GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 16, 2023

Ronda Freeman-McDonald
Altum Care Homes, LLC
23408 Plum Hollow
Southfield, MI 48033

RE: License #: AS630399707
Investigation #: 2023A0993020
The Strides House

Dear Ms. Freeman-McDonald:

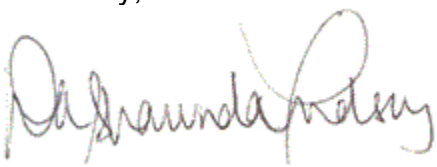
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS630399707
Investigation #:	2023A0993020
Complaint Receipt Date:	03/13/2023
Investigation Initiation Date:	03/13/2023
Report Due Date:	05/12/2023
Licensee Name:	Altum Care Homes, LLC
Licensee Address:	23408 Plum Hollow Southfield, MI 48033
Licensee Telephone #:	(313) 377-3776
Administrator:	Ronda Freeman-McDonald
Licensee Designee:	Ronda Freeman-McDonald
Name of Facility:	The Strides House
Facility Address:	21380 Mada Southfield, MI 48075
Facility Telephone #:	(313) 377-3776
Original Issuance Date:	06/28/2019
License Status:	REGULAR
Effective Date:	12/28/2021
Expiration Date:	12/27/2023
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff abandoned Resident A at the hospital.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/13/2023	Special Investigation Intake 2023A0993020
03/13/2023	Special Investigation Initiated - Telephone Telephone call received from Resident A
03/14/2023	Referral - Recipient Rights Forwarded allegations to recipient rights advocate Darlita Paulding
03/28/2023	Contact - Telephone call made Telephone call made to Providence Hospital social worker Beata J.
03/28/2023	Contact - Telephone call made Telephone call made to TTI case manager Kekendra Thompson Jones. Left a message.
03/29/2023	Contact - Telephone call received Telephone call received from Resident A
03/29/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
04/17/2023	Contact - Telephone call received Telephone call received from Resident A
04/17/2023	Contact - Telephone call made Telephone call made to TTI case manager Kekendra Thompson Jones. Left a message.
04/18/2023	Contact - Telephone call made Telephone call made to licensee designee Ronda Freeman-McDonald
04/18/2023	Contact - Document Received Received email communication regarding discharge notice

04/20/2023	Contact - Telephone call made Telephone call made to staff Unique Austin
04/20/2023	Contact - Telephone call made Telephone call made to staff Jamia Jones. Left a message. Sent a text message.
04/20/2023	Contact - Telephone call made Telephone call made to staff Zita Jones
04/20/2023	Contact - Telephone call made Telephone call made to staff Jamia Jones
04/20/2023	Contact - Telephone call made Telephone call made to TTI case manager Kekendra Thompson Jones. Left a message.
04/20/2023	APS Referral Forwarded allegations to adult protective services (APS). APS denied the intake.
04/20/2023	Contact - Telephone call made Telephone call made to recipient rights advocate Darlita Paulding. Left a message.
04/25/2023	Contact - Telephone call made Telephone call made to TTI case manager Kekendra Thompson Jones. Left a message.
04/25/2023	Contact - Telephone call made Telephone call made to recipient rights advocate Darlita Paulding. Left a message.
04/26/2023	Inspection Completed On-site Conducted an unannounced onsite investigation
05/04/2023	Exit Conference Held with licensee designee Ronda Freeman-McDonald

ALLEGATION:

Staff abandoned Resident A at the hospital.

INVESTIGATION:

On 03/13/2023, I received the allegations from Bureau of Child and Adult Licensing (BCAL) Online Complaints.

On 03/13/2023, I conducted a telephone interview with Resident A. Resident A stated she was transported to the hospital. She is now ready to be discharged; however, staff are refusing to pick her up.

On 03/14/2023, I forwarded the allegations to recipient rights advocate Darlita Pauling.

On 03/28/2023, I conducted a telephone interview with Providence Hospital social worker. Beata J. She verified Resident A is still at the hospital. Resident A was transported to the hospital on 03/08/2023. The facility was contacted on 03/09/2023 and 03/11/2023 to request that Resident A was picked up. Staff refused to pick her up. Resident A was admitted into the psychiatric unit on 03/14/2023. Beata J. transferred me to psychiatric social worker Kristin Davis. Ms. Davis stated the facility was contacted several times. Staff stated they were not planning to pick up Resident A. Resident A was admitted to the psychiatric unit from the emergency room (ER). It is unknown what occurred in the ER to lead to Resident A being in the psychiatric unit. Resident A is ready to be discharge, but her placement is pending. Treatment and Innovations, Inc. (TTI) is currently seeking placement for Resident A.

On 03/29/2023, I spoke with Resident A via telephone. She stated she was still in the hospital.

On 03/29/2023, I conducted an unannounced onsite investigation. I interviewed staff Osheka Ramsey. Ms. Ramsey verified Resident A was no longer living in the facility. Ms. Ramsey did not know how long Resident A had been out of the facility. She also did not know if Resident A was issued a discharge notice.

