



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

December 2, 2021

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

RE: License #: AS330011145  
Investigation #: 2022A0783003  
Oxford Mason 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

A handwritten signature in cursive script that reads "Leslie Herrguth".

Leslie Herrguth, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(517) 256-2181

Enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS330011145
<b>Investigation #:</b>	2022A0783003
<b>Complaint Receipt Date:</b>	10/08/2021
<b>Investigation Initiation Date:</b>	10/08/2021
<b>Report Due Date:</b>	12/07/2021
<b>Licensee Name:</b>	Alternative Services Inc.
<b>Licensee Address:</b>	32625 W Seven Mile Rd, Suite 10 Livonia, MI 48152
<b>Licensee Telephone #:</b>	(248) 471-4880
<b>Administrator:</b>	Jennifer Bhaskaran
<b>Licensee Designee:</b>	Jennifer Bhaskaran
<b>Name of Facility:</b>	Oxford Mason Home
<b>Facility Address:</b>	3375 Harper Rd Mason, MI 48854
<b>Facility Telephone #:</b>	(517) 676-2377
<b>Original Issuance Date:</b>	06/30/1981
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/09/2021
<b>Expiration Date:</b>	01/08/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED

ALLEGATION(S)

	<b>Violation Established?</b>
All six residents admitted to the facility were left at the facility with no staff member on October 7, 2021.	Yes

**II. METHODOLOGY**

10/08/2021	Special Investigation Intake – 2022A0783003
10/08/2021	Special Investigation Initiated - On Site
10/08/2021	Contact - Document Received – <i>AFC Licensing Division Incident/Accident Report</i>
10/08/2021	Contact - Document Received – Employee schedule for October 2021
10/08/2021	Inspection Completed On-site
10/08/2021	Contact - Face to Face interview with direct care staff member and home manager Lacey Carroll
10/08/2021	Contact - Telephone call made to direct care staff member Kelley Kidd
10/08/2021	Contact - Telephone call made to direct care staff member Alexandria Page
10/08/2021	Contact - Telephone call made to direct care staff member Praneeth Naligante
10/08/2021	Contact - Telephone call made to licensee designee Jennifer Bhaskaran
10/11/2021	Contact - Document Received – Employee records for Alexandria Page and Praneeth Naligante
12/01/2021	Exit Conference – left message for Jenny Bhaskaran

## **ALLEGATION:**

**All six residents admitted to the facility were left at the facility with no staff member on October 7, 2021.**

## **INVESTIGATION:**

On October 8, 2021, I received a denied adult protective services (APS) complaint via centralized intake that stated Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F are developmentally disabled, require 24-hour supervision, and assistance with their activities of daily living. The complaint stated two residents in the home use a wheelchair to ambulate, but it is unknown which two. The complaint stated on an unknown date, the six residents were left unattended for at least 20 minutes. The complaint stated direct care staff members Alexandria Page and Praneeth Naligante were working and supposed to be caring for residents at the time, but they were not in the home. The complaint stated it is unknown where the staff members were. The complaint stated none of the residents were harmed while they were left unattended.

On October 8, 2021, I received a written *AFC Licensing Division – Incident/Accident Report* dated October 7, 2021. The written incident report stated on October 7, 2021, staff member Kelly Kidd arrived at the facility and 7:00 pm “to find no vehicles in the driveway. Staff went inside to find no staff in the home. One staff was pulling back into the driveway at 7:20 pm.” The written incident report stated Ms. Kidd “entered the home and found all residents safe without incident. Manager suspended the staff who left and came to the home immediately following contact from Ms. Kidd.” The written incident report stated the licensee designee and residents’ guardians were notified.

On October 8, 2021, I spoke to direct care staff member Kelley Kidd who stated on October 7, 2021, she arrived at 7:00 pm which was three hours before her scheduled shift but she decided to arrive early and sit in her car because the weather was bad. Ms. Kidd said when she arrived at 7:00 pm she noted there were no cars in the driveway of the facility. Ms. Kidd said at 7:18 when there were still no cars in the driveway, she telephoned supervisor Lacey Carroll and asked her who was working at the facility and was told Alexandria Page and Praneeth Naligante were scheduled to work at that time. Ms. Kidd said at approximately 7:25 pm direct care staff member Alexandria Page pulled into the driveway. Ms. Kidd said at that time Ms. Carroll advised Ms. Page to go inside and look for Mr. Naligante which she did and could not locate him inside the house. Ms. Kidd stated at that time there was no staff member inside the facility with residents. Ms. Kidd said Ms. Page came inside, took clothing out of the dryer, and then went back to her car. Ms. Kidd said while Ms. Page was inside, she asked her where she had been and she replied, “the store.” Ms. Kidd said Ms. Page told her Mr. Naligante was at the store at the time. Ms. Kidd said she notified Ms. Carroll who arrived at the facility by 7:45 pm. Ms. Kidd said she telephoned Mr. Naligante and he told her he was at the store and when he

