GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 22, 2021

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS630305248
Investigation #: 2021A0605035
Kingsley Trail

Dear Ms. Bhaskaran:

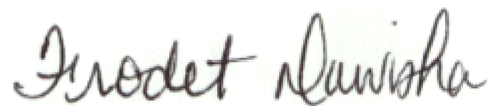
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630305248
Investigation #:	2021A0605035
Complaint Receipt Date:	06/02/2021
Investigation Initiation Date:	06/02/2021
Report Due Date:	08/01/2021
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Dwayne Price, Jr.
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Kingsley Trail
Facility Address:	637 Kingsley Trail Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 593-9297
Original Issuance Date:	02/12/2010
License Status:	REGULAR
Effective Date:	08/14/2019
Expiration Date:	08/13/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED/MENTALLY ILL TRUAMATICALLY BRAIN INJURY

II. ALLEGATION(S)

	Violation Established?
On 5/28/2021, staff allowed Resident A to cut his own toenails without supervision. This resulted in Resident A completely ripping off both big toenails. The weekend staff did not examine or clean Resident A's toes and the wound remained visible.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/02/2021	Special Investigation Intake 2021A0605035
06/02/2021	Adult Protective Services (APS) Adult Protective Services (APS) made referral
06/02/2021	Special Investigation Initiated - Telephone Telephone call made with Oakland County Office of Recipient Rights (ORR) Brittany Navetta. Ms. Navetta is investigating these allegations.
06/02/2021	Contact - Telephone call made I left a voice mail message for Adult Protective Services (APS) Kim Knapp who is the assigned worker investigating these allegations.
06/03/2021	Inspection Completed On-site I along with ORR Brittany Navetta conducted an unannounced on-site investigation. We interviewed Residents B, C, D, E, and F, and the home manager Tarrah Richmond.
06/04/2021	Contact - Document Received I received an email from ORR Brittany Navetta stating she scheduled another on-site visit for 06/15/2021, to interview Resident A, direct care staff (DCS) Trenton Slaughter and Ciera Bevelle.
06/15/2021	Contact - Face to Face I along with ORR Brittany Navetta interviewed Resident A, direct care staff (DCS) Trenton Slaughter and Ciera Bevelle. We also reviewed Resident A's appointment information record for his foot care.

07/22/2021	Contact - Telephone call made I interviewed DCS Artaija Haggins via telephone regarding the allegations.
07/22/2021	Exit Conference Left message for licensee Jennifer Bhaskaran with my findings.

ALLEGATION:

On 5/28/2021, staff allowed resident a to cut his own toenails without supervision. This resulted in Resident A completely ripping off both big toenails. The weekend staff did not examine, or clean Resident A's toes and the wound remained visible.

INVESTIGATION:

On 06/02/2021, intake #179899 was assigned for investigation as Adult Protective Services (APS) made the referral.

On 06/02/2021, I initiated the investigation by contacting Oakland County Office of Recipient Rights (ORR) worker Brittany Navetta. Ms. Navetta stated she is investigating these allegations and will accompany me tomorrow to conduct an unannounced on-site investigation.

On 06/03/2021, I conducted an unannounced on-site investigation in collaboration with ORR worker Brittany Navetta. We interviewed Residents A, B, C, D, and E the home manager Tarrah Richmond regarding the allegations. Resident F was not present during this visit.

The home manager Tarrah Richmond was interviewed regarding the allegations. Ms. Richmond has been with this corporation for about seven months and has been the home manager for about three weeks. On 05/28/2021, Ms. Richmond arrived at her shift around 10PM and was told by DCS Ciera Bevelle, "I don't know what possessed him to do this. He clipped both his toe nails off, completely off." Ms. Richmond stated she was in the living room and could see Resident B cleaning blood off their bedroom floor. Ms. Richmond stated she brought soap, water and Neosporin and began cleaning the blood off Resident A's big toes. She bandaged it and then made an appointment with Resident A's podiatrist who is coming out next week on 06/11/2021. Ms. Richmond stated that Artaija Haggins arrived at her shift at 6AM on 05/29/2021 and Ms. Richmond advised Ms. Haggins to check Resident A's bandage and change it if needed. On 05/30/2021, DCS Ciera Bevelle worked that shift and was also responsible for checking Resident A's bandage and changing it if needed. Ms. Richmond stated she then called DCS Trenton Slaughter on 05/31/2021 advising him to do the same for Resident A's toes. Ms. Richmond returned to work on 06/01/2021 and found that Resident A's bandages were soiled with blood. She described the bandage as "black with dried up blood." Ms. Richmond asked Resident A if anyone had changed his bandage and

Resident A stated, “No.” Resident A reported to Ms. Richmond that his toes are completely numb.