On 04/17/2023, I spoke with Resident A via telephone. Resident A stated she was discharged from the hospital during the first week of April. She is currently living in a room and board. She confirmed she was not issued a discharge notice. In addition, she confirmed staff refused to pick her up from the hospital when she was ready to be discharged.

On 04/18/2023, I conducted a telephone interview with licensee designee Ronda Freeman-McDonald. Ms. Freeman-McDonald acknowledged Resident A was transported to the hospital from the facility. She acknowledged when she was ready to be discharged staff did not pick her up. Per Ms. Freeman-McDonald, TTI was not forthcoming about Resident A's behaviors. In addition, Resident A was able to hold it together long enough to be admitted into a facility. Eventually, Resident A began displaying behavioral concerns. Ms. Freeman-McDonald stated she issued a discharge notice to TTI for Resident A.

On 04/18/2023, I received email communication between Ms. Freeman-McDonald and TTI. The email communication included the following:

- Ms. Freeman-McDonald emailed TTI on 03/07/2023 to request an "immediate alternate placement; [Resident A] poses as a threat to safety for herself and those in close proximity to her".
- Ms. Freeman-McDonald emailed TTI on 03/09/2023 to indicate Resident A was at Providence Hospital, and she could not accept Resident A back into the facility.
- Ms. Freeman-McDonald emailed TTI on 03/13/2023 to follow up on the request to immediately discharge Resident A. She attached a copy of the written discharge notice issued on 03/07/2023.

On 04/20/2023, I conducted a telephone interview with staff Unique Austin. Ms. Austin confirmed Resident A was no longer living in the facility. She stated Resident A was issued a discharge notice. Ms. Austin did not know when the notice was issued. She also did not know when Resident was discharged from facility.

On 04/202/2023, I conducted a telephone interview with staff Zita Jones. Ms. Jones stated Ms. Ronda Freeman-McDonald tried to evict Resident A without giving her a discharge notice. Per Ms. Jones one day the police were called to the facility. Ms. Freeman-McDonald told her to make sure the police took Resident because Resident A could not stay there. Police told Ms. Jones it was a process and that they could not just take Resident A. When Ms. Jones relayed the message to Ms. Freeman-McDonald, Ms. Freeman-McDonald said "oh no. She has to go". Ms. Jones confirmed Resident A is no longer in the facility. She did not recall when Resident A was discharged. She did not know if Resident A was given a written discharge notice.

On 04/20/2023, I conducted a telephone interview with staff Jamia Jones. Ms. Jones denied knowledge of the allegations.

On 04/20/2023, I forwarded the allegations to adult protective services (APS). APS denied the intake.

On 04/26/2023, I conducted an unannounced onsite investigation. I spoke with Ms. Austin. Ms. Austin stated Resident A was admitted into the facility on 02/14/2023. She was discharged from the facility on 03/08/2023, the day she was transported to the hospital.

On 05/04/2023, I conducted an exit conference with licensee designee Ronda McDonald. I informed her of the findings. Ms. Freeman-McDonald stated a written discharge notice was issued to TTI prior to Resident A going to the hospital. Ms. Freeman-McDonald acknowledged she was supposed to pick up Resident A from the hospital as she had not been officially discharged from the facility. She agreed to submit a corrective action plan.

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:	Resident A was transported to the hospital on 05/08/2023. The hospital contacted the facility several times to request that Resident A was picked up. Staff refused to pick up Resident A. Resident A was eventually discharged from the hospital in the first week of April and placed in a room and board. Although a written discharge notice was issued to TTI, Ms. Freeman-McDonald acknowledged she was supposed to pick up Resident A from the hospital as she had not been officially discharged from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the license has determined and documented that any of the following exists:

	(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home. **(b) Substantial risk, or an occurrence, or self-destructive behavior.**
ANALYSIS:	Ms. Freeman-McDonald emailed TTI on 03/07/2023 to request an "immediate alternate placement; [Resident A] poses as a threat to safety for herself and those in close proximity to her". Ms. Freeman-McDonald emailed TTI on 03/13/2023 to follow up on the request to immediately discharge Resident A. She attached a copy of the written discharge notice issued on 03/07/2023.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

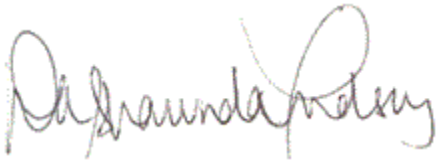
On 04/26/2023, I conducted an unannounced onsite investigation. As I was exiting the facility, I observed that the front door was not equipped with non-locking-against-egress hardware.

On 05/04/2023, I conducted an exit conference with licensee designee Ronda McDonald. I informed her of the findings. Ms. Freeman-McDonald stated a written discharge notice was issue to TTI prior to Resident A going to the hospital. Ms. Freeman-McDonald acknowledged she was supposed to pick Resident A up from the hospital as she had not been officially discharged from the facility. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	During an unannounced investigation on 04/26/2023, I observed the front door was not equipped with non-locking-against-egress hardware.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

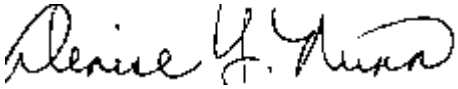
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



05/09/2023

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



05/16/2023

Denise Y. Nunn Date
Area Manager