GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2023

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

RE: License #: AS250304220
Investigation #: 2023A0576036
Weston Road

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.
- Be signed and dated.

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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250304220
Investigation #:	2023A0576036
Complaint Receipt Date:	04/18/2023
Investigation Initiation Date:	04/21/2023
Report Due Date:	06/17/2023
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:	Weston Road
Facility Address:	4181 Weston Drive, Burton, MI 48509
Facility Telephone #:	(810) 736-2011
Original Issuance Date:	08/26/2009
License Status:	REGULAR
Effective Date:	05/21/2022
Expiration Date:	05/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 4/17/2023, staff, Tishara Richards left the home for personal reasons leaving only one staff, Shatangelia Smith in the home. Ms. Smith was cooking and had to assist Resident A in the restroom leaving Resident B wandering around. Concerns regarding adequate supervision of the residents with only one staff on duty.	Yes
Staff do not keep Resident A's walker near him when he is sitting down so he will not get up.	No
There is no furniture in the home due to bed bugs.	No

III. METHODOLOGY

04/18/2023	Special Investigation Intake 2023A0576036
04/21/2023	Special Investigation Initiated - Telephone Interviewed Candy Hamilton, Weston Road, Program Manager
04/21/2023	Contact - Document Received Reviewed Orkin receipts
05/12/2023	Inspection Completed On-site Interviewed Staff, Shatangelia Smith, Tishara Richards, Home Manager, Quante Johnson, Resident A, and viewed Resident B
06/12/2023	APS Referral
06/12/2023	Contact - Telephone call made Interviewed Guardian B
06/12/2023	Contact - Telephone call made Interviewed Lisa Suvoski, Genesee Health System Case Manager
06/12/2023	Contact - Telephone call made Left message for Guardian A to return call
06/12/2023	Contact - Telephone call made Interviewed Kelly Banks, Hope Network Case Manager
06/12/2023	Exit Conference

	Exit Conference conducted with Licensee Designee, Jennifer Bhaskaran

ALLEGATION:

On 4/17/2023, staff, Tishara Richards left the home for personal reasons leaving only one staff, Shatangelia Smith in the home. Ms. Smith was cooking and had to assist Resident A in the restroom leaving Resident B wandering around. Concerns regarding adequate supervision of the residents with only one staff on duty.

INVESTIGATION:

On May 12, 2023, I conducted an unannounced on-site inspection at the home and interviewed Staff, Shatangelia Smith who reported she has worked at the facility since February 2023. Regarding the allegation, Ms. Smith reported there is always at least 2 staff scheduled to work and there are currently 6 residents who live at the home. Ms. Smith and Staff, Tishara Richards was on duty on April 17, 2023, and Ms. Richards left work as she had to take her dad to work. Ms. Richards was gone for about a half hour while she took her dad to work. During this time, Ms. Smith was getting dinner ready and had to assist Resident A in the bathroom. Ms. Smith was in the bathroom with Resident A for approximately 5 minutes and there were no issues or problems with the other residents during this time. Resident B has never messed with the stove and Ms. Smith believes Resident B knows not to mess with the stove. Resident B would not walk out of the home either. Resident B does not have 1 on 1 supervision however Ms. Smith thinks he may require line of sight supervision. According to Ms. Smith, there is never just 1 staff person scheduled and she believes the facility requires 2 staff on duty to ensure the safety of all the residents given their respective needs.

On May 12, 2023, I interviewed Staff, Tishara Richards regarding the allegation. Ms. Richards reported she volunteered to work second shift due to another staff person not coming in to work. Ms. Richards left for about a half hour to run an errand. She let her manager and staff know she was leaving. According to Ms. Richards, there is currently 6 residents who reside at the home and there are always 2 staff on duty. Resident A requires staff assistance with toileting as he wears a brief and he cannot change his brief on his own. According to Ms. Richards, Resident B requires line of sight supervision, and she believes this to be in his plan of service (IPOS). Resident B has ADHD and often walks around the home. Ms. Richards does not think Resident B would walk out of the home or mess with the stove. According to Ms. Richards, the remaining 4 residents are higher functioning and do not require much staff supervision.

On May 12, 2023, I interviewed Home Manager, Quante Johnson regarding the allegation. Mr. Johnson stated Staff, Tishara Richards left work to take her dad to work. She did not tell anyone beforehand and was reprimanded as she was not supposed to leave duty. According to Mr. Johnson, the residents can be adequately and safely

managed with one staff on duty however most of the time it is 2 staff on duty. There are 6 residents at the home, and none require 1 on 1 or line of sight staffing. Resident B will not mess with the stove as “he doesn’t have the comprehension to do” nor would he leave the home. If anything, Resident B would go to the refrigerator to eat if left unsupervised for any extended period. Mr. Johnson does not think Resident B would do anything unsafe however he would just want food. Regarding Resident A, he is a fall risk and staff have to keep an eye on him.