left Ms. Page was there with the residents. Ms. Kidd said she was present when Ms. Page spoke to Ms. Carroll and Ms. Page told Ms. Carroll that she took out the trash and turned her car around in the driveway, but never left the property. Ms. Kidd said when she checked on the residents, some of them were “dirty.” Ms. Kidd said Resident A’s adult incontinence brief was so wet it fell off and Resident A was sitting in the hallway with no brief. Ms. Kidd said Resident B was sitting alone in her bedroom in the dark and wearing a wet shirt. Ms. Kidd said Resident C was lying in bed. Ms. Kidd said Resident D was in bed wearing just an adult brief and he had food on him. Ms. Kidd said Resident E had thrown up on himself and was wet. Ms. Kidd said Resident F was wrapped in a comforter that “was saturated in something.” Ms. Kidd said she arrives early for her shift regularly and has never encountered this before.

On October 8, 2021, I interviewed direct care manager and supervisor Lacey Carroll who said direct care staff member Kelley Kidd arrived three hours early for her 10:00 pm shift and found no vehicles in the driveway. Ms. Carroll said at about 7:20, Ms. Kidd telephoned her and advised there were no vehicles in the driveway, and she wanted to know who was working. Ms. Carroll said Alexandria Page and Praneeth Naligante were scheduled to work at that time. Ms. Carroll said she next telephoned the facility twice and no staff member answered the telephone. Ms. Carroll said she requested that Ms. Kidd go inside the facility to look for Ms. Page and Mr. Naligante and Ms. Kidd advised that she could not locate either staff member inside the facility. Ms. Carroll said she was told Ms. Page pulled into the facility driveway at approximately 7:20 pm. Ms. Carroll said she spoke to Ms. Page and Ms. Page told her she did not leave the facility property, rather she took out the trash and moved her car. Ms. Carroll said she arrived at the facility at 7:45 pm and Ms. Page was there, and Mr. Naligante was not there. Ms. Carroll said at that time she released Ms. Page and Ms. Carroll and Ms. Kidd worked the rest of the shift. Ms. Carroll said Mr. Naligante never returned to the facility but that she spoke to him on the telephone at approximately 7:35. Ms. Carroll said Mr. Naligante told her he was at the store and Ms. Page was at the facility when he left. Ms. Carroll said when she arrived at the facility at 7:45 PM all the residents needed to have their adult briefs changed, and that it “looked like the residents never got up from their afternoon nap, everything was as I left it at 5:00 pm.” Ms. Carroll said she “didn’t expect” either Ms. Page or Mr. Naligante to leave the facility during his/her scheduled shift. Ms. Carroll said Ms. Page has worked at the facility for several months and has never left the facility without another staff member present prior to October 7, 2021. Ms. Carroll said Mr. Naligante has worked at the facility for several months and has never left the facility without another staff member being present prior to October 7, 2021. Ms. Carroll stated two staff members are scheduled for each shift and that the “policy” regarding leaving the facility during a staff member’s assigned shift is that the staff member who desires to leave for any reason must call Ms. Carroll, check with their co-worker, and “come right back.” Ms. Carroll denied that she received a telephone call from Ms. Page nor Mr. Naligante requesting to leave the facility during their scheduled shift on October 7, 2021. Ms. Carroll said all residents admitted to the facility require assistance with all personal care and assistance to evacuate in an

emergency. Ms. Carroll said most residents are incontinent of bowel and bladder and need assistance with transferring and mobility.

On October 8, 2021, I spoke to direct care staff member Alexandria Page who stated she was scheduled to work from 2:00 pm until 10:00 pm on October 7, 2021. Ms. Page said she was working with Praneeth Naligante who was also scheduled to work from 2:00 pm until 10:00 pm. Ms. Page said it is typical for one staff member to leave the facility during his/her scheduled shift for up to 20 minutes. Ms. Page said Mr. Naligante told her he was leaving to go to the store at approximately 6:50 pm and that she expected him to be gone for 20 minutes. Ms. Page said after Mr. Naligante left, she was the only staff member at the facility. Ms. Page said while working alone at approximately 7:00 pm she went outside to move her car because it was raining. Ms. Page said she was outside "a few seconds." Ms. Page said she saw Ms. Kidd's vehicle pull into the driveway and she saw Ms. Kidd go into the facility. Ms. Page said when Ms. Kidd walked out of the facility she went inside and that the two were never inside together. Ms. Page then stated she never told Ms. Kidd that she had been at the store, but that she told her Mr. Naligante was at the store. Ms. Page stated she was in her car, but never left the facility property.

