



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 9, 2025

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

RE: License #: AS500418611
Investigation #: 2025A0464059
Vinecrest

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) 972-9136.

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
 THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS500418611
Investigation #:	2025A0464059
Complaint Receipt Date:	09/16/2025
Investigation Initiation Date:	09/16/2025
Report Due Date:	11/15/2025
Licensee Name:	Adult Learning Systems-Lower Michigan
Licensee Address:	Suite F - 8170 Jackson Road Ann Arbor, MI 48103
Licensee Telephone #:	(734) 408-0112
Administrator:	Sherri Turner
Licensee Designee:	Sherri Turner
Name of Facility:	Vinecrest
Facility Address:	50072 Vinecrest Lane Chesterfield, MI 48047
Facility Telephone #:	(734) 408-0112
Original Issuance Date:	10/03/2024
License Status:	REGULAR
Effective Date:	04/03/2025
Expiration Date:	04/02/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had a physical altercation with direct care staff Amari Ray that resulted in injuries to Resident A.	No
In July 2025, the workshop Social Resources Inc. said Resident A came without lunch.	Yes
The residents only have milk and water to drink. There is inadequate food.	No
There is glass in Resident A bathroom tub.	No

III. METHODOLOGY

09/16/2025	Special Investigation Intake 2025A0464059
09/16/2025	Special Investigation Initiated - Telephone I received a call from Relative A. Relative A addressed some concerns. A formal interview will be conducted later this week.
09/16/2025	Contact - Document Sent Email sent to Sherri Turner, licensee designee and Tracie Shier, administrator.
09/26/2025	Contact - Face to Face I conducted an unannounced onsite investigation. I interviewed Direct Care Staff Ashley King, Resident C and Resident D.
10/17/2025	APS Referral I conducted a phone interview with Deborha Walbecq. Adult Protective Services (APS) investigator.
10/17/2025	Contact - Face to Face I interviewed Resident A at Social Resources Inc. (SRI) Workshop.
10/17/2025	Contact - Face to Face I interviewed Erica Woods, Day Program Supervisor.
11/03/2025	Contact - Document Received I reviewed employee and resident records.

11/04/2025	Contact - Telephone call made I conducted a phone interview with direct care staff Amari Ray.
11/06/2025	Exit Conference I conducted an exit conference with Sherri Turner, licensee designee.

ALLEGATION:

Resident A had a physical altercation with direct care staff Amari Ray that resulted in injuries Resident A.

INVESTIGATION:

On 09/16/2025, I received the complaint via email. In addition to the allegation above, it was reported that last night Resident A got up late for dinner. Amari Ray began cursing at Resident A and telling him to eat quicker and that he needed to take medications. Amari told him to “get off the fucking phone with your fucking mommy” and called him the "N word". Amari pushed Resident A and put him in a chokehold. Amari and Resident A physically fought. Amari held Resident A down with his foot on Resident A's throat, which left a large lump. Resident A has a bruise under his left eye and fat lip with light cut. Another staff member called police. Resident A's mother arrived also, and Amari attempted to lunge on her. Amari has been physically assaultive to other residents in the past, but the group homeowner keeps allowing Amari back.

On 09/16/2025, I received a call from Relative A. Relative A provided the complaint information as well as some information regarding concerns. A formal interview will be conducted later this week. Relative A said that Resident A and direct care staff Amari Ray were in physical fight because Mr. Ray was rushing him to eat. Relative A said that Resident A has bruises. Relative A agreed to have a phone interview later which did not occur.

On 09/26/2025, I conducted an unannounced onsite investigation. I interviewed Direct Care Staff Ashley King. Ms. King said that she is fully trained. Ms. King said that Resident A was out for walk through the neighborhood with another Resident B. Ms. King said that she had been working in the home for 2.5 weeks. The first day of her employment was the day in which Resident A and Amari Ray had physical altercations. Mr. Ray was training her on this day, and Mr. Ray was preparing the evening medications. The residents were eating dinner when Mr. Ray announced that he would be passing their meds after dinner. Mr. Ray waited awhile before asking Resident A if he was ready for his medications and Resident A yelled “I'm not done eating”. Mr. Ray told him that he would wait until he finished eating. Ms. King said that that time she went into the office to get something and could hear Resident A yelling at Mr. Ray she then heard loud sounds as if someone was fighting. Mr. Ray then ran into the office and closed the door to barricade himself from Resident A because he said that Resident A

