GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 1, 2022

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

RE: License #: AS630080974
Investigation #: 2022A0993021
Beacham CLF

Dear Ms. Ostrom:

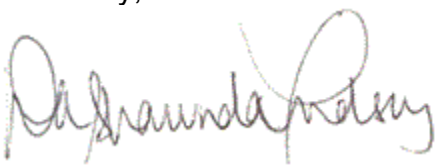
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630080974
Investigation #:	2022A0993021
Complaint Receipt Date:	09/08/2022
Investigation Initiation Date:	09/12/2022
Report Due Date:	11/07/2022
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:	Beacham CLF
Facility Address:	3278 Beacham Waterford, MI 48329
Facility Telephone #:	(248) 335-3280
Original Issuance Date:	08/04/1998
License Status:	REGULAR
Effective Date:	03/05/2021
Expiration Date:	03/04/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
While doing a medication check during shift change, staff realized Resident A had not received all his medications at bedtime.	Yes
The facility is short staffed. The residents are neglected and do not receive adequate care.	No

III. METHODOLOGY

09/08/2022	Special Investigation Intake 2022A0993021
09/08/2022	Referral - Recipient Rights Received allegations from recipient rights advocate Dawn Krull
09/12/2022	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation
09/12/2022	Contact - Telephone call made Telephone call made to recipient rights advocate Dawn Krull. Left a message.
09/12/2022	Contact - Document Received Received an email from recipient rights advocate Dawn Krull
09/12/2022	APS Referral Forwarded allegations to adult protective services (APS).
09/15/2022	Contact - Telephone call made Telephone call made to staff Ayanna Crumb
09/15/2022	Contact - Document Received Received additional allegations
09/19/2022	Inspection Completed On-site Conducted an unannounced onsite investigation
09/19/2022	Contact - Telephone call made Telephone call made to staff Carrie Chambers
09/19/2022	Contact - Telephone call made Telephone call made to staff Amanda Makaroff. Left a message.

09/19/2022	Contact - Telephone call made Telephone call made to the reporting source
09/22/2022	Contact - Telephone call made Telephone call made to staff Amanda Makaroff. Left a message.
10/27/2022	Exit Conference Attempted to conduct exit conference with licensee designee Renee Ostrom. Left a message.
10/31/2022	Contact - Telephone call made Telephone call made to area Supervisor LaShonda Lindsey
11/01/2022	Contact - Document Received Received a copy of the staff schedule
11/01/2022	Exit Conference Held with licensee designee Renee Ostrom

ALLEGATION:

While doing a medication check during shift change staff realized Resident A had not received all his medications at bedtime.

INVESTIGATION:

On 09/08/2022, I received allegations from recipient rights advocate Dawn Krull.

On 09/12/2022, I conducted an unannounced onsite investigation. I interviewed staff Elaine Reyes, staff Lakina McAdory, and home manager Rachel Griffin. I observed Resident A but was unable to interview him due to his limited cognitive abilities

Ms. Reyes stated she has worked in the facility for two years. She works third shift from 8pm to 10am. Ms. Reyes did not have knowledge of Resident A not receiving all his medications. Ms. Reyes stated she completed medication administration training. Staff administer medications as prescribed.

Ms. McAdory stated she has worked in the facility since 08/29/2022. She did not have knowledge of Resident A not receiving all his medications. She has not completed medication administration training. She does not administer medications. To her knowledge, all staff who administer medications have been trained to do so. In addition, staff administer medications as prescribed.

Ms. Griffin confirmed staff Ayana Crumb did not administer all his medications. Per Ms. Griffin, Ms. Crumb has had a couple of medication administration errors. On 08/15/2022, Ms. Crumb only administered Lorazepam to Resident A at “HS” and failed

to give him his other medications. Ms. Griffin did not know Ms. Crumb's reasoning for not administering the rest of Resident A's medications. Ms. Griffin stated "HS" stands for "hours of sleep" or "bedtime". Ms. Crumb was terminated on 09/09/2022.

While at the facility, I reviewed Resident A's medications and medication administration record (MAR) for September 2022. I observed the following:

- I observed a pill (Lorazepam) still in the bubble pack, but staff initialed the MAR at 4pm on 09/06/2022 to show administration of that medication.
- There was no time listed for the evening/night medications. Instead, "HS" was listed.

