STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

August 27, 2021

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

RE: License #: AS780376324
Investigation #: 2021A0584021
Martin Home

Dear Ms. Bhaskaran:

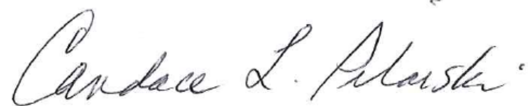
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,



Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-8967

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780376324
Investigation #:	2021A0584021
Complaint Receipt Date:	07/01/2021
Investigation Initiation Date:	07/02/2021
Report Due Date:	08/30/2021
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jeremy Hagerman
Licensee Designee:	Jennifer Bhaskaran, Designee
Name of Facility:	Martin Home
Facility Address:	11410 Lennon Road Lennon, MI 48849
Facility Telephone #:	(810) 621-4721
Original Issuance Date:	08/17/2015
License Status:	REGULAR
Effective Date:	02/17/2020
Expiration Date:	02/16/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident B and Resident C eloped from the facility multiple times in July 2021. Concern proper supervision is not being provided to residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/01/2021	Special Investigation Intake 2021A0584021
07/02/2021	Special Investigation Initiated - Letter Email contact with Ardis Bates, Shiawassee Health and Wellness Recipient Rights Officer.
07/16/2021	Contact - Document Received RRO reported Resident B walked off from the facility on 7/15/2021, missing approximately 2-5 minutes when found by another staff.
07/21/2021	Contact - Face to Face With Resident B and Resident C
07/21/2021	Contact - Face to Face Interview with Zach Crawford, Direct Care Worker
07/30/2021	Exit Conference Via email to J. Bhaskaran, Licensee Designee
08/06/2021	Contact - Telephone call made To Guardian C 1
08/06/2021	Contact - Telephone call made to Guardian B 1
08/20/2021	Contact- Telephone call made To Kim Kurily, Direct Care worker.

ALLEGATION:

Resident B and Resident C eloped from the facility multiple times in July 2021. Concern proper supervision is not being provided to residents.

INVESTIGATION:

On July 7, 2021, I conducted a face-to-face interview with direct care staff member Peggy Luce at the home. Ms. Luce was working with another coworker named Lyndan Tucker. Ms. Luce stated she worked from 6 am to 6 pm the day that Resident B and Resident C left the facility yard without direct care staff knowledge on July 1, 2021. Ms. Luce stated that she was assigned to medications and to monitor Resident B and Resident C. Ms. Luce stated a maintenance man arrived around 9:00 am to work in the bathroom and entered the home through the front door. At approximately 10:15am, Ms. Luce stated she was at the kitchen counter when Ms. Tucker told her she was not able to find Resident B. Ms. Luce stated she did not see either Resident B or Resident C in the living room and went to look for Resident B in other rooms as he likes to go into closets. Ms. Luce did not see Resident B or Resident C in the house and asked if Ms. Tucker checked the back yard as both residents enjoy the backyard. Ms. Luce stated there is a side gate to the backyard that is very difficult to open when latched and it is not to be left open. Ms. Luce said she did not check to see if the side gate was latched at the beginning of her shift. Ms. Luce did not visually check the back yard to see if both residents were there before Ms. Tucker told her Resident B was not found in the home. Ms. Luce stated that she and Ms. Tucker both headed out the front door and saw Resident C standing not far from the door in the front yard. Ms. Luce did not see Resident B but said an older gentleman pulled into the driveway about that time. Ms. Luce said the man asked if they were looking for someone. Ms. Luce told him "Yes" and the man answered there is a man standing in the road down about a half mile away. Ms. Luce stated it was about 10:30 am at this time and the man offered to drive her to where the person was standing. Ms. Luce took the ride with the man while Ms. Tucker walked Resident C back into the home. Ms. Luce said she arrived at the place where Resident B was standing and managed to help him into the man's car. Ms. Luce said the man drove them back to the home. Ms. Luce did not ask the man's name or knew who he was. Ms. Luce said that Resident B entered the home without any problem, and she checked him over for possible injuries. Ms. Luce did not see any injuries. Ms. Luce stated she went to the side gate, and it was open, so she figured that is how Resident B and Resident C left the backyard and premises.