hit him. Said that Mr., Ray said that Resident A punched Mr. Ray in the in face. Ms. King also said she overheard Resident A calling Mr. Ray a “Nigger”. Ms. King said that when Mr. Ray opened the office door thinking that Resident A had moved, Resident A began attacking Mr. Ray and knocked him on the ground. Resident A was on top of Mr. Ray and Mr. Ray was covering his head and yelled at her to call 911. Ms. King said she called 911. Ms. King denied observing Mr. Ray on top of Resident A or having his foot on Resident A’s neck. Ms. King did not hear Mr. Ray tell Resident A to get off the phone. Ms. King does not recall if Resident A had injuries, but the police came to the home and took Resident A to the hospital. He was hospitalized for five days.

On 09/26/2025, I conducted Resident C. Resident C said that he was present during the physical altercation. Resident C said that he only heard Resident A swearing at Amari during the altercation. He did not witness the altercation. Resident C denied ever observing Amari fight or being inappropriate with him or other residents. Resident C has lived at home for three years. Resident C said that he does not have a legal guardian, and he has private room. Resident C said that he feels safe at home with no concerns.

On 09/26/2025, I conducted Resident D. Resident D said that Resident A “cursed out” Amari. Resident D said that he witnessed during the altercation Resident A chasing Amari out of the kitchen and pulling Amari’s shirt. Resident D said that Amari fell to the floor and Resident A got on top of Amari and bit his face. Resident D said the police arrived and Resident A left with the police. Resident D said that Amari has not been back at home since the altercation. Resident D feels safe at home and does not have a legal guardian.

On 10/17/2025, I conducted a phone interview with Deborah Walbecq. APS investigator. Ms. Walbecq said that her investigation is complete and not substantiated. Ms. Walbecq said that she had no concerns. Ms. Walbecq found during her investigation that Resident A was the aggressor and not Amari.

On 10/17/2025, I interviewed Resident A at Social Resources Inc. (SRI) Workshop. Resident A described the physical altercation in detail between him and Amari Ray. Resident A said on the evening of the altercation he was eating dinner and Amari was rushing him to finish his meal. Amari told him that the medication was ready for the evening and that he wanted to pass it. Resident A said that he told Amari to wait and that he was not ready for his medication. Resident A said that he and Amari began to argue and as he got up to go into the living room, Amari bumped his shoulder. Resident A said that he then punched Amari and the two began to tussle. He said that because of the fight he has a scratch on the right side of his neck and the left side of his eye and foot. Resident A went to the hospital after the incident. Amari no longer works in the home. Prior to this incident, he had never had a fight or argument with him. Resident A said that he was just issued and 30-day discharge notice because of the fight. Resident A said that he also had a fight with another resident prior to the fight with Amari. Resident A sent one photo of a faint bruise on the inner foot.

On 11/03/2025, I reviewed employee and resident records. I reviewed the following documents from Resident A's resident record: Assessment Plan, Individual Plan of Service (IPOS) and 30-discharge notice. Resident A has issues with controlling aggressive behavior. He's aggressive when provoked. Resident A is typically friendly, outgoing and verbal. He enjoys going for walks through the neighborhood. Resident A attend outpatient therapy. Resident A has been referred to completing a Behavioral Assessment to work on decreasing his episodes of physical aggression. Resident A has a history of aggression towards group home staff. I reviewed the 30-day discharge notice issued to Resident A and his legal guardian. Resident A was discharged for the following reasons: Resident A presents significant and on-going risk to the other consumers and staff of the Vinecrest home. On 09/11/2025, Resident A assaulted a staff member and caused physical injury. This is the second act of physical aggression by the consumer, with the first occurring in June 2025 with another Vinecrest resident. Effective date of discharge is 09/16/2025, with a move-out date of 10/16/2025.

I reviewed Armari Ray's employee record. Mr. Ray was hired on 04/18/2025 as a direct care worker. Mr. Ray was hired on 04/18/2025 and had verification of two reference checks, and Workforce Background Checks. Mr. Ray was hired on 04/18/2025 as a Is fully trained. Mr. Ray was hired on 04/18/2025 as a is trained in "preventing & De-escalating Crisi Situations. Mr. Ray does not have any disciplinary actions related to physical aggression or inappropriate behavior towards others.

I reviewed the incident report written by Mr. Ray, which was hired on 04/18/2025 as a Dated 09/11/2025. The incident report described that Resident A attacked Mr. Ray was hired on 04/18/2025.