On May 12, 2023, I interviewed Resident A who was sitting in the living room in a rocking chair. Resident A’s speech was somewhat difficult to understand. Resident A said he was doing alright, and he has lived at his home since he was a little boy. Resident A was neat and clean in appearance. Resident A denied any concerns regarding staff.

On May 12, 2023, I viewed Resident B at his home. Resident B is nonverbal, so he was unable to be interviewed. Resident B appeared well and was neat and clean in appearance.

On May 12, 2023, I reviewed Resident A’s IPOS, which revealed Resident A is 71 years old. Resident A is diagnosed with Parkinson’s Disease and experiences delusions and psychosis at times. Resident A has tremors, difficulty walking, and is at risk for falls. Resident A always requires a walker and will refuse to use it at times. Staff are to assist Resident A if needed when going from a sitting to a standing position.

On May 12, 2023, I reviewed Resident B’s IPOS, which revealed Resident B is 66 years old. Resident B has very limited vocabulary and cannot adequately express himself or his needs/desires. Resident B displays verbal and physician aggression at times. Staff will assist Resident B in completing Activities of Daily Living (ADL’s).

On June 12, 2023, I interviewed Resident B’s guardian, Guardian B who reported Resident B has lived at his home for several years and there has never been any issues with the home and their supervision of Resident B. Resident B is nonverbal and does not require any specialized or enhanced staffing. Resident B has never displayed any acts of elopement per Guardian B. Guardian B denied any concerns with Weston Road Home.

On June 12, 2023, I interviewed Resident A’s Case Manager, Lisa Suvoski from Genesee Health System. Ms. Suvoski reported when she goes to the home there is always 2 staff on duty and the home manager is often there also. Ms. Suvoski reported she is familiar with Resident B, and she believes he should have 1 on 1 staffing given the behaviors he presents. Resident B is very low functioning and “is a handful”. On one occasion, Resident B hit Ms. Suvoski without any forewarning. Ms. Suvoski reported she would have concerns regarding resident safety if there was only one staff on duty given the needs of the residents, especially those of Resident A and Resident B. Ms. Suvoski confirmed there would be a safety issue for residents if there were one staff member on duty.

On June 12, 2023, I interviewed Resident B's Case Manager from Hope Network, Kelly Banks. Ms. Banks reported the home always has 2 staff on duty to care for the residents. If one staff were on duty, that would be concerning given the needs of the residents, specifically Resident B. Resident B is nonverbal, and his cognitive development is that of a toddler. Resident B has Pica and puts things in his mouth, which presents a choking hazard. Resident B requires staff to cut his food into small pieces and requires staff supervision while eating as he eats very fast. Ms. Banks stated if Resident B were left unsupervised it would be analogous to leaving a 3-year-old unattended.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	It was alleged that only one staff was on duty, leaving Resident B to wander around the home when the staff was attending to Resident A. Concerns that one staff is not sufficient to properly care for and supervise all the residents of the home. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. Staff, Shatangelia Smith and Tishara Richards confirm Ms. Richards left duty on April 17, 2023, for a brief period leaving Ms. Smith to care for the residents of the home. Ms. Smith was assisting Resident A in the bathroom leaving Resident B unsupervised. According to Resident B's Case Manager, Kelly Banks, she would be concerned with Resident B being left unsupervised due to his limited cognitive abilities. Resident B is nonverbal and could unintentionally to things to put himself in harm's way such as eating things he should not or eat hastily. Staff, Ms. Smith, and Ms. Richards stated that they believe Resident B requires enhanced staffing due to the supervision he requires however this is not noted in his plan of service. Resident A's Case Manager, Lisa Suvoski reported she believes Resident B could use enhanced staffing due to his needs. According to Ms. Suvoski, Resident A is unpredictable and has

	low cognitive function. Ms. Suvoski reported there would be a safety issue if there were one staff on duty. There is a preponderance of evidence to conclude that on April 17, 2023, there was one staff on duty, which is not sufficient for the supervision, personal care, and protection of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff do not keep Resident A's walker near him when he is sitting down so he will not get up.

INVESTIGATION:

On May 12, 2023, I conducted an unannounced on-site inspection at the home and interviewed Staff, Shatangelia Smith who denied the allegation. Ms. Smith reported Resident A has dementia and is mobile, verbal, and his comprehension is good. There are days Resident A walks good and other days he uses a walker to assist with his mobility. Resident A's walker is kept by him, and staff are not trying to keep Resident A sitting down.

On May 12, 2023, I interviewed Staff, Tishara Richards who denied the allegation. Ms. Richard explained that staff keep Resident A's walker near him so he can use it when he wants. Resident A's walker is within arm's reach, and he can get his walker himself. Staff are not trying to keep Resident A in his chair. Resident A will sometimes try to get up on his own without his walker and this is concerning as Resident A is a fall risk.

