



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2022

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

RE: License #: AS630012774
Investigation #: 2022A0611035
Appomattox AIS/MR

Dear Ms. Ostrom:

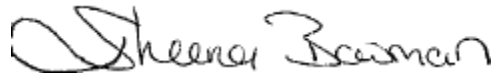
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in black ink that reads "Sheena Bowman". The signature is written in a cursive style with a large initial 'S'.

Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012774
Investigation #:	2022A0611035
Complaint Receipt Date:	08/05/2022
Investigation Initiation Date:	08/09/2022
Report Due Date:	10/04/2022
Licensee Name:	Residential Alternatives Inc
Licensee Address:	14087 Placid Dr Holly, MI 48442
Licensee Telephone #:	(248) 369-8936
Administrator:	Renee Ostrom
Licensee Designee:	Renee Ostrom
Name of Facility:	Appomattox AIS/MR
Facility Address:	10372 Appomattox Holly, MI 48442
Facility Telephone #:	(248) 634-5949
Original Issuance Date:	10/21/1992
License Status:	REGULAR
Effective Date:	12/13/2021
Expiration Date:	12/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff was sleeping on the job.	Yes

III. METHODOLOGY

08/05/2022	Special Investigation Intake 2022A0611035
08/09/2022	Special Investigation Initiated - Letter I emailed recipient rights specialist, Kathleen Garcia inquiring about additional information pertaining to the allegations.
08/09/2022	Contact - Document Received I received a copy of the video of staff member, Crystal Pas sleeping, a picture of Ms. Pas sleeping, and a copy of the incident report regarding the allegations.
08/17/2022	Inspection Completed On-site I completed an unannounced visit. I interviewed the home manager, Annette Thurman, and Resident W. I received a copy of the sleeping policy.
08/22/2022	Contact - Telephone call made I left a voice message for staff member, Felicia Smith requesting a call back.
08/22/2022	Contact - Telephone call made I left a voice message for staff member, Crystal Pas requesting a call back.
08/22/2022	Contact – Telephone call made I made a telephone call to staff member, Crystal Pas. The allegations were discussed.
08/22/2022	Contact – Document Received I received an email from the recipient rights specialist, Kathleen Garcia. Ms. Garcia stated she will be substantiating her investigation.
08/22/2022	Exit Conference I completed an exit conference with the licensee designee, Renee Ostrom via telephone.

ALLEGATION:

Staff was sleeping on the job.

INVESTIGATION:

On 08/05/22, I received the abovementioned allegations. The specific allegations are: On 8/4/22, Oakland Community Health Network Office of Recipient Rights received and reviewed six (6) Incident Reports, one for each individual served. The incident reports were completed by Annette Thurman, Home Manager, documenting that on 8/2/22 she arrived to the home, unannounced at 6:58 a.m. to drop off food. Upon arrival, Ms. Thurman witnessed Crystal Pas, Staff, sitting in the recliner with noise-canceling headphones on and asleep. Felicia Smith, staff, was also present and was witnessed to be assisting David Fuss, Individual Served, to the bathroom for a shower. Ms. Thurman reported that Warren Ganger, Individual Served, was the only other individual served awake at the time that Ms. Pas was witnessed sleeping. Ms. Thurman also reported that she did take a picture and short video of Ms. Pas, as Ms. Pas was "snoring".

On 08/09/22, I received a copy of the video of staff member, Crystal Pas sleeping, a picture of Ms. Pas sleeping, and a copy of the incident report regarding the allegations from the recipient rights specialist, Kathleen Garcia. The video and picture confirmed that Ms. Pas was sleeping in a recliner chair with headphones on. The incident report dated 08/02/22 was completed by the home manager, Annette Thurman. According to the incident report, Ms. Thurman arrived to the AFC group home at 6:58 am and saw Ms. Pas in the living room recliner chair asleep with what appeared to be noise concealing headphones. Ms. Thurman tapped Ms. Pas on the shoulder and woke her up. Ms. Pas will receive disciplinary action.

On 08/17/22, I completed an unannounced visit. I interviewed the home manager, Annette Thurman, and Resident W. I received a copy of the sleep policy.

On 08/17/22, I interviewed the home manager, Annette Thurman. Regarding the allegations, on 08/02/22, Ms. Thurman stated she arrived to the AFC group home unannounced at 6:58 am. Ms. Thurman entered the home from the front door. When Ms. Thurman walked into the home she saw staff member, Crystal Pas sitting in the recliner chair next to the front door. Ms. Thurman was carrying groceries in both of her hands. Ms. Thurman walked past Ms. Pas without looking directly at her and said hello. While walking towards the kitchen, Ms. Thurman saw staff member, Felicia Smith in the hallway pushing Resident D in his wheelchair into the bathroom to give him a shower. Ms. Thurman made eye contact with Ms. Smith and; Ms. Smith facial expression was described as a deer caught in head lights.