On 11/04/2025, I conducted a phone interview with direct care staff Amari Ray. Mr. Ray is still employed at the company but at a different home. Mr. Ray said that the incident occurred on 09/11/2025 around 8:20PM. On this day, Mr. Ray was training a new staff person. Mr. Ray said that he was prepping the medications as the residents ate dinner. Mr. Ray said that he asked Resident A before he sat down for dinner if he wanted to take his medication first or after dinner and Resident A told him that he wanted to take the medication after dinner. Mr. Ray said that time went on about 15-20 minutes, most of the residents were done with dinner except Resident A. He waited while longer and was beginning to get pressed for time and asked Resident A if he could take his medications. Resident A yelled at him loudly calling him a "Nigger" and a "Bitch" and stood up from the table telling him he was not ready to take the medication. Resident A "Don't rush me". Mr. Ray said at that time Resident A swung and punched him in the face. Mr. Ray said that he immediately ran to the office to barricade himself in because Resident A was still throwing punches. Mr. Ray said that when he got into the office, as Resident A chased him, he was able to get into the office and grabbed him out towards the hallway. Mr. Ray said that he fell to the floor and Resident A got on top of him punching and kicking him. Mr. Ray said that he was begging him to stop and told the person he was training to call 911. Mr. Ray said that he was blet to lift from the floor but Resident A then bit his cheek. Mr. Ray said that finally Resident A released him, and he

yelled to the other residents to go to their bedrooms, and he went outside to call the home manager and wait for the police. Relative A arrived at the scene. Mr. Ray said that he had never met Relative A and initially did not know who she was. Relative A began questioning him about the fight and Mr. Ray said that she and Relative A exchanged words. Mr., Ray said he was already upset and injured from the fight. Mr. Ray went to the emergency room and was there for nine hours. Mr. Ray said that he wrote the incident report. Mr. Ray said that prior to this incident he had informed the manager (who is currently out on medical leave) that he wanted to be transferred to a new home because he felt that Resident A was becoming aggressive towards him. Mr. Ray said that there were two prior incidents in which Resident A displayed aggressive behavior directed at home. Mr. Ray said that the first time Resident A snatched a phone from his hands and the second time Resident A snatched medications from his hand. Mr. Ray said that he still has scar on his cheek from the bite mark that will probably never go away. Mr. Ray said that he is traumatized about the incident. Mr. Ray said he has experience working with people with disabilities and has a degree in human services. Mr. Ray sent two photos of his face. I observed a large bruise on the left side of his cheek and teeth marks.

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: (b) Use any form of physical force other than Based on physical restraint as defined in these rules.
ANALYSIS:	Based upon the investigation, there is insufficient evidence to support that direct care staff, Amari Ray, used physical force or physical restraints towards Resident A on 09/11/2025. Mr. Ray was attempting to pass the nightly medications, and Resident A was not ready for his medications. As a result, an argument occurred, and Resident A physically attacked Mr. Ray, resulting in bite marks and bruising on the face. This is supported by interviews with direct care staff, including Ashley King, who witnessed the altercation. Furthermore, Resident C and Resident D reported hearing Resident A use profanity towards Mr. Ray. Resident A was hospitalized several days after the incident. Resident A has a history of aggression towards group home staff per his IPOS. Resident A was issued a discharge notice due to having two physical aggressive episodes, including one against another resident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **In July 2025, the workshop SRI said Resident A came without lunch. This has been ongoing.**
- **The residents only have milk and water to drink. There is inadequate food.**

INVESTIGATION:

On 09/16/2025, I received the complaint via email. In addition to the above allegations, it was reported that there is not enough food in the home. The fridge is empty. Resident A is not provided with breakfast or lunch. At dinner, the staff are not giving him anything to drink. When staff are asked about this, the home manager says that a granola bar or yogurt is available, but this is not enough food. The residents cannot make sandwiches because the bread is frozen. There's inadequate food.

On 09/16/2025, I conducted a phone interview with Relative A. Relative A said that back in July, Resident A called and informed her that he did not have lunch to eat at the workshop. She brought food for him and Resident B. Relative A said that the bread was frozen. Relative A said that Resident A told her that he only has milk and water to drink. Relative A has brought Resident A food to the home many times, per his request.