We reviewed Resident A’s individual plan of service and it states that Resident A requires assistance with his personal hygiene.

Resident A was interviewed in his bedroom. Resident A is blind and reported that his sister is his legal guardian. The allegations were discussed. Resident A stated about 15 years ago, he dropped a guitar on both his big toes. As a result, both of his big toes were damaged, black, and blue underneath the toenails along with pain. Resident A stated to relieve the pain, he broke off the toenail with the nail clippers his brother-in-law gave him. He took the nail clippers and began clipping his toenails. He did not realize that he clipped them too close until his roommate, Resident B notice blood coming out of his toes. Resident A stated the DCS on shift was Ciera Bevelle who he did not tell that he needed assistance clipping his toes. He stated that Resident B told Ms. Bevelle what Resident A did. Resident A stated that Ms. Bevelle looked at his toes but did not clean them up. He stated that the home manager Tarrah Richmond arrived to begin her shift so Resident B told Ms. Richmond what happened. He stated that Ciera left her shift and Resident B and Ms. Richmond helped clean and bandage his toes. Resident A stated he was going to see his podiatrist every two months but due to Covid-19, the last time he saw his podiatrist was in 10/2020. Resident A stated his podiatrist would clip his toenails which would help with the pain. Resident A stated that Ms. Richmond has schedule an appointment with his podiatrist who will be coming out to Kingsley Trail next week.

Resident B was interviewed regarding the allegations. Resident B stated while Resident B was in the shower, Resident A used nail clippers to pull both his big toe nails off. He stated that DSC Ciera Bevelle was in the dining room on her phone or sleeping or laying down. He stated, “I told her (Ciera Bevelle), and she didn’t do anything about it.” Resident B stated that Resident A’s toes were bleeding. He stated that the home manager Tarrah Richmond arrived to begin her shift and came into Resident A’s and Resident B’s bedroom and saw Resident A’s toes bleeding. He stated that Ms. Richmond used alcohol pads to clean the toes and them bandaged them up with gauze. Resident B stated he did not see any DCS check or change Resident A’s bandages, only Ms. Richmond.

Resident C was interviewed regarding the allegations. Resident C stated he saw Resident A “peel off his toes nails and they were bleeding.” He stated the new home manager Tarrah Richmond was present and that Ms. Richmond cleaned Resident A’s toes. He stated he does not recall any other staff cleaning or changing Resident A’s bandages.

Resident D was interviewed regarding the allegations. Resident D stated he does not know anything about Resident A’s toes.

Resident E was interviewed regarding the allegations. Resident E stated he too does not know anything about Resident E's toes but then stated, "he pulls nails out himself." Resident E was unable to provide any more details.

On 06/15/2021, I conducted a follow-up visit in collaboration with ORR worker Brittany Navetta. We interviewed Resident C, DCS Ciera Bevelle, DCS Trenton Slaughter and the administrator Dwayne Price, Jr. regarding the allegations. Resident C was not able to hold a conversation due to his disability; therefore, he did not provide any details regarding the allegations.

DCS Ciera Bevelle began working for this corporation on 01/08/2021. She works the afternoon shift from 2PM-10PM. She works alone during her shift. The allegations were discussed. Ms. Bevelle stated on 05/28/2021 around 10PM, Resident B came out of his bedroom and told Ms. Bevelle that Resident A "cut his toenails and the entire nail was off." She went into their bedroom and stated, "I asked Resident A if he needed help, but he said, no." Ms. Bevelle stated she did not assist Resident A as he was refusing her help. She reported observing blood on his toenails and again she asked him if he needed help cleaning his toes and he again told her "No, I want to finish cutting them." She asked Resident A why he did not ask her to help him cut his toenails and he kept saying, "I got it. I'm ok, I'm ok." She reported she did not know that Resident A had possession of any nail clippers. Ms. Bevelle stated that the home manager Tarrah Richmond arrived to begin her shift, so Ms. Bevelle reported to Ms. Richmond what happened. Ms. Richmond told Ms. Bevelle, "I have it from here." Ms. Bevelle left after her shift ended at 10PM.

