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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2022

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

RE: License #: AS250010919
Investigation #: 2022A0779059
Maple Road 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) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

Alternative Services Inc.

I. IDENTIFYING INFORMATION

License #:	AS250010919
Investigation #:	2022A0779059
Complaint Receipt Date:	09/20/2022
Investigation Initiation Date:	09/20/2022
Report Due Date:	11/19/2022
Licensee Name:	Alternative Services Inc
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Candy Hamilton
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Maple Road Home
Facility Address:	4341 W. Maple Avenue Flint, MI 48503
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	11/05/1990
License Status:	REGULAR
Effective Date:	11/15/2021
Expiration Date:	11/14/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
During first shift on Sunday 9/18/22, Staff TyQuandra "Nina" Thames grabbed Resident A's left wrist and arm causing the resident to fall and scrape her knees.	No
Additional Findings	Yes

III. METHODOLOGY

09/20/2022	Special Investigation Intake 2022A0779059
09/20/2022	Special Investigation Initiated - Telephone Interview conducted with administrator, Candy Hamilton.
09/21/2022	Contact - Telephone call made Interview conducted with Resident A.
09/21/2022	Contact - Telephone call made Interview conducted with staff person, Daejaney Williams.
09/21/2022	Contact - Telephone call made Interview conducted with staff person, TyQuandra Thames.
09/21/2022	Contact - Telephone call made Interview conducted with Resident B.
09/22/2022	APS Referral Complaint referred to APS centralized intake.
09/22/2022	Contact - Telephone call made Spoke to recipient rights investigator, Kim Nguyen-Forbes.
10/04/2022	Inspection Completed On-site
10/20/2022	Contact - Telephone call received Spoke to recipient rights investigator, Ms. Nguyen-Forbes.
10/21/2022	Contact - Telephone call received Spoke to APS worker, Jacqueline Williams.
10/22/2022	Exit Conference Held with administrator, Candy Hamilton.

ALLEGATION:

During first shift on Sunday 9/18/22, Staff TyQuandra "Nina" Thames grabbed Resident A's left wrist and arm causing the resident to fall and scrape her knees.

INVESTIGATION:

On 9/20/22, a phone interview was conducted with administrator, Candy Hamilton. She stated that she aware of the allegation and confirmed that Resident A does have scrapes on her knees. Ms. Hamilton stated that she saw Resident A during the evening of 9/18/22 and after the alleged incident and that Resident A never said anything to her about Ms. Thames grabbing her or dragging her on the ground. Ms. Hamilton reported that on 9/19/22, she saw Resident A interacting positively with Ms. Thames on the day after the incident as Resident A was letting Ms. Thames do her hair for her. Ms. Hamilton stated that Resident B and Resident C may have been present to witness the incident.

On 9/21/22, Resident A was interviewed by phone. She stated that on 9/18/22, she got upset and chose to walk out of the house. She stated that staff Ms. Thames followed her. Resident A claims that Ms. Thames grabbed her wrist and arm, which made her fall onto her knees in the driveway, and Ms. Thames dragged her on the ground a little. She stated that she has scrapes on both her knees. Resident A stated that she thought that Resident B may have witnessed the incident.

On 9/21/22, an attempt was made to interview Resident B by phone. Resident B refused to talk.

On 9/21/22, Resident C was interviewed by phone. She confirmed that she was aware of Resident A having scraped knees. Resident C stated that she did not see Ms. Thames grab Resident A's wrist and/or arm and she did not see Resident A on her knees on the driveway.

On 9/21/22, staff person, Daejaney Williams, was interviewed by phone. Ms. Williams confirmed that she worked 1st shift on 9/18/22 with Ms. Thames and that she was outside and witnessed when Resident A was on her knees in the driveway. She stated that Resident A was having a behavior and was wanting to walk away from home. Ms. Williams stated that her and Ms. Thames kept trying to redirect Resident A away from the street. Ms. Williams reported that she did not see Ms. Thames grab Resident A's arms and/or wrist. Ms. Williams stated that she saw Resident A throw herself on the ground and then crawl on the ground to the porch steps. She stated that she tried twice to help Resident A get up off the ground but she would not get up. She stated that Ms. Thames was standing right there, but did not ever touch Resident A.

