GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN
ACTING DIRECTOR

August 3, 2023

Renee Ostrom
Residential Alternatives Inc
124B N Saginaw Street
Holly, MI 48442

RE: License #: AS630012774
Investigation #: 2023A0602021
Appomattox AIS/MR

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012774
Investigation #:	2023A0602021
Complaint Receipt Date:	04/11/2023
Investigation Initiation Date:	04/12/2023
Report Due Date:	06/10/2023
Licensee Name:	Residential Alternatives Inc
Licensee Address:	124B N Saginaw Street Holly, MI 48442
Licensee Telephone #:	(248) 369-8936
Administrator:	Renee Ostrom
Licensee Designee:	Renee Ostrom
Name of Facility:	Appomattox AIS/MR
Facility Address:	10372 Appomattox Holly, MI 48442
Facility Telephone #:	(248) 634-5949
Original Issuance Date:	10/21/1992
License Status:	REGULAR
Effective Date:	12/13/2021
Expiration Date:	12/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 4/08/2023 Resident A's midnight medication was administered at 8 pm.	Yes

III. METHODOLOGY

04/11/2023	Special Investigation Intake 2023A0602021
04/12/2023	Special Investigation Initiated - Telephone Call made to the home. Spoke with staff member Tamara Harrison.
05/02/2023	Contact – Telephone call made Call made to staff member, Tonya Dixon – unable to leave a message.
06/15/2023	Contact – Telephone call made Spoke with the licensee designee, Renee Ostrom.
06/16/2023	Contact – Document received Received documents from Ms. Ostrom.
06/16/2023	Contact – Telephone call made Call made to staff member, Tonya Dixon – unable to leave a message.
06/29/2023	Exit Conference Held with the licensee designee in person.

ALLEGATION:

Per incident report, on 4/08/2023 Resident A's midnight medication was administered at 8 pm.

INVESTIGATION:

On 4/11/2023, a complaint was received and assigned for investigation alleging that on 4/08/2023, Resident A’s midnight medication was administered at 8 pm.

On 4/12/2023, I spoke with staff member/assistant home manager Tamara Harrison by telephone. Ms. Harrison stated on 4/08/2023 she worked the midnight shift between the hours of 10 pm and 10 am. Resident A is prescribed Sucralfate 1 gm tablet to be taken four times daily (7 am, 4 pm, 8 pm and 12 am). Ms. Harrison stated when she attempted to administer Resident A his 12 am medication, the tablet was missing from the pack. She immediately called staff member Tonya Dixon as she worked the previous shift between the hours of 10 am and 10 pm. Ms. Dixon informed Ms. Harrison that she administered Resident A's 12 am Sucralfate 1 gm at 8 pm. Ms. Harrison contacted Resident A's primary care physician at Clarkson Family Medicine and informed them of the medication error and was instructed to administer the next dose at the regularly scheduled time and continue to monitor Resident A for any changes in behavior.

On 6/15/2023, I spoke with the licensee designee, Renee Ostrom by telephone and requested copies of Resident A's medication administration record (MAR) and staff schedule for the month of April 2023. I also requested a copy of Resident A's health care appraisal and individual plan of service (IPOS).

On 6/16/2023, I received and reviewed the requested documents from Ms. Ostrom. According to the staff schedule dated 4/01/2023 – 4/15/2023, on 4/08/2023 Ms. Dixon was scheduled to work between the hours of 10 am and 10 pm and Ms. Harrison was scheduled to work between the hours of 10 pm and 10 am. The MAR indicated that Resident A is in fact prescribed Sucralfate 1 gm tablet to be taken four times daily (7 am, 4 pm, 8 pm and 12 am). On 4/08/2023 there were no staff initials documented on the MAR for the 12 am dosage as the medication was missing from the container. Ms. Dixon's initials were documented on 4/08/2023 for the 8 pm dosage. According to the IPOS, Resident A has a diagnosis of autism spectrum disorder, dysphagia, and bilateral blindness with ocular prosthesis in both eyes.

On 6/29/2023, I conducted an exit conference with the license designee, Renee Ostrom in person while on-site at another facility. I informed Ms. Ostrom of the investigative findings and recommendation documented in this report. Ms. Ostrom stated Ms. Dixon was disciplined and in-serviced on medication administration but later decided to separate from the company. Ms. Dixon no longer works for Residential Alternatives Inc.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on the information obtained from Ms. Harrison and Ms. Ostrom, there is sufficient information to determine that on 4/08/2023 Ms. Dixon administered Resident A his 12 am dose of Sucralfate 1 gm at 8 pm instead of 12 am as prescribed. According to Ms. Ostrom, Ms. Dixon was disciplined and was in-serviced on medication administration but no longer works in the home as she chose to separate from the company.
CONCLUSION:	**VIOLATION ESTABLISHED**

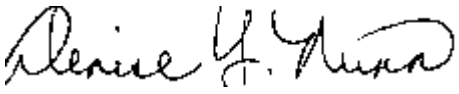
IV. RECOMMENDATION

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

7/03/2023

Cindy Berry — Date
Licensing Consultant

Approved By:



08/03/2023

Denise Y. Nunn — Date
Area Manager