GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 24, 2022

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

RE: License #: AS630012774
Investigation #: 2023A0612001
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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012774
Investigation #:	2023A0612001
Complaint Receipt Date:	10/10/2022
Investigation Initiation Date:	10/10/2022
Report Due Date:	12/09/2022
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?
On 10/05/22 around 1:05 AM, direct care staff Javont'e McQueen was witnessed sleeping on shift.	Yes

III. METHODOLOGY

10/10/2022	Special Investigation Intake 2023A0612001
10/10/2022	Special Investigation Initiated - Letter I sent an email to Recipient Rights Specialist, Katie Garcia regarding the allegation
10/10/2022	Contact - Document Received I received copies of the Incident Reports written by home manager, Annettee Thurman
10/10/2022	APS Referral I made a referral to Adult Protective Services (APS) via Centralized Intake
10/10/2022	Contact - Telephone call made I completed a telephone interview with home manager Annettee Thurman
10/10/2022	Contact - Document Received I received a copy of Residential Alternative Inc's sleeping policy, a photo and a video of direct care staff, Javont'e McQueen asleep, and Residents A, B, C, D, and E's Individual Plans of Service
10/10/2022	Contact - Telephone call made I completed a telephone interview with direct care staff Rhonda Nichols
10/10/2022	Contact - Telephone call made I called and texted direct care staff Javont'e McQueen
10/12/2022	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed home manager, Annettee Thurman, Resident A, Resident, B, Resident D, Resident E, and Resident F

10/13/2022	Exit Conference I made a telephone call to licensee, Renee Ostrom to discuss my findings

ALLEGATION:

On 10/05/22 around 1:05 AM, direct care staff Javont'e McQueen was witnessed sleeping on shift.

INVESTIGATION:

On 10/10/22, I received a complaint from Recipient Rights Specialist, Katie Garcia that indicates on 10/06/22, Oakland Community Health Network (OCHN) - Office of Recipient Rights (ORR) received five Incident Reports (one completed for each resident) written by home manager, Annette Thurman. The Incident Reports indicate that on 10/05/22, around 1:05 am direct care staff Javont'e McQueen was witnessed sleeping while on duty. Direct care staff Rhonda Nichols was also on shift when this occurred. Home manager Annette Thurman went to the home and woke up Mr. McQueen. I initiated my investigation with an email to Recipient Rights Specialist, Katie Garcia regarding the allegation. Ms. Garcia is investigating. I completed a referral to Adult Protective Services (APS) via Centralized Intake. APS denied the referral for investigation.

On 10/10/22, I completed a telephone interview with home manager Annettee Thurman. Ms. Thurman stated on 10/05/22, she called the home and asked to speak with direct care staff Javont'e McQueen. Direct care staff, Rhonda Nichols went to give him the phone and found him sleeping on the living room couch. Ms. Thurman was on her way to the home to relieve Ms. Nichols from shift, she arrived around 1:05 am. When she walked inside, she heard snoring coming from the living room. Mr. McQueen was laying on the couch, in the living room, asleep. All six of the residents were in bed asleep. No issues or injuries occurred while Mr. McQueen was asleep on shift. Ms. Thurman stated Residential Alternative's sleeping policy indicates staff will not sleep on shift. Ms. Thurman took a photo and a video of Mr. McQueen sleeping. She provided the evidence to me via text message. Mr. McQueen was written up and re- in serviced on Residential Alternative's sleeping policy.

On 10/10/22, I completed a telephone interview with direct care staff Rhonda Nichols. Ms. Nichols has been working at the Appomattox AIS/MR home for three weeks. She stated on 10/05/22, she worked from 2:00 pm – 10:00 pm. The staff assigned to relieve her at 10:00 pm did not show up for their scheduled shift so she stayed to work the next shift from 10:00 pm – 7:00 am. This was the first time she had worked with Mr. McQueen. Ms. Nichols stated around midnight, all the residents were asleep in bed, she stepped outside to take a smoke break. Mr. McQueen was inside the home. While she was outside, she heard the telephone ringing. She assumed Mr. McQueen would answer it since he was inside however, the phone was not picked up. Ms. Nichols

stated she went back inside and observed Mr. McQueen asleep and snoring on the living room couch. Home manager, Ms. Thurman called, she asked to speak to Mr. McQueen. Ms. Nichols informed her that he was asleep. Ms. Thurman arrived at the home around 1:05 am. Ms. Nichols stated Mr. McQueen was still asleep on the couch when Ms. Thurman got to the home. Ms. Nichols stated there were no issues or incidents with the residents while Mr. McQueen was asleep on shift. Ms. Nichols ended her shift after Ms. Thurman arrived.

On 10/10/22, I called direct care staff Javont'e McQueen. There was no answer, I left a voicemail requesting a return call. I then sent Mr. McQueen a text message. There was no response.

On 10/10/22, I reviewed the following documents:

- Five Incident Reports (IR's) written by home manager, Annettee Thurman
  In summary, the IR's indicate on 10/05/22, around 1:05 am Ms. Thurman walked into the home and heard a staff snoring. Direct care staff, Javont'e McQueen was laying on the couch, in the living room, asleep.
- A photo and a video of a man lying on a couch asleep and snoring
  Home manager, Annettee Thurman and direct care staff, Rhonda Nichols identify the man in the photo and video as direct care staff, Javont'e McQueen.
- Residential Alternative Inc's sleeping policy
  In summary, the policy states, all staff working are 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.
- Resident A, Resident B, Resident C, Resident D, and Resident E's MORC Individual Plans of Service (IPOS). In summary, all the residents require 24-hour supervision, personal care, and protection.

On 10/12/22, I completed an unscheduled onsite investigation. I interviewed home manager, Annettee Thurman, Resident A, Resident, B, Resident D, Resident E, and Resident F.

On 10/12/22, I interviewed home manager, Annettee Thurman. Ms. Thurman stated on 10/11/22, direct care staff Javant'e McQueen was terminated due to sleeping on shift.

On 10/12/22, I observed Resident B, Resident E, and Resident D sitting in the living room watching TV. When prompted, Resident B, Resident E, and Resident D did not respond to interview questions.

On 10/12/22, I interviewed Resident A. Resident A was sitting in his bed. Resident A stated staff sleep on shift. Resident A was unable to provide any additional details.

On 10/12/22, I interviewed Resident F. Resident F stated direct care staff. Mr. McQueen has gone to sleep on shift. Resident F stated this occurs during the midnight shift. He likes staying up late to watch TV and while doing so he has heard Mr. McQueen snoring from the living room. Resident F stated when a staff falls asleep, they always wake themselves up and care for his and his housemates needs.

On 10/13/22, I held an exit conference with licensee, Renee Ostrom to review my findings. Ms. Ostrum stated Mr. McQueen has been terminated.

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 sufficient information to conclude that the residents personal care including protection and safety were not attended to at all times. The residents require 24-hour supervision, personal care, and protection. It is the policy of Residential Alternative, Inc that all staff working are to be awake at all times. Direct care staff, Javant'e McQueen was unable to provide the residents with supervision, safety, and protection while asleep on shift.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR# 2022A0611035; CAP dated 10/04/2022**

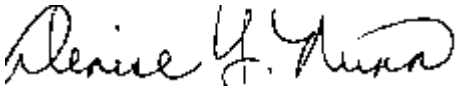
IV. RECOMMENDATION

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

10/13/2022

Johnna Cade — Date
Licensing Consultant

Approved By:



10/24/2022

Denise Y. Nunn — Date
Area Manager