GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 30, 2023

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

RE: License #: AS250010669
Investigation #: 2023A0580052
Marshall Group Home

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.
- 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.

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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010669
Investigation #:	2023A0580052
Complaint Receipt Date:	07/12/2023
Investigation Initiation Date:	07/14/2023
Report Due Date:	09/10/2023
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Amber Harris
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Marshall Group Home
Facility Address:	1531 Cedarwood Flushing, MI 48433
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	10/07/1981
License Status:	REGULAR
Effective Date:	06/11/2023
Expiration Date:	06/10/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was found with bruises today during her occupational therapy assessment. Resident A has dementia and does not remember how the bruises were obtained.	Yes

III. METHODOLOGY

07/12/2023	Special Investigation Intake 2023A0580052
07/12/2023	APS Referral This referral was denied by APS for investigation.
07/14/2023	Special Investigation Initiated - Telephone Call made to the complainant.
07/25/2023	Inspection Completed On-site An onsite inspection was conducted. Interview with staff, Latwone Hardy.
07/25/2023	Contact - Face to Face Face to face with Resident A.
07/26/2023	Contact - Telephone call made Spoke with Chris Ann Haven, assigned GHS case manager for Resident A.
07/26/2023	Contact - Telephone call made Call to Tracey McLaurin, Home Manager.
07/28/2023	Contact - Document Received Documents requested were received.
08/22/2023	Contact - Telephone call made

	Call to Lead staff, Jessica Washington.
08/22/2023	Contact - Telephone call made spoke with staff, Kairisca Nolen.
08/22/2023	Contact - Telephone call made Call to staff, Dariesha Bobo.
08/23/2023	Contact - Telephone call made Call to staff, Latwone Hardy.
08/25/2023	Contact - Telephone call received Call from staff, Latwone Hardy.
08/25/2023	Contact - Telephone call received Call from staff, Dariesha Bobo.
08/25/2023	Exit Conference Call to Amber Harris, license administrator.
08/29/2023	Exit Conference Call to Jennifer Bhaskaran, licensee designee.

ALLEGATION:

Resident A was found with bruises today during her occupational therapy assessment. Resident A has dementia and does not remember the bruises were obtained.

INVESTIGATION:

On 07/12/2023, I received a complaint via BCAL Online Complaints. This complaint was denied by APS for investigation.

On 07/14/2023, I spoke with Aylssa Anton, Physical Therapist at Genesee Health Systems (GHS). She stated that during her visit with Resident A, conducted on 07/14/2023, she observed bruising under Resident A's left eye. To her knowledge, Resident A was taken to urgent care and to the hospital for imaging, mainly because no

one knows what happened. Staff working the day prior, 07/11/2023, stated that they did not observe any bruising. She has had no prior concerns regarding Resident A's care.

On 07/25/2023, I conducted an onsite inspection at Marshall. Contact was made with direct staff, Jamilah Washington, and Latwone Hardy, who both stated that they do not know how the bruising occurred to Resident A. Everyone noticed the bruises the next day.

On 07/25/2023, while onsite, I spoke with Resident A. She stated that she fell off the toilet. I was able to observe Resident A's left eye, which presented as being in the healing stages of a black eye. Purple bruising was noted. Resident A was adequately dressed, while sitting in the living room amongst her peers and staff. Other residents in the home were observed outside on the porch.

On 07/26/2023, I placed a call to the home manager, Tracey McLaurin. She stated that 1st shift staff, Monique Mims called her around 3pm on 07/12/2023, informing her that Resident A had bruises. It was unknown how the bruises occurred. She instructed staff to transport her to the Urgent Care. 2nd shift staff, Dariesha Bobo took Resident A to urgent care. Resident A was referred to McLaren Hospital, and transported by 3rd shift staff, Kairisca Nolen for a CAT Scan, which yielded no concussion or internal bleeding. Resident A expressed that she fell in the bathroom. Resident A requires toileting assistance and can walk on her own with the assistance of a walker. Staff Monique Sims and Latwone Hardy were both written up due to not reporting the injury in a timely manner. The incident report, assessment plan and medical discharge papers for Resident A were requested.

On 07/26/2023, I spoke with Chris Ann Haven, assigned GHS case manager for Resident A. She stated that Resident A stated to her that she hurt herself on the doorframe, to others she has stated that hurt herself on the wall. It is possible that she bumped into the wall. She uses a walker and is unsteady on her feet. She adds that Resident A could have also fallen while on the toilet as she stated. If so, she would have needed assistance to get up. No one has any idea how the bruising occurred. Resident A does not purposely harm herself. Chris Ann Haven stated that she has no concerns with the current staff, or the care being provided in the home.

On 07/28/2023, I received a copy of the assessment plan for Resident A. It indicates that Resident A may need some assistance walking and will use a wheelchair in the community/long distances. The plan also indicates that Resident A is verbal and able to communicate her needs. Resident A also requires assistance with toileting. Staff are to assist with all her toileting needs.

The incident report dated 07/12/2023 indicates that 1st shift staffed contacted the home manager at 3pm, indicating that Resident A needed to go to the hospital due to a black eye and a knot in her head. 2nd shift staff was given directive to take Resident A to urgent care for medical attention. No one knew what happened. 2nd shift staff transported Resident A to urgent care and hospital ER. Full CAT Scan of head given.

No signs of bleeding internally. Resident A was given an ice pack for her left-eye and Tylenol for pain.

The McLaren Flint Emergency Department Discharge Instructions, dated 07/12/023, indicate that the reason for the visit is a fall. Resident A received a head and spine scan while at the hospital. No internal bleeding was found. Her final diagnosis is a facial contusion and a head injury.

On 08/22/2023, I placed a call to staff, Jessica Washington. She shared that she was scheduled to work 6am-6pm, however, she departed at 2am that day. Staff Kairisca Nolen was the remaining staff working that evening. She stated that Resident A is usually attached to her hip, so to speak, when she's working. She did not observe Resident A fall or injure herself while working. She shared that Resident A uses her walker to get to the restroom, however, she requires assistance with pulling her brief up and down.

On 08/22/2023, I spoke with staff, Kairisca Nolen. She stated that she worked 3rd shift the day before Resident A's bruise being observed. She stated that she toileted Resident A throughout the night at 2:am, 4am and again between 5-5:15am and no bruising was observed. She did not observe Resident A injure herself in any manner during her shift. She departed that morning around 9 or 10am. