GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

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

RE: License #: AS630012764
Investigation #: 2022A0602040
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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012764
Investigation #:	2022A0602040
Complaint Receipt Date:	09/13/2022
Investigation Initiation Date:	09/14/2022
Report Due Date:	11/12/2022
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:	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?
Incident report dated 9/10/2022 indicated that staff member Robert Johnson thumped residents.	No
Additional Allegation received on 10/17/2022: Resident C did not receive his 7 am medication Fluoxetine on 10/03/2022, 10/04/2022 and 10/05/2022 because the home manager did not contact the pharmacy and have the medication refilled.	Yes

III. METHODOLOGY

09/13/2022	Special Investigation Intake 2022A0602040
09/14/2022	Special Investigation Initiated - Telephone Call made to the home manager.
09/14/2022	APS Referral Adult Protective Services (APS) referral made but denied.
09/19/2022	Inspection Completed On-site Interviewed the home manager, Rosalind Alexander, Resident A and Resident B.
09/21/2022	Contact – Telephone call made Call made to staff member, Melita Jurick, mailbox full - unable to leave a message.
10/17/2022	Contact – Telephone call made Call made to staff member, Robert Johnson, mailbox full - unable to leave a message.
10/17/2022	Contact – Document received Additional allegation received.
10/21/2022	Contact – Telephone call made Message left for Rosalind Alexander.
10/21/2022	Contact – Telephone call made Interviewed staff member Christina Quick.

10/21/2022	Contact – Telephone call made Interviewed staff member Melita Jurick.
10/21/2022	Exit Conference Held with the licensee designee, Renee Ostrom by telephone.

ALLEGATION:

Incident report dated 9/10/2022 indicated that staff member Robert Johnson thumped residents.

INVESTIGATION:

On 9/13/2022, a complaint was received and assigned for investigation alleging that staff member Robert Johnson thumped residents.

On 9/19/2022, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Rosalind Alexander, Resident A, and Resident B. Ms. Alexander stated she did not witness Mr. Johnson thumping any of the residents. Staff member, Melita Jurick informed her that staff member, Christina Quick told her Mr. Johnson was thumping Resident A and Resident B. Ms. Alexander stated she only reported what was reported to her.

On 9/19/2022, I attempted to interview Resident A but was unable to obtain any information regarding the allegation due to his severe cognitive impairment. Resident A can make sounds and point but is unable to carry on a conversation. When questioned, Resident A responded by pointing his hand in a downward motion to every question asked. I did not observe any marks or bruises on Resident A.

On 9/19/2022, I attempted to interview Resident B but was unable to obtain any information regarding the allegation due to his cognitive impairment. I did not observe any marks or bruises on Resident A.

On 10/21/2022, I interviewed Ms. Quick by telephone. Ms. Quick stated she never told Ms. Jurick or anyone else that she saw Mr. Johnson thumping Resident A or Resident B. She has worked with Mr. Johnson in the past and has never witnessed him being inappropriate with any of the residents. She went on to state that she was very upset that Ms. Alexander reported false information.

On 10/21/2022, I interviewed Ms. Jurick by telephone. Ms. Jurick stated she never told Ms. Alexander that Ms. Quick told her Mr. Johnson thumped Resident A or Resident B. She said she has never witnessed Mr. Johnson thump any of the residents and Ms. Quick never told her that he did either.

On 10/21/2022, I spoke with the licensee designee, Renee Ostrom by telephone. Ms. Ostrom stated she believes the allegation was an attack on Mr. Johnson for reasons unknown.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the information obtained during the investigation, I determined there is insufficient information to determine if Mr. Johnson thumped Resident A or Resident B. According to Ms. Quick, she never told Ms. Jurick that Mr. Johnson thumped Resident A or Resident B. According to Ms. Jurick, she never told Ms. Alexander that Ms. Quick informed her that Mr. Johnson thumped Resident A or Resident B because it never happened.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident C did not receive his 7 am medication Fluoxetine on 10/03/2022, 10/04/2022 and 10/05/2022 because the home manager did not contact the pharmacy and have the medication refilled.

