GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2022

Renee Ostrom
Residential Alternatives Inc
P.O. Box 709
Highland, MI 48357-0709

RE: License #: AS630012764
Investigation #: 2022A0991015
Timber Hill AIS

Dear Ms. Ostrom:

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,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012764
Investigation #:	2022A0991015
Complaint Receipt Date:	02/15/2022
Investigation Initiation Date:	02/16/2022
Report Due Date:	04/16/2022
Licensee Name:	Residential Alternatives Inc
Licensee Address:	14087 Placid Dr Holly, MI 48442
Licensee Telephone #:	(248) 369-8936
Licensee Designee:	Renee Ostrom
Name of Facility:	Timber Hill AIS
Facility Address:	555 Timber Hill Dr Ortonville, MI 48462
Facility Telephone #:	(248) 369-8936
Original Issuance Date:	10/28/1992
License Status:	REGULAR
Effective Date:	07/03/2021
Expiration Date:	07/02/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 2/12/2021 direct care worker, Christina Quick, left her shift early, leaving only one staff with five residents.	Yes
Direct care worker, Roy Key, hit Resident A on the hand and left Resident B in bed wearing only a brief with the window open.	No

III. METHODOLOGY

02/15/2022	Special Investigation Intake 2022A0991015
02/16/2022	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker, Dawn Krull
02/16/2022	Referral - Recipient Rights Received from ORR
02/16/2022	APS Referral Completed by ORR worker, Dawn Krull
02/16/2022	Contact - Document Received Plans of service, time sheets, E-scores, and disciplinary action
02/22/2022	Contact - Document Received Staff logs, home policy
02/22/2022	Inspection Completed On-site Unannounced onsite inspection completed
03/07/2022	Contact - Telephone call received From Adult Protective Services (APS) worker, Candid Jamerson
03/21/2022	Contact - Telephone call made To direct care worker, Roy Key
03/21/2022	Contact - Telephone call made To direct care worker, Christina Quick
04/06/2022	Exit Conference Via telephone with licensee designee, Renee Ostrom

ALLEGATION:

On 2/12/2021 direct care worker, Christina Quick, left her shift early, leaving only one staff with five residents.

INVESTIGATION:

On 02/15/22, I received a complaint from the Office of Recipient Rights (ORR) alleging that on Saturday, 02/12/22, direct care worker, Christina Quick, left her shift early leaving direct care worker, Roy Key, as the only staff on shift with five residents. Ms. Quick called the home manager and reported that she had a family emergency. The home manager told Ms. Quick that she could not leave five residents with one staff person, but Ms. Quick refused to return to the home. Ms. Quick later reported that she left her shift early because she was mad the other staff, Roy Key. Ms. Quick reported that Mr. Key hit Resident A's hand and left Resident B in his bed wearing only an adult brief with the bedroom window open.

I initiated my investigation on 02/16/22, by contacting the assigned ORR worker, Dawn Krull. Ms. Krull made a referral to Adult Protective Services (APS) and the complaint was assigned to APS worker, Candid Jamerson, for investigation. Ms. Krull indicated that she interviewed the Timber Hill home manager, Lashonda Lindsey. Ms. Lindsey reported that there are supposed to be two staff on shift at all times in the home. The home's evacuation scores (E-scores) show that they need to have two staff. Staff know that in an emergency they can call her, and she will come in to relieve them. They are not supposed to leave the home without coverage. On 02/12/22, Christina Quick did not call the manager and just left the home. Ms. Quick was aware that she could not leave based on previous conversations with the home manager. Ms. Lindsey received a call from Roy Key indicating that Ms. Quick left him at the home alone with five residents. Ms. Lindsey called Ms. Quick and asked her to go back to the home until she could get there. Ms. Quick refused to return to the home, stating that her husband had to go to work. Ms. Lindsey reported that Ms. Quick left her shift around 8:30am on 02/12/22. Ms. Lindsey arrived at the home around 8:50am. The residents were awake and in their wheelchairs in the dining room when Ms. Lindsey arrived.

On 02/22/22, I conducted an unannounced onsite inspection at Timber Hill with the assigned ORR worker, Dawn Krull. I interviewed direct care worker, Marita Jurick. Ms. Jurick indicated that she has worked in the home for approximately three years. She stated that she typically works the day shift from 10:00am-8:00pm. Roy Key and Christina Quick typically work the second shift from 8:00pm-9:00am. Ms. Jurick was not working when Ms. Quick left her shift early. Ms. Jurick stated that the home requires two staff on shift at all times in order to meet the needs of the residents. Three residents use wheelchairs. One staff person could not safely evacuate all of the residents if there was a fire.

