



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

June 4, 2025

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

RE: License #: AS500390465  
Investigation #: 2025A0990009  
Trombley

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

A handwritten signature in cursive script that reads "L. Reed".

LaShonda Reed, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place, Ste 9-100  
Detroit, MI 48202  
(586) 676-2877

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS500390465
<b>Investigation #:</b>	2025A0990009
<b>Complaint Receipt Date:</b>	01/29/2025
<b>Investigation Initiation Date:</b>	01/29/2025
<b>Report Due Date:</b>	03/30/2025
<b>Licensee Name:</b>	Adult Learning Systems-Lower Michigan
<b>Licensee Address:</b>	Suite F 8170 Jackson Road Ann Arbor, MI 48103
<b>Licensee Telephone #:</b>	(734) 408-0112
<b>Administrator:</b>	Sherri Turner
<b>Licensee Designee:</b>	Sherri Turner
<b>Name of Facility:</b>	Trombley
<b>Facility Address:</b>	34294 Maple Lane Sterling Heights, MI 48312
<b>Facility Telephone #:</b>	(734) 408-0112
<b>Original Issuance Date:</b>	04/18/2018
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/17/2024
<b>Expiration Date:</b>	10/16/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
A pot roast was made at night on 01/14/2025 and was still sitting on the stovetop at 4:06 a.m. It was then put away, and on the aluminum foil, "Dinner 01/15/2025" was written to be served that day.	No
There are worn toilet seats, the finish on the toilet seat is worn down, and the wood is showing.	Yes
There is rust in the bathtub on the tub floor and near the drains.	Yes
There is paint chipping on the back of a personal bathroom door.	Yes
The dryer handle is broken.	Yes
Additional Findings	Yes

**III. METHODOLOGY**

01/29/2025	Special Investigation Intake 2025A0990009
01/29/2025	Special Investigation Initiated - Letter I emailed Amanda Sultes from Office of Recipient Rights (ORR). I reviewed the photographs.
01/31/2025	Contact - Face to Face I conducted an unannounced onsite investigation. I interviewed direct care staff Porchia Leonard, Resident A, Resident B and Resident C. Resident D was leaving with family as I entered the home and was not interviewed.
01/31/2025	Contact - Document Received Resident A sent several photos and videos of the home.
02/03/2025	Contact - Document Sent

	I emailed Sherri Turner, licensee designee and requested staff phone numbers and Resident A's resident record documents.
02/03/2025	Contact - Telephone call received I conducted a phone interview with Ms. Turner. I did a MI court record search.
03/11/2025	Contact - Document Received Resident A sent a text message asking about the status of the investigation.
03/12/2025	Contact - Document Received I reviewed Resident A's Individual Plan of Service (IPOS).
03/12/2025	Contact - Telephone call made I conducted a phone interview with Drew Hicks, case manager assigned to Resident A.
03/13/2025	Contact - Telephone call made I called Lateshia Johnson, direct care staff. The voice mail box was full and could not receive messages. No return call to date.
03/13/2025	Contact - Telephone call made I conducted an interview with Tracie Shier, administrator. Ms. Shier sent Resident A's <i>Assessment Plan</i> .
03/14/2025	Contact - Telephone call made I conducted a phone interview with Kalisha Lovely, direct care staff.
03/14/2025	Contact - Telephone call made I called Jakia Stallings, direct care staff. I left a detailed voice message.
03/14/2025	Exit Conference I conducted an exit conference with Ms. Shier, administrator.

## **ALLEGATION:**

**A pot roast was made at night on 01/14/2025 and was still sitting on the stovetop at 4:06 a.m. It was then put away, and on the aluminum foil, "Dinner 01/15/2025" was written to be served that day.**

## **INVESTIGATION:**

On 01/29/2025, I received the complaint via email. No additional information was provided regarding the allegation.

On 01/31/2025, I conducted an unannounced onsite investigation. I interviewed direct care staff member Porchia Leonard, who has worked for the company for 12 years. Ms. Leonard said that she did not witness the pot roast incident but was informed of the allegations by Resident A. Ms. Leonard stated that dinner is cooked by the afternoon shift, and leftovers are to be properly stored in the refrigerator. I observed an adequate food supply and food stored properly in the refrigerator and cabinets. The refrigerator and freezer thermometers read within range. I observe menus that had balanced and variety of meals.

On 01/31/2025, I interviewed Resident A. Resident A said that the staff takes the food out to thaw in the sink or counter. Resident A said a pot roast was cooked on 01/14/2025 and left out overnight. Resident A took pictures of the pot roast on the counter. Resident A said the same pot roast was served for dinner on 01/15/2025. Resident A said he did not eat the pot roast because it was improperly stored. Resident A said he cooks his meals because he is concerned about the food.