Ms. Bevelle stated she returned to work on 05/30/2021 and asked Resident A how his toenails were, and Resident A said, "ok." Ms. Bevelle stated Ms. Richmond never advised her that there was any aftercare and Ms. Bevelle stated she never asked Ms. Richmond either. She stated she asked Resident A "do you want me to change the bandage?" Resident A stated, "No." She never saw the bandage during her shift because Resident A had his shoes on, and she did not ask to see Resident A's toenails. She stated she asked Resident A twice during her shift if she needed to change the bandages and each time Resident A stated "No."

DCS Trenton Slaughter has worked 15 years for this corporation and for the past eight years he has worked at Kingsley Trail. He works the morning shift but sometimes helps the afternoon and midnight shifts when he is needed. The allegations were discussed. Mr. Slaughter stated he did not work on 05/28/2021 when Resident A clipped his toenails off. He stated he worked on 06/01/2021 which is when he found out what Resident A did with his toenails. He stated he checked Resident A's toes by taking the bandage off and asked Resident A if his toenails hurt. Resident A said, "No." Mr. Slaughter stated that the midnight shift told him that they too cleaned Resident A's toes and changed the bandage. He stated that ever since Resident A has been at this home, Resident A has asked staff to assist him with clipping his toenails. Mr. Slaughter stated he has never clipped Resident A's toenails but that he has heard Resident A ask Dwayne Price, Jr., to help clip his toenails. Mr. Slaughter stated that he recalls Resident

A having nail clippers but when Mr. Slaughter asked Resident A where the nail clippers were, Resident A stated, “I don’t know.” Mr. Slaughter stated, “I guess he must have found them.” Mr. Slaughter stated that Resident A goes to a podiatrist who clips his toenails every two months, and that Mr. Slaughter is the staff who schedules these appointments. Mr. Slaughter was only able to locate one appointment record dated 08/06/2020 where Resident A was taken to his podiatrist and his toenails were trimmed. Mr. Slaughter stated when he came in on 06/01/2021, Resident A’s bandage was clean, and the toenails appeared to be healing properly. He denied that the bandages were soiled in blood.

The administrator Dwayne Price Jr. has been with the corporation for 15 years. He was interviewed regarding the allegations. Mr. Price was informed by the home manager Tarrah Richmond that Resident A cut his toenails off and they were bleeding. Ms. Richmond told Mr. Price she did not know how Resident A got the nail clippers. Mr. Price stated he spoke with Ciera Bevelle who informed him that Resident A had the clippers with him and she too did not know how Resident A obtained the nail clippers. Mr. Price stated he reviewed Resident A’s IPOS which states that Resident A requires assistance for health and safety concerns. Ms. Bevelle told Mr. Price that the situation with Resident A clipping his toenails occurred without her knowledge. He stated that Ms. Bevelle told Mr. Price that she offered to help Resident A several times, but Resident A refused. According to Mr. Price, Resident A does not allow any staff to assist except for Ms. Richmond.

On 07/22/2021, I interviewed Artaija Haggins via telephone regarding the allegations. Ms. Haggins has been working for this corporation for about two years. She works the afternoon shifts from 4:30PM-10PM. Ms. Haggins did not work on 05/28/2021 when Resident A clipped his toenails but did come in the day after on 05/29/2021. She stated the home manager Tarrah Richmond advised her what happened during Ciera Bevelle’s shift. Ms. Richmond told Ms. Haggins that Ms. Richmond took care of the bandage, and that Resident A was all set, but to inform Ms. Bevelle when she comes in on 05/30/2021 to clean and change Resident A’s bandage since the incident with Resident A occurred during Ms. Bevelle’s shift. Ms. Haggins stated she informed Ms. Bevelle when Ms. Bevelle arrived at her shift on 05/30/2021. Ms. Richmond told Ms. Bevelle she needed to change Resident A’s bandage and Ms. Bevelle said, “Why do I have to do it?” Ms. Richmond replied, “I’m just telling you what Tarrah told me to tell you.”