On 09/26/2025, I conducted an unannounced onsite investigation. I interviewed Direct Care Staff, Ashley King. Ms. King said that there is plenty of food in the home. Ms. King was not employed at home in July 2025. I observed an ample amount of bread, beverages, and food in the kitchen of the house. I observed a surplus of food in the basement and garage freezer. Ms. King said that residents who attend the workshop take lunch daily. Dinner tonight is pork chops, mashed potatoes, and mixed vegetables.

On 09/26/2025, I conducted Resident C. Resident C said that there is always food to eat and drink in the home. Resident C said that he takes lunch to the workshop daily. Resident C denied that he was unable to bring lunch to the seminar because the lunch food was frozen.

On 09/26/2025, I conducted a Resident D. Resident D said that there is plenty of food to eat and drink in the home. Resident D said that he does not attend the workshop. Resident D said that he has three meals a day, including snacks.

On 10/17/2025, I conducted a phone interview with Deborah Walbecq. APS investigator. Ms. Walbecq said that she observed an adequate food supply in the home.

On 10/17/2025, I interviewed Resident A at the SRI Workshop. Resident A said that some of the food is good. At times, he feels like there is not enough food to eat for him. Staff will tell him that he has had enough food. The staff offers snacks. Resident A said that back in July, there was no lunch meat or bread to take to the workshop. He was told by the staff to take a granola bar for lunch twice. Resident A said that Relative A

had to bring him lunch, as well as Resident B. At times, the bread is frozen, and lunch cannot be made. It has not happened recently.

On 10/17/2025, I interviewed Erica Woods, Day Program Supervisor. Ms. Woods said that there were a few times when Resident A and Resident B did not have lunch for the workshop. Ms. Woods said that it happened around July. Relative A brought food for both residents. Ms. Woods said that Resident A told her that they could not get lunch on those days because the bread and lunch meat were frozen.

On 11/03/2025, I reviewed Resident A's Weight record and IPOS. I reviewed grocery receipts. Resident A can prepare small meals and attend SRI five days per week. Resident A is to assist with meal prep, setting the table, and cleaning up after meals. Resident S requires verbal prompts. Resident A can also help with the menu and grocery list and needs assistance with shopping for groceries. I observed grocery receipts from July to September from Walmart, Meijer, and Kroger totaling \$3,056.64. I observed Resident A's weight records, and he is weighed monthly with an average weight of 282 pounds.

On 11/04/2025, I conducted a phone interview with direct care staff Amari Ray. Mr. Ray said there is always food in the home. Mr. Ray works the afternoon shift; therefore, he is not home when the residents make their lunches and take lunch to the workshop.

On 09/16/2025, I received the complaint via email. In addition to the above allegations, it was reported that there is not the proper amount of food in the home. The fridge is empty. Resident A is not provided with breakfast or lunches. At dinner, the staff are not giving him anything to drink. When staff are asked about this the home manager says that a granola bar or yogurt is available, but this is not enough food. The residents cannot make sandwiches because bread is frozen. There's inadequate food.

On 09/16/2025, I conducted a phone interview with Relative A. Relative A said that back in July Resident A called and informed her that he did not have lunch to eat at workshop. She brought food for him and Resident B. Relative A said that the bread was frozen. Relative A said that Resident A told her that he only has milk and water to drink. Relative A has brought Resident A food to the home nay times per his request.

On 09/26/2025, I conducted an unannounced onsite investigation. I interviewed Direct Care Staff Ashley King. Ms. King said that there is plenty of food in the home. Ms. King was not employed at home in July 2025. I observed ample amount of bread, beverages and food in the kitchen of the home, I observed a surplus of food in the basement and garage freezer. Ms. King said that residents take lunch daily that attend workshop. Dinner tonight is pork chops, mashed potatoes and missed vegetables.

On 09/26/2025, I conducted Resident C. Resident C said that there is always food to eat in drink in the home. Resident C said that he takes lunch to workshop daily. Resident C denied that he has not able to take lunch to workshop because lunch food was frozen.

On 09/26/2025, I conducted Resident D. Resident D said that there is plenty of food to eat and drink in the home. Resident D said that he does not attend workshop. Resident D said that he has three meals a day including snacks.

On 10/17/2025, I conducted a phone interview with Deborah Walbecq. APS investigator. Ms. Walbecq said that she observed adequate food supply in the home.