On July 7, 2021, I conducted a face-to-face interview with Lyndan Tucker, direct care worker. Ms. Tucker was scheduled to work either 6am to 2pm or 6am to 6pm, she could not recall exactly. Ms. Tucker verified that Peggy Luce was her coworker scheduled on July 1, 2021, and they were the only two people working. Ms. Tucker stated a maintenance man entered the home through the front door and was working on the bathroom. Ms. Tucker said both Resident B and Resident C have a

habit of walking around the inside of the home and completing a path to the backyard of the home. Ms. Tucker said she realized she had not seen Resident B and Resident C walking in and out of the home and decided to go outside to look for them. Ms. Tucker stated she walked the path outside to the side gate that encloses the backyard. Ms. Tucker said the side gate was open and told Ms. Luce the gate was not secure. Ms. Tucker stated Ms. Luce was standing at the kitchen counter at the time she notified her, and they both went out the front door to look for Resident B and Resident C. Ms. Tucker saw Resident C right away as she was standing in the front yard and returned to the home when she saw Ms. Tucker. Ms. Tucker then said a man arrived in the driveway and asked if they were looking for someone. Ms. Tucker said that Ms. Luce chatted with the man while she went inside to monitor the rest of the residents. Ms. Tucker said that other residents were still in their bedrooms, some asleep. Ms. Tucker said when Ms. Luce returned home with Resident B, Ms. Luce called the home manager Nichole Frye and also notified Recipient Rights of the incident.

On July 16, 2021, an email report was received at our BCHS Online Intake mailbox regarding Resident B leaving the home property unsupervised.

On July 21, 2021, I conducted a face-to-face interview with Zach Crawford, a Shiawassee Health and Wellness worker who was filling in as a direct care worker and monitoring the residents during this incident. Mr. Crawford stated the lawn maintenance was at the home mowing. Mr. Crawford makes sure all residents are in the home during mowing as it is safer to have them not in the way of the mowers. Mr. Crawford stated he had not heard the mower or any other lawn machinery, so he thought the maintenance people had left. Mr. Crawford said he allowed Resident B to go out in the backyard. Mr. Crawford stated this was about 2:45pm in the afternoon. Mr. Crawford said he did not check to see if the maintenance people had left but then heard a weed whipper being used. Mr. Crawford said he went outside to check on Resident B and found the side gate open. Mr. Crawford stated he went to the front yard to see a staff member Kim Kurily walking down the driveway with Resident B. Mr. Crawford stated it was not more than five minutes between Resident B going into the backyard and then seeing him returning with Ms. Kurily. Mr. Crawford stated Ms. Kurily arrived about 10 minutes early for her afternoon shift and saw Resident B walking on the side of the road not far from the driveway of the home.

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:	The staff were not providing supervision and protection to Resident B and C on July 1 and July 15 when Resident B's and Resident C's whereabouts were unknown and both residents managed to leave the property without direct care staff members immediate knowledge.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On July 7, 2021, I conducted face-to-face interviews with both Peggy Luce and Lyndan Tucker. Both Ms. Luce and Ms. Tucker stated they did not write an *AFC Incident/Accident Report* regarding Resident B and Resident C leaving the home without their knowledge.

On July 21, 2021, I conducted a face-to-face interview with Zach Crawford. Mr. Crawford did not write an *AFC Incident/Accident Report* on Resident B being absent without notice on July 15, 2021.

On July 21, 2021, I reviewed Resident B's and Resident C's file and did not find a written *AFC Incident/Accident Report* regarding either resident elopement in the files.

On August 6, 2021, I conducted a phone interview with Guardian C1. Guardian C1 did not receive a verbal or written notice that Resident C was absent without notice from the facility on July 1, 2021.

On August 6, 2021, I conducted a phone interview with Guardian B1. Guardian B1 did not receive a verbal or a written notice that Resident B was absent without notice from the facility on July 1, 2021, and on July 15, 2021.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence. **(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff**

	member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved, and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.** **(7) A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.**
ANALYSIS:	**Staff working on the days Resident B and Resident C were absent without notice stated they did not write an incident report documenting these elopement incidents. Guardian B1 and Guardian C1 did not receive a verbal report or a written report that their wards were absent without notice from the home. A review of Resident B's and Resident C's file did not have a written copy of the absent without notice incidents in the file.**
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receiving an acceptable corrective action plan, I recommend no change in the status of this license.

8/27/2021

Candace Pilarski Date
Licensing Consultant

Approved By:

08/30/2021

Dawn N. Timm Date
Area Manager