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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2023

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

RE: License #: AS630012764
Investigation #: 2023A0612012
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,

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 #:	AS630012764
Investigation #:	2023A0612012
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/23/2023
Report Due Date:	03/21/2023
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?
On 01/18/23, Resident M's forearm was bitten by Resident T.	Yes
On 01/19/23, assistant manager, Mebel Massey left Resident T unsupervised in the van.	Yes

III. METHODOLOGY

01/20/2023	Special Investigation Intake 2023A0612012
01/20/2023	APS Referral Referral was denied by Adult Protective Services (APS)
01/23/2023	Special Investigation Initiated - Letter I made a referral to the Office of Recipient Rights via email
01/23/2023	Referral - Recipient Rights Referral made to Oakland Community Health Network - Office of Recipient Rights via email
01/23/2023	Contact – Document Received Resident T's MORC Crisis Plan dated 01/10/23
01/24/2023	Contact - Telephone call made Telephone interview completed with home manager, LaShonda Lindsey
01/25/2023	Contact - Telephone call made Telephone interview completed with direct care staff, Mebel Massey
01/25/2023	Contact - Document Received I received a photo of Resident M's injury sent via text message
02/02/2023	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed Resident M and Resident T
02/07/2023	Contact – Telephone call made Telephone interview with Resident M's mother
02/07/2023	Exit Conference

	I completed an exit conference via telephone with licensee designee, Renee Ostrom.

ALLEGATION:

On 01/18/23, Resident M's forearm was bitten by Resident T.

INVESTIGATION:

On 01/20/23, I received a complaint that indicated in 2022, Resident M was beat in the back by Resident T. This occurred while they were in a van being transported to their workshop. Resident M's mother spoke with the home provider regarding the concerns. It was reported that Resident M and Resident T should not have both been in the back of the van together. On 01/18/23, Resident M's forearm was bitten by Resident T. Again, this occurred while in the van being transported to their workshop. Resident M was not taken to receive medical care for the bite until after workshop. His medication was not picked up until 01/19/23. Resident M's arm is tender to touch, red, and swollen. There are concerns that this occurred due to lack of supervision by the staff members. I initiated my investigation by making a referral to the Office of Recipient Rights. I coordinated with Recipient Rights Specialist, Sarah Rupkus regarding the allegation. Additionally, a referral was made to Adult Protective Services (APS). APS denied the referral**.** During the initiation of this investigation, it was reported that on 01/19/23, assistant manager, Mebel Massey left Resident T unsupervised in the van. This allegation was added to this report.

On 01/24/23, I interviewed home manager, LaShonda Lindsey via telephone. Ms. Lindsey was informed by assistant manager, Mebel Massey that on 01/18/23, four residents were in the van being transported to workshop. All the residents use wheelchairs, and they were seated in their wheelchairs in the van. Resident J was behind the driver's seat. Resident I was behind the passenger seat. Resident T was behind Resident J on the driver's side. Resident M was behind Resident I on the passenger side. Resident T was cold, he put his head on Resident M's shoulder. Resident M threw his arms up and Resident T bite Resident M. Ms. Massey pulled over, assessed the residents, and separated them for safety. Ms. Massey asked Resident M if he wanted to go to workshop or go to the urgent care and he chose workshop. Resident M was taken to workshop and Resident T was taken to urgent care. Resident T had scratches on his face. Urgent care advised treating it with antibacterial ointment. Ms. Massey picked Resident M up from workshop at 3:00 pm and took him to urgent care for evaluation. Resident M was prescribed an antibiotic to be taken four times, daily for seven days. Resident M's urgent care appointment ended at 4:30 pm. The pharmacy closes at 6:00 pm. The pharmacy said they could not deliver the medication on 01/18/23. The medication would be available for pick up the next morning. When the pharmacy re-opened the next day, Ms. Massey picked up the medication at 9:00 am. Resident T took his first dosage of medication on 01/19/23.

Ms. Lindsey stated there is nothing in Resident M or Resident T's Individual Plan of Service (IPOS) or Crisis Plan that states they cannot sit by one another in the van. She is not aware of an incident that happened in the past which prevents these two residents from sitting next to one another during transport. Ms. Lindsey stated if there was a previous incident between the two residents it may have occurred when the home had a different home manager. That home manager is no longer with the company. Ms. Lindsey stated on 01/18/23, Resident M's mother came to the Timber Hill home. She was irate. She was yelling at staff and yelling at Resident T. Resident T was removed from the situation and 911 was called. Resident M's mother left the home before emergency services arrived.