On 03/21/22, I interviewed direct care worker, Roy Key, via telephone. Mr. Key indicated that he was working the second shift with Christina Quick on 02/12/22 when Ms. Quick left her shift early. Mr. Key was scheduled to work until 10:00am and Ms. Quick was scheduled to work until 9:00am. Around 8:30am, the home manager called the facility's phone looking for Ms. Quick. Mr. Key could not locate Ms. Quick in the home. Ms. Quick did not tell him that she was leaving her shift early. The home manager arrived at the home approximately 15-20 minutes later. Mr. Key indicated that the home requires two staff on shift at all times. Ms. Quick never left her shift early prior to this incident.

On 03/21/22, I interviewed direct care worker, Christina Quick, via telephone. Ms. Quick indicated that she left her shift early on 02/12/22. She was scheduled to work until 9:00am. At approximately 8:30am, her husband was waiting outside for her because he needed to be to work at 9:00am. Ms. Quick indicated that she was mad at the other staff on shift that day, Roy Key, so she did not feel like talking to him and did not tell him that she was leaving. She stated that Mr. Key has an attitude, and she did not get along with him very well. Ms. Quick stated that the home manager called her and told her to go back to the home, but she could not go back because her husband needed to go to work. She stated that there should always be two staff on shift, and they are not supposed to leave the home until the next staff person comes on shift. Ms. Quick indicated that she was written up for leaving the home early.

I reviewed a copy of the time sheet from 02/12/22, which notes that Ms. Quick worked until 8:00am on 02/12/22. I reviewed a copy of the employee disciplinary report, which notes that Christina Quick left her shift before her relief arrived on 02/12/22. Ms. Quick was scheduled to work until 9:00am and left at 8:30am. The schedule had been posted for more than seven days. The disciplinary action notes that Ms. Quick must remain on shift until she is relieved or until she has made contact with her supervisor and receives permission to leave.

I reviewed a copy of the home's E-scores which note that the level of evacuation difficulty for the home is rated as "slow" with two staff on shift. I reviewed copies of the individual plans of service and crisis plans for the residents in the home and noted the following:

Resident A uses a wheelchair and will continuously attempt to "get up" and stand out of his wheelchair. Resident A is not able to walk on his own at this time without assistance. Caregivers should monitor Resident A closely for attempts to walk and assist.

Resident B uses a wheelchair. His whereabouts in the home should be known and he should be within hearing or calling distance. Resident B requires assistance for personal hygiene, bathing, dressing, grooming, feedings, and transferring. He requires a mechanical lift of two-person lift for all transfers.

Resident C requires indirect supervision within the home. Staff will do visual checks on Resident C at least every 15 minutes during awake hours. Resident C is able to pivot transfer. He independently operates his power wheelchair for mobility.

Resident D uses a wheelchair that he can only propel for short distances himself and does not have safety skills. Resident D requires indirect supervision (whereabouts known, within hearing, and calling distance) when at home.

Resident E uses a wheelchair for all ambulation. He requires indirect supervision (within hearing and calling distance) in the home and during waking hours. Staff must know his whereabouts at all times. Resident E has a long history of inappropriate sexual touching and forcing himself on others.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(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.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the home did not have sufficient direct care staff on duty on 02/12/22 when direct care worker, Christina Quick, left her shift early, leaving only one staff person on shift with five residents. Several of the residents in the home use wheelchairs and the E-Scores show that the home requires two staff at all times in order to safely evacuate the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care worker, Roy Key, hit Resident A on the hand and left Resident B in bed wearing only a brief with the window open.

INVESTIGATION:

The complaint also alleged that direct care worker, Roy Key, hit Resident A's hand and left Resident B in his bed wearing only an adult diaper with the window open. On 02/16/22, I contacted the assigned ORR worker, Dawn Krull. Ms. Krull indicated that she interviewed the home manager, Lashonda Lindsey. Ms. Lindsey indicated that direct care worker, Christina Quick reported to her that she observed Resident B in his bed with just a brief on and his window open. Ms. Quick shut the window and checked Resident B. Resident B was cold to the touch. The other staff on shift, Roy Key, was

dressing Resident B and then walked away. When he came back to finish dressing Resident B, Ms. Quick told Mr. Key that he could not leave the window open. Ms. Quick was not sure how long Resident B was in the room without clothing. The home manager indicated that the incident seems to have happened in Resident B's bedroom. Resident B shares a room with Resident A; however, both residents are nonverbal. Ms. Lindsey also indicated that there was a note in the staff log indicating that staff are not to open the windows when it is so cold. Ms. Quick wrote an incident report and indicated that this happened on 01/30/22, but she made it sound like it happened on 02/12/22, which was the date when she first reported it to the home manager. On 02/12/22, Ms. Quick also reported to the home manager that she saw Roy Key hit Resident A on his hand. Ms. Quick also made it seem as though this happened on 02/12/22, but she wrote an incident report which indicated that is happened on 02/10/22. Ms. Quick reported that Resident A reached for Mr. Key's arm and Mr. Key slapped Resident A's hand. Ms. Quick told the home manager that this happened in Resident A's bedroom, but she indicated that it happened in the dining room on the incident report. Ms. Lindsey indicated that she never witnessed Mr. Key hit anyone and no other staff have ever reported Mr. Key being physically aggressive towards the residents in the three years that he has worked in the home.