On 10/17/2025, I interviewed Resident A at SRI Workshop. Resident A said that some of the food is good. At times he feels like there is not enough food to eat for him. Staff will tell him that he has had enough food. The staff offers snacks. Resident A said that back in July there was no lunch meat or bread take lunch to make for workshop. He was told by staff to take a granola bar for lunch two times. Resident A said that Relative A had to bring him lunch as well as Resident B. At times the bread is frozen, and lunch cannot be made. It has not happened recently.

On 10/17/2025, I interviewed Erica Woods, Day Program Supervisor. Ms. Woods said that there were a few times that Resident A and Resident B did not have lunch for workshop. Ms. Woods said that it happened around July. Relative A brought food for both residents. Ms. Woods said that Resident A told her that they could not bring lunch those days because the bread and lunch meat were frozen.

On 11/03/2025, I reviewed Resident A's Weight record and IPOS. I reviewed grocery receipts. Resident A has to prepare small meals and attend SRI five days per week. Resident A is to assist with meal preps, setting the table, and cleaning up after meals. Resident S requires verbal prompts. Resident A also can assist with the menu and grocery list and needs assistance with shopping for groceries. I observed grocery receipts from July to September from Walmart, Meijer and Kroger totaling \$3,056.64. I observed Resident A's weight records, and he is weighed monthly with an average weight of 282 pounds.

On 11/04/2025, I conducted a phone interview with direct care staff Amari Ray. Mr. Ray said there is always food in the home. Mr. Ray works afternoon shift therefore, is not home when the residents make their lunches and take lunch to workshop.

APPLICABLE RULE	
R 400.14313	Resident nutrition.
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	<p>Based upon the investigation, there is evidence to support that in July of 2025, Resident A and Resident B did not have lunch at the workshop due to frozen bread and lunch meat. According to Erica Woods, Program Manager from SRI, she recalled there were a few times when Resident A and Resident B did not have lunch. Ms. Woods said that Relative A brought both residents lunch to the program. Relative A had to bring Resident A and Resident B lunch to the program because they did not have lunch prepared.</p> <p>Per Resident A's IPOS, he can make and prepare meals with assistance. However, he requires help with food supplies. Resident A weighs an average of 282 with no weight loss. Resident A said that the times he wants more food are more likely due to his larger weight and appetite.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14402	Food service.
	(5) A home shall be properly equipped as required by the health authority, to prepare and serve adequate meals.
ANALYSIS:	<p>Based on the investigation, there is insufficient evidence that there are inadequate food and drink in the home. On 09/26/2025, I conducted an unannounced onsite investigation, and I observed an abundance of food. Tracie Shier, the administrator, provided several receipts for food purchased from July to September 2025, totaling \$3,056.64.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is glass in Resident A's bathroom tub.

INVESTIGATION:

On 09/16/2025, I received a call from Relative A. Relative A said that Resident A told her that there was glass in the tub in this bathroom. Relative A did not observe this but was informed of it by Resident A.

On 09/26/2025, I interviewed Ashley King, a direct care worker. Ms. King denied knowing anything about a glass in a tub in any of the residents' bedrooms.

On 09/26/2025, I conducted Resident D. Resident D is roommates with Resident A, and they have a private bathroom. Resident D said that there was a time where the door was repaired, but he does not recall that there was glass left behind.

On 10/17/2025, I interviewed Resident A at the SRI Workshop. Resident A said that there were pieces of glass left in the shower after the shower door was fixed. The shower sliding door was broken, and a worker came to repair and clean it, but left glass behind. He could not recall how long the glass had been there. Resident A sent a photo of a hand with a black glove with pieces of glass.

On 11/04/2025, I conducted a phone interview with direct care staff Amari Ray. Mr. Way does not recall observing or hearing about glass being left in the tub in Resident A's and Resident D's bathrooms.

On 11/06/2025, I conducted an exit conference with Sherri Turner, licensee designee. Ms. Runer was informed of the findings. Ms. Tuner said that Relative A brings Resident A food to the home all the time, per his request. Ms. Turner said that she would address the frozen bread and lunch meat with the staff at the workshop if this occurred again.

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based upon the investigation, there is insufficient evidence that there was glass left in Resident A and Resident D's bathroom tub. Resident D denied observing this. Resident A sent a photo of glass in his hand; however, it could not be determined where the glass came from. Direct care staff, Ashley King and Amari Ray, denied observing the glass in the tub.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

L. Reed

11/14/2025

LaShonda Reed
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

11/24/2025

Denise Y. Nunn
Area Manager

Date