Ms. Thurman put the groceries in the kitchen and left the home from the garage door to get more items from her car. Ms. Thurman came back into the kitchen from the garage door. Ms. Thurman walked back to the front room and saw Ms. Pas sleeping in the recliner chair with headphones on. Ms. Thurman called Ms. Pas name but she did not respond. Ms. Thurman could hear Ms. Pas snoring. Ms. Thurman recorded a video of Ms. Pas sleeping and then she took a picture of her. Ms. Thurman called Ms. Pas name again but she did not respond. Ms. Thurman tapped Ms. Pas on the shoulder and Ms. Pas jumped up. Ms. Thurman told Ms. Pas they needed to talk about this. Ms. Thurman asked Ms. Pas if she was on medication. Ms. Pas stated she took Dayquil. Ms. Thurman told Ms. Pas that this issue will be addressed. Ms. Pas finished her shift. Ms. Pas shift was from 10:00pm to 10:00am.

Ms. Thurman stated she went into all the residents bedrooms to check on them and; only Resident D and Resident W were awake. The other four residents in the AFC group home were asleep. Ms. Thurman stated the staff should be getting the residents up between 6:30am and 7:00am and; they should be leaving for workshop by 8:30am.

Ms. Thurman stated Ms. Pas and Ms. Smith were written up and they received a re-in-service training on the sleep policy on 08/03/22. Ms. Thurman stated there has not been a previous issue with Ms. Pas sleeping during her shift. Ms. Smith has been disciplined before a couple years ago for sleeping during her shift. Ms. Pas contacted Ms. Thurman via text message on 08/07/22 resigning from her position effective immediately. Ms. Thurman stated Resident D is not capable of being interviewed.

On 08/17/22, I interviewed Resident W. Resident W is blind. Regarding the allegations, Resident W moved into the AFC group home this year. Resident W stated he likes living at the AFC group home. Resident W stated he wakes himself up in the morning with the help of a watch he has. Resident W stated when he wakes up, he eats breakfast and then he goes into the community. Resident W thinks staff checks on him throughout the night. Resident W stated he cannot say whether or not there has been a time staff were not available. Resident W could not say whether or not he has heard of staff sleeping during their shift. Resident W is pretty sure the staff stay awake most of the night and they know what is going on. Resident W stated staff take good care of him which is why he moved into this home.

On 08/17/22, I received a copy of the sleep policy. According to the sleep policy, all employees are expected to be awake at all times. Employees should not be making the environment comfortable enough to encourage sleeping on duty. Each employee working on shift has the responsibility to encourage their co-worker not to get comfortable enough to fall asleep and to stay awake.

On 08/22/22, I received a copy of the employee disciplinary report for Ms. Pas and Ms. Smith from Ms. Ostrom via email. Ms. Pas signed her disciplinary report on 08/03/22 and Ms. Smith signed her disciplinary report on 08/04/22.

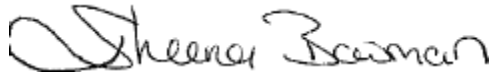
On 08/22/22, I made a telephone call to staff member, Crystal Pas. Regarding the allegations, Ms. Pas confirmed that she was sleeping while on duty. Ms. Pas stated she was asleep between a hour and a half or two hours. Ms. Pas stated this was the first time she went to sleep while on duty. Ms. Pas stated she was sick with a sinus infection and ear infection. Ms. Pas stated she told Ms. Thurman that she was sick prior to coming to work, however Ms. Thurman advised her not to call off. Ms. Pas stated she quit working at the AFC group home on 08/07/22 due to having anxiety about not getting coverage when she needed it.

On 08/22/22, I completed an exit conference with the licensee designee, Renee Ostrom. Ms. Ostrom stated Ms. Thurman sent her a picture of Ms. Pas sleeping in the recliner chair at the AFC group home. Ms. Ostrom advised Ms. Thurman to discipline Ms. Pas and to complete a re-in-service training regarding the sleep policy with Ms. Pas. Ms. Ostrom also advised Ms. Thurman to discipline Ms. Smith as she allowed Ms. Pas to sleep on duty by not reporting it to management. Ms. Ostrom stated there hasn't been a previous issue with Ms. Pas sleeping while on duty as she only worked for the AFC group home for less than 90 days. Ms. Smith was caught sleeping while on duty by Ms. Ostrom around 2017 or 2018. Ms. Ostrom was informed the allegations will be substantiated and a corrective action plan will be required.

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:	On 08/02/22, Ms. Pas did not ensure the residents personal needs, protection, or safety were attended to at all times as she was observed sleeping in the living room while on duty.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

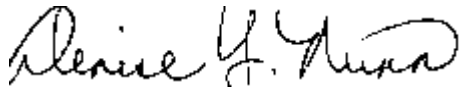
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Sheena Bowman
Licensing Consultant

08/22/22
Date

Approved By:



10/04/2022

Denise Y. Nunn
Area Manager

Date