On May 12, 2023, I interviewed Home Manager, Quante Johnson who reported Resident A has Parkinson's Disease and is a fall risk. Resident A will try to get up on his own and his legs are week. Resident A can walk using his walker however his legs will shake. Resident A's walker is normally beside him and within arm's length. Resident A will sometimes try to get up on his own without the walker and staff must keep an eye on him. Staff do not try to keep Resident A's walker from him to keep him sitting down. Staff are doing all they can to keep Resident A safe as he is very independent and has fallen with his walker in the past.

On May 12, 2023, I interviewed Resident A who was sitting in the living room in a rocking chair. Resident A's speech was somewhat difficult to understand. Resident A said he was doing alright, and he has lived at his home since he was a little boy. Resident A's walker was by his chair and was within Resident A's reach. Resident A confirmed his walker is always near him when he needs it. Resident A was neat and clean in appearance.

On June 12, 2023, I interviewed Resident A's Case Manager, Lisa Suvoski from Genesee Health System. Ms. Suvoski reported Resident A is a fall risk and will attempt to get up without his walker. Staff are not trying to keep Resident A sitting down and are trying to keep him safe. Resident A will start physical therapy soon and Ms. Suvoski has no concerns regarding staff. Staff are attentive to the residents of the home and treat them very well.

On June 12, 2023, I left message for Resident A's guardian, Guardian A to return call.

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: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purposes of immobilizing a resident.**
ANALYSIS:	It was alleged that staff are attempting to immobilize Resident A by not keeping his walker near him, so he does not get up. Upon conclusion of investigative interviews, there is not a preponderance of evidence to conclude a rule violation. Staff, Shatangelia Smith and Tishara Richards, and Home Manager, Quante Johnson deny staff are trying to immobilize Resident A. They explain Resident A is a fall risk and his walker is kept by him. According to Resident A's IPOS, Resident A will refuse to utilize his walker and is at risk of falls. Resident A's Case Manager, Lisa Suvoski reported she has never seen staff try to keep Resident A sitting down and the staff are trying to keep Resident A safe. Resident A was interviewed, and confirmed his walker is always available to him for use. There is not a preponderance of evidence to conclude staff are attempting to restrain Resident A's movement by keeping his walker from him to keep him sitting down.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is no furniture in the home due to bed bugs.

INVESTIGATION:

On April 21, 2023, I interviewed Administrator, Candy Hamilton who reported the facility is being treated for bed bugs. Only living room furniture was discarded due to having bed bugs and the furniture has since been replaced.

On April 21, 2023, I reviewed receipts from Orkin that detailed services provided to Weston Home. On February 10, 2023, the home was provided an initial “bed bug pest protection” as well as a bed bug monthly service completed in March 2023.

On May 12, 2023, I conducted an unannounced on-site inspection at the home and interviewed Staff, Shatangelia Smith who reported the living room furniture had bed bugs, so the couch and sofa were discarded. The residents had other chairs to sit in if they were in the living room including chairs from the dining room table. New furniture was purchased about 3 weeks ago and is in the home. Only the living room furniture had bugs and the home was treated for the bugs by Orkin. Orkin was out today to re-check for any bed bug activity and there was none.

On May 12, 2023, I interviewed Staff, Tishara Richards who reported the allegation is false and the residents had furniture to use. All resident bedrooms had their furniture including beds and chairs and the living room had chairs for residents to sit in. 2 couches from the living room were discarded as they had bed bugs and there were no bugs in any bedrooms only in the living room. The living room has since received new furniture about 2 months ago and Orkin has been out to service the home for the bugs.

On May 12, 2023, I interviewed Home Manager, Quante Johnson who reported that in February the living room furniture was discarded due to bed bugs. The residents still had their furniture and there were no bed bugs found in any resident bedrooms. While waiting for new living room furniture to arrive, the residents were able to sit on dining room chairs if they wanted to sit in the living room area of the home. Most of the residents have their own televisions in their respective bedrooms so it was not much of an issue to wait for the new living room furniture to arrive.

On May 12, 2023, I viewed the living room and dining room, which is a large open area, to have adequate furniture for the residents. The home had new living room furniture that included a couch, sofa, and rocking chair. The dining room table had adequate seating for the residents of the home and resident bedrooms were adequately furnished.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	It was alleged that the home had no furniture due to bed bugs. Upon completion of investigative interviews and an unannounced on-site inspection to the home, there is not a preponderance of evidence to conclude a rule violation. Staff confirm the facility had bed bugs and receipts were provided to confirm the facility is being treated for the pests. The bed bugs were only in the living room, so the living room furniture was discarded. The home has since obtained new living room furniture. Resident bedrooms did not have any bed bug activity and had adequate furnishings.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On June 12, 2023, I conducted an Exit Conference with Licensee Designee, Jennifer Bhaskaran. I advised Ms. Bhaskaran I would be requesting a corrective action plan for the cited rule violation.

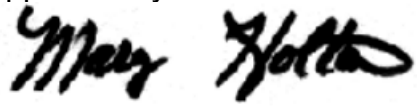
IV. RECOMMENDATION

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

6/13/2023

Christina Garza Date
Licensing Consultant

Approved By:



6/13/2023

Mary E. Holton Date
Area Manager