On 9/21/22, a phone interview was conducted with staff person, TyQuandra Thames. She stated that Resident A was having behaviors and got into a verbal argument with Resident B. She stated that Resident A tried to walk away from the home and that she

stood in-between Resident A and the street, while trying to verbally redirect Resident A back to the home. Ms. Thames reported that Resident A grabbed her arms and she snatched her arms away from her. Ms. Thames stated that this is when Resident A threw herself on the ground and refused help with getting up. She stated that while Resident A was still on the ground, she took the rest of the residents to the store and that Ms. Williams stayed with Resident A. Ms. Thames claims that it was Resident A that grabbed her arms and that she never actually touched Resident A during this incident.

On 9/22/22, a phone conversation took place with recipient rights investigator, Kim Nguyen-Forbes, who confirmed that she was investigating the same allegation. Ms. Nguyen-Forbes stated that Resident A told her that Ms. Thames grabbed her arms and pulled her to the ground. She stated that Resident A admitted to her to that she crawled on the ground to the stairs of the porch. Ms. Nguyen-Forbes reported that she interviewed Resident B, who told her that staff were trying to redirect Resident A and that she saw Resident A throw herself on the ground. She stated that Resident B said that Ms. Thames never touched Resident A.

On 10/21/22, a phone conversation took place with APS worker, Jacqueline Williams, who confirmed that she investigated the same allegations. Ms. Williams stated that she received the same information as noted above and that she was not substantiating that any abuse took place.

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:	It was confirmed that on 9/18/22, Resident A was having a behavior and ended up on her knees in the driveway. Staff person, Daejaney Williams, and Resident B have stated that they witnessed the incident and both stated that Resident A threw herself on the ground. They both stated that they did not see staff person, TyQuandra Thames, grab Resident A by the wrist and/or arms or make Resident A fall to the ground. Ms. Thames has denied that she grabbed Resident A or that she was the cause of Resident A being on the ground. There were no other known witnesses to this incident. There was insufficient evidence found to prove that Ms. Thames used any form of inappropriate force on Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 9/21/22, staff person, TyQuandra Thames, stated that while working on 9/18/22, staff person, Daejaney Williams, was on a Facetime call with several, maybe 4, girls. Ms. Thames stated that Ms. Williams was talking about Resident A and the behaviors she was having that day and was laughing about it. She stated that Resident A may have been on camera but was not sure.

On 9/22/22, Ms. Williams denied that she was on a Facetime call during work on 9/18/22 and that she ever had Resident A on her camera phone. Ms. Williams did admit that she was on a normal phone call with a previous staff from this home and that she was talking about Resident A.

On 9/23/22, recipient rights investigator, Ms. Nguyen-Forbes, stated that during an interview she had with Resident A, Resident A told her that staff person, Ms. Williams, was on speaker phone with a previous staff of this home. Ms. Nguyen-Forbes stated that Resident A claims that she knows the voice of this previous staff and that Ms. Williams was talking to this previous staff about the behaviors she was having that day.

During the on-site inspection on 10/4/22, Resident A confirmed that on 9/18/22, staff person, Ms. Williams, was on speaker phone with a previous staff of this home and was talking to this person about the behaviors she was having that day. Resident A stated that she was positive about who Ms. Williams was talking to because she knew the voice as a staff who used to work at this home. She stated that she actually said hi to this previous staff person, while she was on the phone with Ms. Williams. Resident A reported that she did not see anyone on the camera of Ms. Williams phone and that she is not sure if she was being recorded or not.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Staff person, TyQuandra Thames, stated that staff person, Daejaney Williams, was on a facetime call during work and was talking to people about Resident A. Ms. Williams denied that it was a Facetime call, but admits that she was on her phone talking about Resident A and her behaviors. Resident A confirmed that she saw and heard Ms. Williams on her speaker phone and talking about her. Whether or not it was an actual Facetime call or not, it was confirmed that Ms. Williams was on her phone during work hours and was speaking to someone about Resident A. This is a violation of Resident A's right to personal dignity and privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/22/22, an exit conference was held with administrator, Candy Hamilton. She was informed that a corrective action plan is required to address the above licensing rule violation.

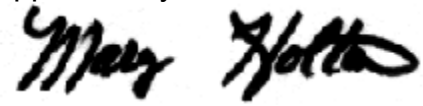
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

11/2/2022

Christopher Holvey Date
Licensing Consultant

Approved By:



11/2/2022

Mary E. Holton Date
Area Manager