On 01/31/2025, I interviewed Resident B. Resident B did not know food was being left out overnight. He said that the staff cooks all the meals and that he had no concerns about the food quality.

I interviewed Resident C on 01/31/2025. Resident C said that he had no concerns about the food quality and was not aware of food being left out overnight.

On 01/31/2025, Resident A sent several photos and videos of the home. I observed an image of a package of meat turned upside down in the kitchen sink, a photo of cooked food on the kitchen counter with a text that read, "Put in the fridge at 4:01 AM after being left out the day before"; a photo of a dish covered in foil "Dinner 1-15-24" written in marker on the foil; a photo of a package of raw pork chops sitting in a large plastic bowl on the kitchen counter.

On 03/14/2025, I conducted a phone interview with Kalisha Lovely, a direct care staff member. Ms. Lovely said that she had not witnessed food being left out overnight. She said she heard about this happening from a resident but did not observe it.

<b>APPLICABLE RULE</b>	
<b>R 400.14402</b>	<b>Food service.</b>
	<b>(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.</b>
<b>ANALYSIS:</b>	<p>Based on the investigation, there is insufficient evidence to support that a pot roast was left out overnight and served to the residents the next day.</p> <p>Resident B and C denied having or observing issues with the food in the home. Resident A is the only resident who observed the pot roast being left out overnight. Although a photo of the pot roast was observed, there is no evidence to confirm how long it was on the counter. There was also a photo of what is believed to be the pot roast sitting in the fridge.</p> <p>Resident A provided photos of raw meat on the counter and in the kitchen sink. However, it could not be determined how long the meat had been there, supporting the claim that it was thawing improperly.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

- **There are worn toilet seats, the finish on the toilet seat is worn down, and the wood is showing.**
- **There is rust in the bathtub on the tub floor and near the drains.**
- **There is paint chipping on the back of a personal bathroom door.**
- **The dryer handle is broken.**

**INVESTIGATION:**

I received the complaint via email on 01/29/2025. In addition to the allegations, it was reported that a new dryer had been ordered. The residents are opening it using a rusty caulking gun.

01/29/2025 I emailed Amanda Sultes from the Office of Recipient Rights (ORR). Ms. Sultes attached the video/photographs received from Trombley. Ms. Sultes said additional complaints from a resident that she has already determined are not ORR violations, such as the physical plant concerns. Ms. Sultes said that the doors have dark-colored hardware, and the hardware is not in working order, but the doors open and close without issue. Ms. Sultes said that there is a bi-fold door that was not installed in one of the bedrooms. However, it has since been installed. Ms. Sultes sent 18 photographs of the home and two videos (I could not open them). Ms. Sultes said that she believes that there are three residents.

On 01/31/2025, I conducted an unannounced onsite investigation. I observed the following physical plant issues:

- There is a broken handle on the dryer door (I observed the rusted caulking gun on top of the dryer)
- The toilet seat in bathroom number one has rust and is loose
- Rust stains in the bathtub in bathroom number one
- Door handles with chipped paint for bathroom one
- Rusted door jambs for bathroom one
- Rust spots in bathroom number two shower
- Bathroom number one ventilation makes a strange sound

On 01/31/2025, I interviewed Resident A who expressed many concerns about the physical plant issues; Resident A said that the bathroom tubs have rust, the door hinges are rusty, and the toilet seat is broken. Resident A said that his bedroom door paint was chipping, that the dryer handle had been broken for some time, and that they were using a rusted caulking gun on top of it. Resident A said that the living room carpet has stains, and I observed this. The bathroom ventilation is distracting when on because it makes strange sounds in which, I observed. The microwave plate was broken and was recently repaired. The showerhead molding is peeling in bathroom one, which I observed. When the dryer is used, it makes a loud sound. I walked through the home with Resident A and confirmed the physical plant issues.

On 01/31/2025, I interviewed Resident B. Resident B did not express any concerns about the physical plant issues. He said that this home is better than his last home and that he has no concerns.

On 01/31/2025, I interviewed Resident C. Resident C did not have any issues or input regarding the physical plant concerns.

On 01/31/2025, Resident A sent several photos and videos of the home. The photos were for the same physical plant items observed during the onsite inspection. In addition, Resident A sent a video of the smoke detector in his bedroom that was beeping with a low battery. Resident A also sent a video of opening and closing the refrigerator to display the clicking sound.

On 03/11/2025, Resident A sent a text message asking about the status of the investigation. Resident A also texted that it's been over a month, and the dryer handle has not been fixed. The door hinges are still rusted and missing paint. Resident A said that the carpet had not been cleaned. Resident A said that there is no access to the basement, and Resident A said that prior residents' belongings are still in the basement.