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(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.
ANALYSIS:	Based on my investigation and information gathered, Resident A was not provided with the personal care as defined by his assessment plan. Resident A is legally blind and according to

	his Easterseals IPOS dated 02/05/2021, Resident A requires monitoring for health and safety due to being legally blind. On 05/28/2021, Resident A had nail clippers and began clipping his toenails to the point of cutting the toenails completely off which they then began to bleed. This incident occurred during DCS Ciera Bevelle's shift. Ms. Bevelle did not know what Resident A was doing in his bedroom with the door closed until Resident B came out of the bedroom and told her what had happened. Ms. Bevelle attempted to assist Resident A but Resident A refused her help and continued to clip his toenails.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 06/03/2021, it was reported by the home manager Tarrah Richmond that DCS Trenton Slaughter was sleeping on his shift on 05/15/2021 when she arrived at her shift. Ms. Richmond took a picture of Mr. Slaughter sleeping on the chair. I viewed the picture and observed Mr. Slaughter sleeping sitting up on the chair. Ms. Richmond stated she woke Mr. Slaughter up and this was an isolated incident. There are no residents at Kingsley Trail that require a 1:1 staff. We interviewed Residents A, B, C, D, and E regarding Mr. Slaughter sleeping and all the residents denied seeing him sleep during his shift. Mr. Slaughter was interviewed and first denied sleeping but then after learning that someone took a picture of him sleeping, he stated he works two jobs and may have just sat down and closed his eyes for a couple of minutes. He stated this was an isolated incident that he would not be repeating. DCS Ciera Bevelle and Artaija Haggins as well as the administrator Dwayne Price denied seeing Mr. Slaughter asleep during his shift.

Ms. Richmond also reported on 06/03/2021 that she had a recording of DCS Trenton Slaughter yelling at Resident A. I heard the recording of Mr. Slaughter saying the following:

> "You're blind and you do not know what you're doing. You're doing it and not only that you're doing it, but you're also not telling no one in the house you have an opened wound. Who got to take you to the hospital? I do. Nobody else is making your appointments but me. I'm the only one that does everything for you. Who is going to do it, nobody but me?"

Residents A, B, C, D, and E were interviewed, and all reported that Mr. Slaughter has a bad temper and yells at them. Resident A reported that Mr. Slaughter tells all the residents, "I'm tired of your lazy stupid asses and I'm going to quit because you're acting like uncivilized people." Resident C stated that Mr. Slaughter is a "great worker," but sometimes he "yells at me." Resident D reported that he is sometimes afraid of Mr.

Slaughter because Mr. Slaughter “yells at me.” Resident E stated, “he yells at me, but I don’t mind it.”

Mr. Slaughter was interviewed regarding these allegations, and he stated he is not yelling at the residents, but that sometimes his voice raises when he tries to encourage the residents to become more independent. He stated, “I tell them you have to do better.” Mr. Slaughter stated he does not have anger issues and that there have not been any complaints about him from any of these residents.

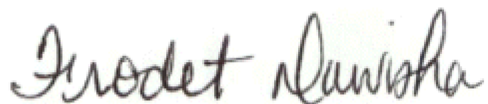
Mr. Price stated he was not aware there was a recording regarding Mr. Slaughter yelling at Resident A. He heard the recording and stated that there have not been any complaints regarding Mr. Slaughter from any resident. However, he will be addressing the issues with Mr. Slaughter sleeping and yelling at Resident A.

On 07/22/2021, I contacted licensee designee Jennifer Bhaskaran via telephone to conduct the exit conference with my findings but was unsuccessful, so I left her a voice mail message.

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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	Based on my investigation and information gathered, DCS Trenton Slaughter subjected Resident A to mental or emotional cruelty and verbal abuse when he yelled at Resident A and began criticizing Resident A for not telling anyone about an open wound. I heard a recording of Mr. Slaughter yelling at Resident A who did not respond at all.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

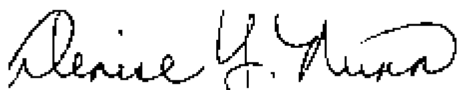
Contingent upon receiving an acceptable corrective action plan, I recommend that this special investigation is closed and no change to the status of the license.



07/22/2021

Frodet Dawisha — Date
Licensing Consultant

Approved By:



07/22/2021

Denise Y. Nunn — Date
Area Manager