GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

August 5, 2025

RE: License #: AM170306632
Investigation #: 2025A0873015
Cedar Street Home

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

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 #:	AM170306632
Investigation #:	2025A0873015
Complaint Receipt Date:	06/17/2025
Investigation Initiation Date:	06/17/2025
Report Due Date:	08/16/2025
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:	Cedar Street Home
Facility Address:	931 Cedar St. Sault Ste. Marie, MI 49783
Facility Telephone #:	(906) 635-3025
Original Issuance Date:	09/27/2011
License Status:	REGULAR
Effective Date:	03/01/2024
Expiration Date:	02/28/2026
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Employee hit Resident A	Yes
Additional Findings	Yes

III. METHODOLOGY

06/17/2025	Special Investigation Intake 2025A0873015
06/17/2025	Inspection Completed On-site
06/17/2025	Special Investigation Initiated - On Site
06/17/2025	Contact - Face to Face Interviews with staff
06/26/2025	Contact - Telephone call made Interview with ORR
07/15/2025	Contact - Telephone call made Interview with employee Alexis Hooey
08/05/2025	Inspection Completed-BCAL Sub. Compliance
08/05/2025	Exit Conference With Karen LaFave
08/05/2025	APS Referral Referred to APS

ALLEGATION:

Employee hit Resident A

INVESTIGATION:

On 6/17/25, I interviewed home manager Krystal Barrette at the facility. Employee Suzie Izzard allegedly slapped Resident A after she took a sip of bleach water cleaning solution that was present in the kitchen area. Resident A is deaf and non verbal so communication is difficult. Resident A was not feeling well and was possibly dehydrated that day. She came into the kitchen and saw what looked to her like water and drank it. Afterward, Ms. Izzard was seen by employee Alexis Hooey smacking Resident A in the head.

On 6/17/25, I reviewed Resident A's assessment plan and individualized plan of service. I saw no indications of a PICA diagnosis but noted there can be issues regarding impulsivity around food and drink.

On 6/26/25, I interviewed Hiawatha Behavioral Health officer of recipient rights Elizabeth Eidenier. Resident A does not have a PICA diagnosis but eats food without understanding what she is eating or drinking. Ms. Eidenier has heard allegations of verbal abuse toward residents involving Ms. Izzard in the past.

On 7/15/2025, I interviewed employee Alexis Hooey over the telephone. After Resident A drank the cleaning solution, Ms. Hooey observed Ms. Izzard slap Resident A on the side of her head. Ms. Izzard has never been observed hitting residents in the past but has said to other employees that, at times, she wants to "whack them." Since this incident, Ms. Izzard has been terminated from her position.

On 7/15/2025, I called Ms. Izzard on the telephone and left a voicemail explaining the situation. I have not received a call back.

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:	Ms. Hooey observed Ms. Izzard slap Resident A on the side of the head.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 6/26/25, I interviewed Ms. Eidenier over the telephone. Resident A was known to have impulse control issues around food and drink.

On 7/15/25, I interviewed Ms. Hooey over the telephone. Resident A was heard throwing up. Ms. Hooey was cleaning and put the cleaning bucket on the edge of the island in the kitchen to attend to Resident A. While Ms. Hooey was cleaning up after Resident A, she went into the kitchen and drank some of the cleaning solution.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Although it was known by staff that Resident A had impulse control issues around food and drink, a bucket of cleaning solution containing bleach was left out around the kitchen. Resident A was able to access this and drink some. Review of Resident A's assessment plan revealed the staff had a responsibility to protect the resident from items that posed a risk to her due to her impulsiveness.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/5/25, I explained the results of this investigation to licensee designee Karen LaFave. Ms. Izzard no longer works for the company due to this incident.

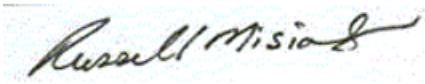
IV. RECOMMENDATION

Contingent upon receipt of an appropriate corrective action plan, I recommend no changes to the status of this license.

8/5/25

Garrett Peters — Date
Licensing Consultant

Approved By:



8/6/25

Russell B. Misiak — Date
Area Manager