On 01/25/23, in collaboration with the Recipient Rights Specialist, Sarah Rupkus I interviewed assistant manager, Mebel Massey via telephone. Ms. Massey has been employed at Timber Hill for four months. She works Monday – Friday, 8:00 am – 8:00 pm. Ms. Massey stated on 01/18/23, she drove Resident M and Resident T to workshop. Resident T was sitting on the passenger side next to Resident M. Resident T became clingy towards Resident M. Resident M pushed Resident T away. Then, Resident T bite Resident M's arm. Resident M swung his arm back and forth to get Resident T off him. Resident T sustained a scratch to his face. Resident M had a mark on his left arm. The mark was red however, it was not shaped like a bite mark. Ms. Massey provided a photo of the injury via text message.

Ms. Massey asked Resident M if he would like to go to workshop or be taken to urgent care. Resident M chose to go to workshop. Ms. Massey took Resident M to workshop and dropped him off. Shortly after, she received a call from the workshop stating they observed the red mark on Resident M's left arm. Ms. Massey picked Resident M up from workshop around 2:30 pm and took him to urgent care for evaluation.

Ms. Massey stated she and Resident M did not get home from the urgent care until sometime between 4:00 pm and 4:15 pm. Resident M was prescribed an antibiotic - Cechalexin 500 mg take four times daily. The medication was called into the pharmacy. The pharmacy stated it would not be ready for pick up until the next morning. Ms. Massey stated she picked up the medication the following morning. Resident M received his first dosage on 01/19/23 at noon. Ms. Massey stated she has been instructed by home manager, LaShonda Lindsey that Resident M and Resident T should not sit next to each other in the van because they fight. Ms. Massey remarked, she did not think the two residents were going to fight on that day which is why she chose to sit them together in the van on 01/18/23.

On 01/25/23, I observed a photo of Resident M's left arm. The photo was taken on 01/18/23 while at the urgent care. The front of Resident M's forearm has bruising. The bruise is red. There is no broken skin or teeth marks.

On 02/02/23, I completed an unscheduled onsite investigation. I interviewed Resident M. I observed Resident T laying on the couch in the living room. Resident T was well groomed and appropriately dressed. He was observed watching TV and playing with

action figures. Resident T is nonverbal. He waved hello but was unable to answer questions related to this investigation.

On 02/02/23, I interviewed Resident M. Resident M stated he and Resident T got into a fight in the van on the way to work. Resident T started the fight, he bit his left arm. Resident M said, Resident T bit him and would not let go. He had to defend himself, so he scratched Resident T in the face. Resident M remarked, he did not want to fight with Resident T. Resident M stated he had a mark on his arm. Staff asked him if he wanted to go to the doctor or go to work, he said that he wanted to go to work first. Resident M stated he has gotten into a fight with Resident T once before. He and Resident T are not supposed to sit next to each other in the van because they fight.

On 02/07/23, I interviewed Resident M's mother via telephone. Resident M's mother stated on 01/18/23, Resident M's forearm was bitten by Resident T. This occurred while in the van on the way to workshop. Resident M was yelling "he bit me, he bit me," the staff driving did not pull over. Resident T was taken to urgent care for scratches on his face. However, Resident M went to work and was not taken to urgent care until after workshop. Residents M's mother stated Resident M was assaulted, his arm was swollen and bruised. Resident M's mother went to the timber hill home and the police were called because she refused to leave the home. However, they did not inform the police that she was upset due to the altercation that occurred between the two residents. Resident M's mother stated she is preparing to move Resident M out of the Timber Hill home and into her home. She is preparing for the move to occur around 02/15/23.

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 Resident T and Resident M's personal needs, including protection and safety were not attended to on 01/18/23. Assistant manager, Mebel Massey had been instructed that Resident T and Resident M should not sit next to one another in the van as they have a history of fighting. However, she chose to sit them next to another in the van which resulted in a physical altercation where both residents sustained injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that Resident M's health care needs were not addressed immediately. Resident M sustained a minor injury to his arm. His skin was not broken, there were no open cuts or wounds. Resident M does not have a legal guardian. Ms. Massey and Resident M consistently stated Resident M was offered the opportunity to go to urgent care immediately following the incident however, he chose to attend workshop first and go to urgent care after work. Resident M was taken to urgent care immediately upon leaving workshop. Resident M was prescribed an antibiotic which was picked up from the pharmacy and administered to him as soon as it became available.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 01/19/23, assistant manager, Mebel Massey left Resident T unsupervised in the van.