INVESTIGATION:

On 10/17/2022, an additional allegation was received alleging that Resident C did not receive his 7 am medication Fluoxetine on 10/03/2022, 10/04/2022 and 10/05/2022 because the home manager did not contact the pharmacy and have the medication refilled.

On 10/21/2022, I interviewed staff member, Christina Quick by telephone. Ms. Quick stated on 09/30/2022 she administered Resident C his 7 am medication, Fluoxetine. The medication was running low, so she left a note for the home manager, Rosalind Alexander informing her that the prescription needed to be refilled. When she arrived for her evening shift on 9/30/2022 she did not see a new bottle of Fluoxetine for Resident C. Ms. Quick said on 10/02/2022 she left another note for Ms. Alexander informing her

that she administered Resident C the last dose of Fluoxetine on 10/02/2022 at 7 am and he was completely out. On the morning of 10/03/2022 Ms. Quick spoke with Ms. Alexander and informed her that Resident C was out of Fluoxetine. Ms. Alexander replied, “Ok.” When Ms. Quick arrived for her evening shift on 10/03/2022, there was no Fluoxetine for Resident C. There was a staff meeting on 10/06/2022 and Ms. Quick told Ms. Alexander that she needed to have Resident C’s Fluoxetine refilled because he had been out for a few days. Ms. Alexander said she ordered it on 10/05/2022 but it had not arrived. She agreed to contact the pharmacy. Ms. Quick said whenever medication is ordered for the residents, the pharmacy delivers it the same day.

On 10/21/2022, I interviewed staff member Melita Jurick by telephone. Ms. Jurick stated she does not administer any 7 am medication as this is the responsibility of the midnight staff and she works days and afternoons. When she realized Resident C was out of his Fluoxetine (exact date unknown) she informed Ms. Alexander. Ms. Alexander told her that she was aware of it. Ms. Jurick went on to state that Ms. Quick left Ms. Alexander notes when the medication was getting low, but she did not call the pharmacy for a refill.

On 10/21/2022, I received and reviewed a copy of Resident C’s medication log for the month of October 2022. According to the log, there were x’s marked on 10/03/2022, 10/04/2022, 10/05/2022 and 10/06/2022 for Resident C’s 7 am dose of Fluoxetine. It was documented on the back of the log that Resident C did not receive the medication because it was not in the facility on those dates. On 10/06/2022, it was documented on the back of the log that Resident C received Fluoxetine after the prescribed time.

On 10/21/2022, I conducted an exit conference with the licensee designee, Renee Ostrom by telephone. Ms. Ostrom stated she became aware of the incident during a staff meeting on 10/06/2022. She checked Resident C’s medication log and observed that he had not received his 7 am Fluoxetine on 10/03/2022, 10/04/2022 or 10/05/2022. The pharmacy was immediately contacted, delivered the medication on 10/06/2022 and advised staff to administer it even though it was past 7 am. Ms. Ostrom stated it is the responsibility of the home manager to ensure resident medication is ordered and received prior to running out and Ms. Alexander failed to do. As a result, Ms. Alexander was demoted as home manager and assigned to work in another home. On 10/19/2022 Ms. Alexander resigned from the company.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on the information obtained from Ms. Quick, Ms. Jurick and Ms. Ostrom, there is sufficient information to determine that Resident C did not receive his 7 am dose of Fluoxetine on 10/03/2022, 10/04/2022 and 10/05/2022 as Ms. Alexander failed to notify the pharmacy and obtain a refill. Ms. Quick informed Ms. Alexander that the medication was getting low on 9/30/2022. On 10/02/2022 she notified her that the medication was completely out and again on 10/06/2022. Ms. Jurick also notified Ms. Alexander that Resident C was out of Fluoxetine, but she never had the medication refilled. Ms. Ostrom stated it is the responsibility of the home manager to ensure resident medication is ordered and received prior to running out.
CONCLUSION:	**VIOLATION ESTABLISHED**

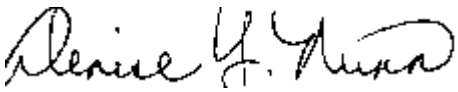
IV. RECOMMENDATION

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

10/21/2022

Cindy Berry — Date
Licensing Consultant

Approved By:



10/25/2022

Denise Y. Nunn — Date
Area Manager