I also reviewed three incident reports. I learned the following:

- On 08/30/2022, while doing medication check for shift change, staff realized Resident A's "HS" medications had not been administered to him. Resident A's primary care physician, guardian and provider were notified of the error. The missed medications were Lacosamide 200mg, Melatonin 5mg, Risperidone 2mg, Topiramate 100mg, and NAC 600mg.
- On 08/30/2022, staff Ayanna Crumb stated area supervisor LaShonda Lindsey administered Resident A's medications, but Ms. Lindsey denied doing so.
- On 09/07/2022, while doing the morning medication check, it was observed that a pill (Lorazepam) was put back in the bubble pack and taped. It was put back in on a day (09/06/2022) that had already been passed at 4pm.

I verified staff Ayanna Crumb, staff Elaine Reyes, staff Amanda Makaroff, and home manager Rachel Griffin completed medication administration training Macomb Oakland Regional Center (MORC). I observed their training certificates.

On 09/12/2022, I received documentation. I observed a disciplinary report for Ms. Crumb. Per the report, Ms. Crumb failed to administer Resident A's medications at "HS" on 08/30/2022. The corrective action involved Ms. Crumb being supervised while passing medications for 10 consecutive days.

On 09/15/2022, I conducted a telephone interview with staff Ayanna Crumb. Ms. Crumb verified she used to work at the facility. She stated one day (she could not recall the date) she administered Resident A's narcotics to him. She did not administer his other medications because she thought area supervisor LaShonda Lindsey administered them to him. Ms. Crumb verified she completed medication administration training. She stated she administered medications as prescribed.

On 09/19/2022, I conducted an unannounced onsite investigation. I interviewed area supervisor LaShonda Lindsey and staff Tanya Dixon.

Ms. Lindsey verified Ms. Crumb was terminated due to multiple medication errors. Per Ms. Lindsey, Ms. Crumb completed medication administration training. Ms. Lindsey stated there was an incident where one of Resident A's Lorazepam pills "reappeared" in the bubble pack. On another occasion, (Ms. Lindsey could not recall the date of the

error), Ms. Crumb passed Resident A's narcotics but did not pass his other medications. Ms. Crumb was wrote up. In addition, Ms. Crumb was told someone had to supervise her while passing medications for 10 days. Ms. Crumb passed medications without someone supervising her. She was going to be terminated as a result; however, Ms. Crumb quit.

Ms. Lindsey confirmed Resident A is administered medications at "HS". According to Ms. Crumb "HS" means "hours of sleep". She stated medications administered during this time may be administered at anytime in the evening.

Ms. Dixon did not have knowledge of the allegations. She stated she completed medication administration training. To her knowledge, all staff administer medications as prescribed.

On 09/19/2022, I conducted a telephone interview with staff Carrie Chambers. Ms. Chambers did not have knowledge of the allegations. She stated she completed medication administration training. To her knowledge, all staff administer medications as prescribed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 08/30/2022, while doing medication check for shift change, staff realized Resident A's "HS" medications had not been administered to him. Resident A's primary care physician, guardian and provider were notified of the error. The missed medications were Lacosamide 200mg, Melatonin 5mg, Risperidone 2mg, Topiramate 100mg, and NAC 600mg. On 09/07/2022, while doing the morning medication check, it was observed that a pill (Lorazepam) was put back in the bubble pack and taped. It was put back in on a day (09/06/2022) that had already been passed at 4pm.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(iv) Time to be administered.**
ANALYSIS:	On 09/12/2022, I reviewed Resident A's MAR. There was no time listed for the evening/night medications. Instead, "HS" was listed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is short staffed. The residents are neglected and do not receive adequate care.

INVESTIGATION:

On 09/15/2022, I received the allegations from Bureau of Child and Adult Licensing (BCAL) Online Complaints.

On 09/19/2022, I conducted an unannounced onsite investigation. I interviewed area supervisor LaShonda Lindsey, staff LaKina McAdory, and staff Tanya Dixon. I also interviewed Resident B and Resident C.

Ms. Lindsey acknowledged the facility is short staffed; however, there is always enough staff in the facility with the residents. Sometimes staff from other facilities are asked to work in the facility to ensure there is enough staff coverage. Per Ms. Lindsey, there never has been a time when the residents were left in the facility without staff. Ms. Lindsey stated the residents are not neglected. The residents are properly cared for.

Ms. McAdory stated she has worked in the facility for about one month. She works 10am to 3pm on Monday and Wednesdays and 10am to 8pm on Saturdays and Sundays. Ms. McAdory denied the allegations. She stated there is always enough staff in the facility to care for the residents. The residents are not neglected. The residents are properly cared for.