On October 8, 2021, I spoke to direct care staff member Praneeth Naligante who stated he was scheduled to work from 2:00 pm until 10:00 pm on October 7, 2021 and that he was working with Alexandria Page who was scheduled to work the same shift. Mr. Naligante said at approximately 6:50 he left to go get food and Ms. Page was at the facility. Mr. Naligante denied that Ms. Page informed him that she was going to leave the facility nor move her car, take out the trash, etc. Mr. Naligante said at approximately 7:30 Ms. Carroll telephoned him and told him not to return to the facility. Mr. Naligante said staff members regularly leave the facility to get food when there are two staff members scheduled to work. Mr. Naligante said he spoke with Ms. Page, and she told him she never left the property but acknowledged that she was in her car while the residents were alone inside. Mr. Naligante stated he regularly worked with Ms. Page and does not believe she would have left the property without another staff member present. Mr. Naligante stated when he left at 6:50 "everything was in order," and the residents were not in soiled briefs, etc. as described by Ms. Kidd and Ms. Carroll.

On October 8, 2021, I spoke to licensee designee Jennifer Bhaskaran who said Ms. Carroll telephoned her the previous evening at approximately 7:40 pm and told her she received a call from staff member Kelley Kidd relaying that neither Alexandria Page nor Praneeth Naligante who were scheduled to work at the time were at the facility when she arrived three hours early for her shift. Ms. Bhaskaran stated she was told that when Ms. Kidd arrived at the facility at approximately 7:00 pm there were no staff vehicles in the driveway and when Ms. Kidd entered the facility at approximately 7:20 pm she verified there was no staff member present. Ms. Bhaskaran stated Ms. Page alleged that she was in her car but did not leave the property, and that Ms. Page's "story didn't make sense." Ms. Bhaskaran described Ms. Kidd as reliable, dependable, a "revered" staff member, and having a great deal

of integrity. Ms. Bhaskaran stated based on Ms. Carroll's and Ms. Kidd's' statements she believes there was no staff member at the facility for an unknown length of time on October 7, 2021.

On October 8, 2021, I reviewed a facility schedule and noted that on October 7, 2021, Lacey Carroll was scheduled to work from 7:00 am until 5:00 pm, April Westfall was scheduled to work from 6:00 am until 2:00 pm, Alexandria Page was scheduled to work from 2:00 pm until 10:00 pm, Praneeth Naligante was scheduled to work from 5:00 pm until 10:00 pm, Kimberly Barnes was scheduled to work from 10:00 pm to 6:00 am and Kelly Kidd was scheduled to work from 10:00 pm until 6:00 am.

On October 11, 2021, I reviewed employee records for Alexandria Page and Praneeth Naligante. Neither staff member had any prior disciplinary infractions similar to the allegation in this report. Both employees participated in a background clearance and were found to be suitable to work with vulnerable adults in an adult foster home. Both employees provided references who were contacted and did not relay any concerning information. Finally, both employees completed all the required training.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.</b>
<b>ANALYSIS:</b>	Based on the written employee schedule direct care staff members Alexandria Page and Praneeth Naligante were scheduled to work at approximately 7:00 pm when according to the written incident report and verbal statements made by those interviewed, staff member Kelley Kidd arrived and found no staff member at the facility. Mr. Naligante acknowledged that he left to get something to eat during his shift, leaving Ms. Page to work alone. Though she stated it was incorrect that she left the facility property, Ms. Page acknowledged that she left the facility and sat in her car for an unspecified amount of time while six vulnerable residents were inside the facility with no staff member. At minimum, from approximately 7:00 pm until 7:20 pm residents were inside the facility with no staff member, thus there was not sufficient staff on duty during that time for the supervision, personal care, and protection of residents.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>



**III. RECOMMENDATION**

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

*Leslie Herrguth*

12/01/2021

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Leslie Herrguth  
Licensing Consultant

Date

Approved By:

*Dawn Timm*

12/02/2021

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Dawn N. Timm  
Area Manager

Date