On 02/22/22, I conducted an unannounced onsite inspection at Timber Hill. I interviewed direct care worker, Marita Jurick. Ms. Jurick indicated that sometimes Mr. Key opens the windows to air out the room if Resident B has a bowel movement. He will open the window for a brief period and then close it. She never arrived on shift to find the window was left open. During the onsite inspection, I observed Resident B's bedroom. Resident B's bed is located next to the window. During the onsite inspection, the windows were closed, and the room was heated to an appropriate temperature. Ms. Jurick indicated that Resident A and Resident B share a bedroom. They were both at workshop at the time of the onsite inspection. Ms. Jurick indicated that both Resident A and Resident B are nonverbal and would not be able to answer questions. Ms. Jurick stated that she never witnessed or heard of anyone being physically aggressive towards any of the residents in the home. She did not have any concerns about the staff in the home.

On 03/21/22, I interviewed direct care worker, Roy Key, via telephone. Mr. Key indicated that Resident A is in a wheelchair and will often stick out his hand when staff walk by. Mr. Key stated that he will give Resident A a high five or "pat-a-cake" as he walks by, hitting his hand palm to palm in a friendly gesture. He has never hit Resident A on the top of the knuckles or in a slapping manner. Mr. Key stated that nobody messes with Resident A, and he never saw anyone else hit Resident A or act in a physically aggressive manner. He stated that he verbally redirects Resident A if Resident A is grabbing at him or if he is busy with another resident. Mr. Key stated that he never left Resident B in his bedroom with the window open. He stated that Resident B is incontinent, so he sometimes cracks the window to get the urine smell out of the room when he takes Resident B in for his shower. He opens the window while he is showering Resident B and then closes it before he brings Resident B back into the room to get dressed. He did not recall a time when he left Resident B in the bedroom wearing

only a brief with the window open. He stated that all of the staff crack the window to air out the bedroom. Nobody ever mentioned to him that the window was left open while Resident B was in the room.

On 03/21/22, I interviewed direct care worker, Christina Quick, via telephone. Ms. Quick indicated that on 01/30/22, she went into Resident B's bedroom and saw him lying on his bed with just his brief on. The window was open, and it was freezing cold in the bedroom. She shut the window, and the other staff on shift, Roy Key, came into the room. She told Mr. Key that he could not leave the window open. Mr. Key did not say anything and put Resident B's clothes on him. Ms. Quick stated that she did not know how long the window was open for. It could have been less than five minutes, but Resident B did not have on any clothes or a blanket. He was only wearing a brief. Ms. Quick stated that sometimes staff open the window to air out the room, but it should only be opened if the residents are not in the bedroom. Ms. Quick stated that on 02/10/22, she saw Mr. Key slap Resident A's hand. Resident A likes to grab and pinch staff. She stated that Resident A was grabbing Mr. Key's arm and he slapped his hand to make him stop. It was not hard and did not leave any marks or bruises. Ms. Quick stated that she did not say anything to Mr. Key when this happened, and she did not report it to anyone else at the time. She did not know that she needed to write an incident report about her co-worker. Ms. Quick indicated that she reported both incidents to the home manager on 02/12/22, which was the day she left her shift early. She stated that the issues with Mr. Key had been building up. She wrote incident reports regarding both incidents on 02/12/22.

On 03/07/22, I spoke with the assigned APS worker, Candid Jamerson. Ms. Jamerson indicated that she did not believe she had enough evidence to substantiate the allegations of physical abuse or neglect.

On 04/06/22, I contacted the licensee designee, Renee Ostrom, to conduct an exit conference, via telephone. Ms. Ostrom indicated that direct care worker, Christina Quick, was written up and in-serviced regarding leaving her shift early. She indicated that she would submit a corrective action plan to address the violation.

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:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident B was not treated with dignity and that his personal needs were not attended to at all times. Direct care worker, Roy Key, denied leaving Resident B undressed in his bedroom with the window

	open. He stated that staff open the window to air out the bedroom, but the window is closed before Resident B is brought back into the bedroom.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that direct care worker, Roy Key, used physical force towards Resident A and slapped his hand. Mr. Key indicated that he only slaps hands with Resident A palm-to-palm in a high five or pat-a-cake motion.
CONCLUSION:	VIOLATION NOT ESTABLISHED

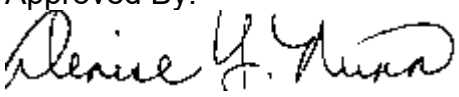
IV. RECOMMENDATION

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

04/06/2022

Kristen Donnay Date
Licensing Consultant

Approved By:



04/11/2022

Denise Y. Nunn Date
Area Manager