Ms. Dixon stated she has worked in the facility since July 2022. She works mainly 3pm to 8pm, but she, sometimes, works 3pm to 10pm. Ms. Dixon denied the allegations. She

stated there is always enough staff in the facility to care for the residents. The residents are not neglected. The residents are properly cared for.

Resident B stated he has lived in the facility for approximately eight years. He described the staff as “pretty good”. Staff take good care of the residents. He does not require assistance with personal care needs (e.g., bathing/showering, eating, dressing, etc.). He stated three of the other residents require assistance and staff assist them as needed. Resident B stated there is always enough staff to care for the residents.

Resident C also described the staff as “good”. He stated staff assist him with bathing/showering, brushing his teeth, and dressing. He stated there is always enough staff to care for the residents.

During the unannounced onsite investigation, Resident B and Resident C did not appear neglected. They were adequately groomed and dressed.

On 09/19/2022, I conducted a telephone interview with staff Carrie Chambers. Ms. Chambers stated she has worked in the facility for a couple of years. She works all shifts, but she mainly works the afternoon shift. Ms. Chambers denied the allegations. She stated there is always enough staff in the facility to care for the residents. The residents are not neglected. The residents are properly cared for.

On 09/22/2022, I conducted a telephone interview with the reporting source. The reporting source stated there are only three permanent staff in the facility. Staff from other facilities are pulled to work in this facility to ensure there is enough staff coverage. He stated there is always enough staff with the residents. He stated he felt the residents are neglected and not properly cared for. In addition, he stated there was a medication administration error. When asked to provide more details about the neglect and improper care of the residents, the reporting source did not provide more details.

On 11/01/2022, I reviewed the staff schedule from 09/18/2022 until 10/01/2022. I observed the following:

- Staff Elaine Reyes was scheduled to work on 09/18/2022 from 8pm to 9am. However, she called off. The schedule was not updated to show who worked the shift.
- No staff was scheduled to work on 09/23/2022 from 10am to 2pm, on 09/26/2022 from 9am to 10am, or on 09/27/2022 from 8am to 9am.
- Ms. Reyes was scheduled to work on 10/01/2022 from 8pm to 10am. The schedule showed there was staff coverage that day from midnight to 10am. However, the schedule was not updated to show who worked from 8pm to midnight.

On 11/01/2022, I conducted an exit conference with licensee designee Renee Ostrom. I informed her of the findings. Per Ms. Ostrom, Ms. Lindsey covered all open shifts to ensure there was enough staff coverage. She acknowledged the schedule was not

updated to show there was always enough staff coverage. She agreed to submit a corrective action plan.

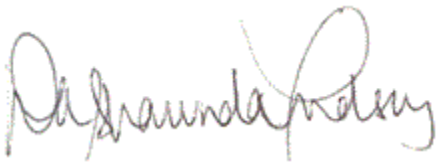
APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Ms. Lindsey, Ms. McAdory, Ms. Dixon, Ms. Chambers as well as Resident B and Resident C stated there are always enough staff in the facility with the residents. The reporting source stated there are only three permanent staff in the facility. Staff from other facilities are pulled to work in this facility to ensure there is enough staff coverage. There is always enough staff with the residents. Despite the schedule not being updated to show scheduling changes, Ms. Ostrom stated Ms. Lindsey covered all open shifts to ensure there was enough staff coverage.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(e) Any scheduling changes.**
ANALYSIS:	I reviewed the staff schedule from 09/18/2022 to 10/01/2022. During this period, there were some periods where staff called off and/or there was no staff scheduled to work. The schedule was not updated to show scheduling changes. Per Ms. Ostrom, Ms. Lindsey covered all open shifts to ensure there was enough staff coverage.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Ms. Lindsey, Ms. McAdory, Ms. Dixon, and Ms. Chambers denied the allegations. The residents are not neglected. The residents are properly cared for. Resident B and Resident C stated staff are good and assist the residents with their needs. During an unannounced onsite investigation on 09/19/2022, Resident B and Resident C did not appear neglected. They were adequately groomed and dressed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

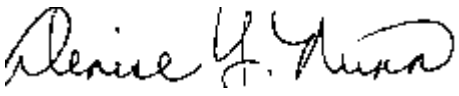
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



11/01/2022

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



11/03/2022

Denise Y. Nunn — Date
Area Manager