ORR
07/29/2024	Contact - Face to Face Interviews with staff
08/06/2024	Contact - Face to Face Interviews with staff at ALS
08/07/2024	APS Referral Referred to APS
08/07/2024	Inspection Completed On-site
09/17/2024	Exit Conference With Karen LaFave, licensee designee

ALLEGATION:

Staff locked Resident A in her bedroom.

INVESTIGATION:

On 7/26/24, I interviewed Casey Olsen from Pathways community mental health (CMH) office of recipient rights (ORR) over the telephone. Midnight staff at the facility locked Resident A in her bedroom.

On 7/29/24, I interviewed midnight staff Jamie Benson at Adult Learning Systems (ALS) offices. Resident A was violent toward staff. She kicked, punched, and spit on staff. When Resident A's behaviors became difficult, Ms. Benson was told by other staff to lock Resident A in her bedroom until she calms down. Resident A's bedroom

does not lock. After Resident A was escorted to her bedroom, Ms. Benson sat outside the door and did not let Resident A out. Resident A tried to get out of her bedroom. Staff have only done this twice and it's only when Resident A's behavior was out of control.

On 7/29/24, I interviewed midnight staff Michelle Metternich, at ALS offices. Resident A was aggressive the last several weeks and she attacked staff members. Ms. Metternich and staff member Emma Sawyer took turns sitting outside Resident A's bedroom door to keep her in her bedroom. Each time this was for about an hour.

On 8/6/24, I interviewed midnight staff Emma Sawyer at ALS offices who recounted that Resident A was aggressive and behavioral. During the course of that night, Ms. Sawyer reports that she was physically attacked by Resident A. The other staff member on duty that night, Ms. Metternich, several times, took Resident A back to her room. However, Resident A kept coming out of her room within a couple minutes. Eventually, Ms. Metternich sat outside Resident A's door to ensure Resident A stayed in her room. This occurred for at least 45 minutes.

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: **(d) Confine a resident in an area, such as a room, where egress is prevented**
ANALYSIS:	All staff interviewed admitted to either knowing that Resident A was prevented from leaving her bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Ms. Benson stated that, although she did not sleep during her shift, she is aware that other staff members have.

Ms. Metternich also mentioned that most nights at the house, midnight staff are sleeping during their shift.

Ms. Sawyer stated that, staff members slept regularly on their shift. Staff members would routinely set their alarms to wake up after going to sleep around 3am.

I reviewed ALS's employee policy manual, reviewed annually by all employees, where it explicitly prohibits staff from sleeping during their shift.

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:	Several staff members admitted to having slept while on duty.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/17/24, I explained the findings of this report to Karen LaFave, licensee designee. Ms. LaFave was aware of the investigation at the home and understood the reason for the rule violations. One staff member in this report has been terminated from her position. The other two are currently suspended pending the results of this investigation.

IV. RECOMMENDATION

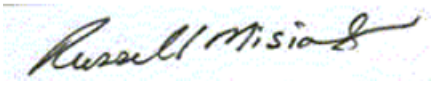
Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

9/16/24

_____

Garrett Peters Date
Licensing Consultant

Approved By:



9/17/24

_____

Russell B. Misiak Date
Area Manager