GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 17, 2023

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

RE: License #:	AS250077486
Investigation #:	2023A0123048
	Stanley Road

Dear Jennifer Bhaskaran:

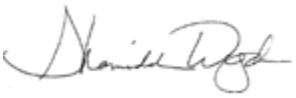
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate 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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250077486
Investigation #:	2023A0123048
Complaint Receipt Date:	06/08/2023
Investigation Initiation Date:	06/08/2023
Report Due Date:	08/07/2023
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:	Stanley Road
Facility Address:	2162 Stanley Road Mt Morris, MI 48458
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	10/22/1997
License Status:	REGULAR
Effective Date:	06/27/2022
Expiration Date:	06/26/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff Valerie Walton arrived at the home at 5:30 am on 6/6/23 and found that Resident A had spent the night on the floor because staff Earline Jackson did not call for help to get Resident A up.	Yes

III. METHODOLOGY

06/08/2023	Special Investigation Intake 2023A0123048
06/08/2023	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Pat Shephard via phone.
06/15/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
06/21/2023	Contact - Telephone call made I interviewed staff Earline Jackson via phone.
06/21/2023	Contact - Telephone call made I spoke with Guardian 1 via phone.
06/21/2023	APS Referral APS referral completed.
07/14/2023	Exit Conference I spoke with licensee designee Jennifer Bhaskaran via phone.

ALLEGATION: Staff Valerie Walton arrived at the home at 5:30 am on 6/6/23 and found that Resident A had spent the night on the floor because staff Earline Jackson did not call for help to get Resident A up.

INVESTIGATION: On 06/08/2023, I spoke with recipient rights investigator Pat Shepard via phone. She stated that on 06/06/2023 at about 5:30 am, home manager Valerie Walton arrived at the home, and reported hearing Resident A yelling from inside the home. There was one staff on duty for third shift, that could not get Resident A in the bed, and Resident A spent the night on the floor. At shift change between second and third shift on 06/05/2023, staff did not get Resident A up from the floor, as second shift did not inform third shift. The second shift staff reported that Resident A was not on the floor at the end of the second shift. Ms. Shephard stated that the staff notes indicate otherwise, as the notes are suspicious. Ms. Shephard stated that notes about Resident A getting in bed unassisted appeared as though they were added later. Resident A has physical limitations, can talk, and tell

stories, but the stories can be incomplete. She stated that Resident A has a contracture of the left knee and has difficulty walking.

On 06/15/2023, I conducted an unannounced on-site visit at the facility. I conducted the following interviewed with staff and residents:

Resident A was interviewed. It was difficult to understand everything Resident A verbalized. Resident A did state that one day there was a staff person who could not pick Resident A up because Resident A was too heavy. Resident A could not remember the staff person's name. Resident A was on the floor all night long. Resident A reported not knowing how Resident A got on the floor, but the staff who works in the office found Resident A on the floor. Resident A denied getting up from the floor, stating that staff could not help. Resident A stated reported having two pillows and two blankets while on the floor.

During this on-site, I spoke with staff Lisa Hairston who showed me some dark bruising on Resident A's arms that may have been the result of being on the floor. Staff Hairston stated that it was said that Resident A fell on second shift, and the third shift staff found Resident A on the floor. The second shift staff person, Dena Descamps, did not relay anything about Resident A to the third shift staff person.

Staff Dena Descamps was interviewed. Staff Descamps reported working second shift on 06/05/2023. Staff Descamps stated that during the shift, Resident A was in the bathroom and had a behavior. Resident A sat on the floor instead of the wheelchair. Resident A then used the handrails to get back into the wheelchair. Staff Descamps reported taking Resident A back to the bedroom, and Resident A got into bed. Staff Descamps stated that Resident A is capable of getting out of the bed independently. Staff Descamps stated that while assisting another resident, Resident A yelled out for assistance, and this occurred between 8:00 pm and 8:30 pm. When Staff Descamps got to Resident A's room, Resident A was on the floor. Staff Descamps reported getting Resident A back into bed, but it took a while due to Resident A's weight. When third shift arrived, Resident A was on the floor. Staff Descamps stated that Resident A can get in and out of bed independently. Resident A can also transfer from the toilet without assistance. Staff Descamps stated that she would not leave a resident on the floor or hurt someone. Staff Descamps reported doing bed checks multiple times between getting Resident A back in bed and when third shift arrived while walking back and forth down the hallway completing end of shift tasks. Staff Descamps stated that during this time, Resident A was not on the floor, and was in bed. Staff Descamps stated that Resident A being on the floor had to have happened between the time third shift came in, and Staff Descamps leaving at the end of the shift. Staff Descamps stated that the third shift staff, Earline Jackson, told Staff Descamps that Resident A was on the floor at the start of Staff Jackson's shift.