<b>APPLICABLE RULE</b>	
<b>R 400.14403</b>	<b>Maintenance of premises.</b>
	<b>(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.</b>
<b>ANALYSIS:</b>	Based on the investigation, sufficient evidence supports several maintenances of premises concerns. There are rust spots in both bathrooms' shower/tubs and chipped paint on bedroom doors and bathroom handles. There is a broken dryer handle, stains on the living room carpet, a smoke detector battery low status, the refrigerator door cracking, the ventilation in the bathroom making a malfunctioning sound, and rusted door jambs with chipped molding around handles. The toilet seat is discolored and not fitted properly on the toilet.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 01/31/2025, I interviewed Resident A. Resident A displayed his bedroom linen and curtains and stated that the patterns on them were distracting and triggering his anxiety. Resident A said that he would prefer solid-colored linens and curtains. I observed that the linen on the curtains had erratic patterns and colors throughout.

Resident A also expressed that he is to do chores such as taking out the trash and cleaning the bathroom. He said this was not something he was told to do before moving into the home.

On 01/31/2025, I interviewed Resident B. Resident B said he does chores such as taking out the trash and cleaning the bathroom.

On 02/03/2025, I conducted a phone interview with Ms. Turner, licensee designee. Ms. Turner said that she is aware of the allegations, and they are being addressed.

Resident A moved into the home in December 2024. Resident A was homeless before moving into the house. Ms. Turner said that Resident A rode an Uber to their main office in Ann Arbor, Michigan, to serve her with a lawsuit. Resident A is suing her for torture and \$25,000. Ms. Turner is consulting with an attorney regarding this. Ms. Turner does not believe the home is a good setting for Resident A. He complained about having a roommate on his first day. Ms. Turner said that she plans to meet with Resident A's case manager to work on transitioning him to a new home. I completed a MICourt Case record search. Resident A is the plaintiff in a civil matter and Adult Learning Systems is listed as the defendant. The case was filed on 01/13/2025.

On 03/11/2025, I received a text message from Resident A. Resident A said that there were "homosexual paintings and schizophrenic images" on the walls.

On 03/12/2025, I reviewed Resident A's Individual Plan of Service (IPOS), *Assessment Plan*, and *Health Care Appraisal*. Resident A does not have a guardian. Resident A is diagnosed with major depressive disorder, alcohol dependence, and congenital missing digits on hands and feet. Resident A has a history of psychosis with depression. Resident A is prescribed a regular diet. Resident A has a case manager, and the case manager addresses housing and transportation for Resident A. The case manager is working with Resident A using motivational interviewing and mindfulness. Resident A wants to learn to cope with his hallucinations and suicidal thoughts. Resident A will utilize psychotherapy to work on communication strategies, coping skills, and interpersonal therapy; Resident A agrees to take medications as prescribed and to discuss auditory hallucinations. Resident A is afraid to live alone. Resident A's Assessment Plan or the IPOS did not document household chores.

On 03/13/2025, I conducted a phone interview with Drew Hicks, the case manager assigned to Resident A. Mr. Hicks is aware of the allegations and is scheduled to meet with Resident A today. Mr. Hicks is looking for a new home for Resident A. Resident A became his client due to an extended hospitalization. Mr. Hicks said that this is Resident A's first adult foster home placement. Resident A prefers a private bedroom.

On 03/14/2025, I conducted a phone interview with Kalisha Lovely, a direct care staff member. Ms. Lovely said that Resident A was required to complete household chores, which each resident rotated. However, based on the Office of Recipient Rights recommendation, Resident A is no longer required to complete chores.

On 03/14/2025, I conducted an exit conference with Ms. Shier, administrator. Ms. Shier was informed of the findings. Ms. Shier said that she would address food safety with staff. Although no violation was found, concerns about how the food is thawing may be an issue. Ms. Shier said that they have ordered a new washer and dryer and have begun working on the repairs. Ms. Shier said that Resident A orders DoorDash daily for his meals.

<b>APPLICABLE RULE</b>	
<b>R 400.14303</b>	<b>Resident care; licensee responsibilities</b>
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization. (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.
<b>ANALYSIS:</b>	Based on the investigation, insufficient evidence supports that Resident A's bedding and curtains in his bedroom were not designed to improve his intellectual functioning.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

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

*L. Reed*

03/25/2025

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LaShonda Reed  
Licensing Consultant

Date

Approved By:

*Jay Calwerts*

For

06/04/2025

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Denise Y. Nunn  
Area Manager

Date