INVESTIGATION:

On 01/24/23, I interviewed home manager, LaShonda Lindsey via telephone. Ms. Lindsey stated on 01/19/22, Resident J fell at workshop. Direct care staff Ms. Massey took Resident J and Resident T with her to McLaren Hospital so Resident J could be assessed. Ms. Lindsey drove her personal vehicle to the hospital so that she could pick up the company van. She arrived at the hospital at 3:45 pm. Ms. Massey was in the back with Resident J. She asked Ms. Massey where Resident T was, and Ms. Massey said he was in the van. Resident T had been in the van alone since 3:39 pm. Ms. Lindsey went to the van and observed Resident T alone, without supervision. Resident T did not have any issues or sustain any injuries while he was alone in the van. Ms. Lindsey informed the licensee, Renee Ostrom of the incident, completed an incident report, and contacted the Office of Recipient Rights. Ms. Massey was in-serviced on Resident T's crisis plan.

On 01/25/23, in collaboration with the Recipient Rights Specialist, Sarah Rupkus I interviewed assistant manager, Mebel Massey via telephone. Ms. Massey stated on 01/19/23, she worked 8:00 am – 8:00 pm with direct care staff, Melita Jurick. Resident J

fell at workshop and needed to go to the emergency room for evaluation. Ms. Massey picked up Resident J, Resident T, and Resident M from workshop. Ms. Jurick was at the Timber Hill home with two other residents. Ms. Massey took Resident M to the Timber Hill home and dropped him off with Ms. Jurick. Then, she took Resident J and Resident T to McLaren Hospital with her. Ms. Massey took Resident J into the hospital and left Resident T in the van alone, unsupervised. Ms. Massey remarked, “I know I wasn’t supposed to. My head was full.” Ms. Massey estimated Resident T was alone in the van for 15 minutes. There were no issues or injuries as a result of him being left unsupervised. Ms. Massey stated she knows that she should have taken Resident T inside the hospital with her. Ms. Massey stated home manager, LaShonda Lindsey came to the hospital as she needed to retrieve the company van. At which time she informed Ms. Lindsey that Resident T was alone in the van. Ms. Lindsey went to the van and waited with Resident T until she finished the appointment with Resident J.

On 01/23/24, I reviewed Resident T’s MORC Crisis Plan dated 01/10/23. The crisis plan indicated, while in the community Resident T requires direct supervision (within eyesight and close enough proximity for staff to assist) as Resident T lacks safety skills and is unaware of environmental hazards. Caregivers will remain within close enough proximity to assist while in unsecured settings such as parking lots, crossing streets and/or crowded community events.

On 02/02/23, I completed an unscheduled onsite investigation. I observed Resident T laying on the couch in the living room. Resident T is nonverbal. He was unable to answer questions related to this investigation.

On 02/07/23, I held an exit conference with licensee designee, Renee Ostrom via telephone to review my findings. Ms. Ostrom stated Ms. Massey has been a top-notch staff. However, she became rattled when Resident M’s mother came to the house on 01/18/23. Ms. Ostrom acknowledged the rule violations and vocalized understanding that a corrective action plan is required.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to conclude assistant manager, Mebel Massey did not provide Resident T with supervision and protection as outlined in his assessment plan. Per Resident T’s crisis plan he requires direct supervision while in the community as he lacks safety skills and is unaware of environmental hazards. Ms. Massey admitted that on 01/19/23, she left

	Resident T alone in the van, unsupervised although she knew she was not supposed to.
CONCLUSION:	**VIOLATION ESTABLISHED**

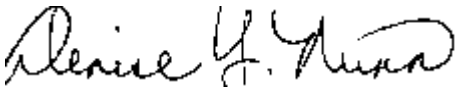
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remains unchanged.

02/07/23

Johnna Cade Date
Licensing Consultant

Approved By:



02/08/2023

Denise Y. Nunn Date
Area Manager