I interviewed home manager Valerie Walton at the facility. Staff Walton stated that when arriving at the facility around 5:20 am (on 06/06/2023), Staff Walton could hear

Resident A hollering. Staff Earline Jackson was trying to help Resident A up. Once Staff Walton stepped in to assist, Resident A calmed down and let both staff assist Resident A into the wheelchair. Staff Jackson reported trying to catch Staff Descamps before Staff Descamps left to help get Resident A up from the floor. Staff Walton stated that Resident A would not allow staff to assist. Staff Walton stated understanding Resident A having a behavior, but questions if Resident A was on the floor all night, why staff did not call Staff Walton about it. Staff Walton stated that Resident B saw Staff Descamps refuse to assist Resident A get up from the floor. Staff Jackson also did not call anyone for assistance because Resident A just wanted to lay on the floor. Resident A reported laying on the floor because of being upset that staff would not help. Staff Walton stated that Resident A is not attention seeking. Staff Walton stated that just an abrasion was observed on Resident A's left arm and knee after the incident. Staff Walton stated that Resident A just moved into the home recently and has been doing well.

During this on-site, I received copies of requested documentation from staff Valeria Walton. An Alternative Service, Inc. *Unusual Incident Report* dated 06/06/2023 was completed by Staff Walton. It states the following:

"*Upon arrival to 1st shift consumer on floor yelling & screaming staff help me get her off floor. Check her over she was fine L (left) knee had a red mark*." The staff involved are listed as staff Dena Descamps, staff Earline Jackson, and Staff Walton.

A copy of Resident A's Genesee Health System *IPOS (Individual Plan of Service) Review* was obtained. It is dated 03/02/2023. On page two of the plan, it notes that Resident A received a 24-hour emergency discharge notice from a previous placement. The previous placement "*was struggling prior to the notice with her not cooperating with care, and not helping with transfers, as well as other disruptive behavior*." Resident A's IPOS does note on page five that "*the majority of her resistance does appear to be about transferring*." On page eight, it sates that Resident A is able to transfer to/from the wheelchair independently, and also has a walker that can be use sometimes. On page 10, it states that Resident A "*can get up from a seat height surface on her own but often requires physical assistance when she does not cooperate*." Resident A's Assessment Plan for AFC Residents dated 03/30/2023, states that Resident A does not walk, and is a transfer only.

I interviewed Resident B. Resident B stated that Resident A was in the bathroom first. While Resident A was in the room with Staff Descamps, they were trying to get Resident A into bed. Staff let go of Resident A, and Resident A fell. Resident A then had to stay on the floor all night long. Resident B stated that staff Earline Jackson had not arrived at the home yet when Resident A fell. Resident B reported remembering Staff Descamps being on shift when Resident A fell. Resident A was upset that Staff Descamps would not help Resident A off the floor. Resident B stated that this was cruel. She stated that Staff Descamps told Resident A "*I can't help you. I've got a bad back.*" Resident B repeatedly indicated that Staff Descamps actions were cruel. Resident B stated that Resident A was on the floor all night, and

Resident B heard Resident A screaming. Resident B stated that Resident A was still on the floor when Resident B woke up the next morning. Resident B stated that Resident A was yelling "*help!*" Resident B reported thinking that Staff Jackson tried to help Resident A up from the floor, and this is the first time Resident A has been treated this way. Resident B reported not thinking that Staff Descamps treats them good, and that Staff Descamps ignores them. Resident B stated that sometimes Staff Descamps will tell Resident A that Staff Descamps will leave Resident A while Resident A is struggling to get into bed. Resident B stated that Resident A is also told by Staff Descamps "*you'll just have to wait a minute*" when Resident A is in a rush to go to the bathroom. Resident B stated that it is just Staff Descamps that treats them bad.

On 06/21/2023, I interviewed staff Earline Jackson via phone. Staff Jackson stated that when arriving to work on 06/05/2023, Resident A was on the floor. Staff Jackson reported assisting Resident A onto the bed, but Resident A scooted back down to the floor with a pillow and told Staff Jackson that Staff Jackson was "too small" to get Resident A off the floor. Staff Jackson reported getting Resident A in the bed, and all Staff Jackson needed to do was roll Resident A over into the bed more. Staff Jackson stated that Resident A told Staff Jackson that Resident A would just sleep on the floor. Staff Jackson reported telling Resident A that Staff Jackson couldn't just let Resident A lay on the naked floor, so Staff Jackson put Resident A's comforter on the floor for Resident A. Staff Jackson stated that Resident A chose to stay on the floor, and that Staff Descamps did not report anything to Staff Jackson about Resident A at shift change. Staff Jackson stated that Resident A stayed on the floor until Staff Walton arrived at the home the following morning. When I asked Staff Jackson if she recalled if Resident A was screaming at that time, Staff Jackson stated that she couldn't remember. Staff Jackson stated that Resident A screams a lot, all of the time, and was screaming last night. Staff Jackson reported going to Resident A's room to check on, talk to, and redirect the behavior. Staff Jackson stated that Resident A will get out of bed independently. Staff Jackson stated that Resident A got out of bed last night, (got into the wheelchair) and rolled to the bathroom. Resident A will request assistance from staff. Staff Jackson stated that Resident B reported that Staff Descamps left Resident A on the floor. Staff Jackson stated that Resident A didn't appear to be upset about anything on 06/05/2023. Staff Jackson reported not calling for assistance with Resident A because sometimes they don't come, and because Resident A chose to stay on the floor. Staff Jackson stated that Resident A used to not stand up for staff at all when Resident A first moved into the home.

On 06/21/2023, I spoke with Resident A's public guardian, Guardian 1 via phone. Guardian 1 denied having any knowledge of the allegations. Guardian 1 stated that Resident A has improved significantly since living in the current home. Guardian 1 reported having had no concerns and received no complaints from Resident A. Guardian 1 reported being informed that in previous placements, Resident A would accuse staff of not helping Resident A, and Resident A would have dramatic behaviors when upset with someone. Guardian 1 reported hearing of Resident A

throwing herself to the floor and accusing staff of dropping Resident A, but there's been no issues to Guardian 1's knowledge recently of Resident A having behaviors. Guardian 1 stated that Resident A will refuse to allow staff to help Resident A get up, because Resident A does not think she can bear weight.

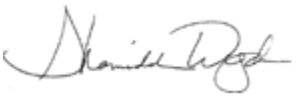
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A reported staying on the floor all night long because staff were unable to get Resident A up. Staff Dena Descamps denied leaving Resident A on the floor. Staff Valeria Walton reported hearing Resident A screaming on 06/06/2023 at about 5:20 am, upon arrival to the facility, and found that Resident A had been on the floor all night. Staff Walton stated that Resident B observed Staff Descamps refuse to get Resident A up from the floor. Staff Walton also reported that Resident A had an abrasion on the left arm and knee after the incident. An incident report written by Staff Walton indicates Resident A had a red mark on the left knee. Resident B was interviewed and reported that Staff Descamps let go of Resident A, Resident A fell before Staff Earline Jackson arrived for third shift, and Resident A stayed on the floor all night. Resident B stated that Staff Descamps refused to help Resident A off the floor. Resident B also reported that Resident A was screaming while on the floor. Staff Earline Jackson was interviewed and stated that Resident A refused assistance getting back in bed. Staff Jackson also reported not calling for another staff to report to the home to assist with Resident A. Guardian 1 denied having any knowledge of the incident. Guardian 1 stated that Resident A will refuse assistance with getting up because Resident A does not think she can bear weight. There is a preponderance of evidence to substantiate a rule

	violation in regard to staff not appropriately handling Resident A's behavior which resulted in her lying on the floor all night on the night/morning of 06/05/2023 through 06/06/2023 and having a documented red mark on her knee.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/14/2023, I conducted an exit conference with licensee designee Jennifer Bhaskaran via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home license (capacity 1-6).



07/14/2023

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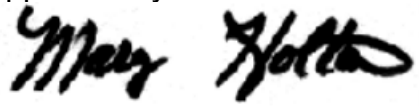
Shamidah Wyden Date
Licensing Consultant

Approved By:



07/17/2023

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Mary E. Holton Date
Area Manager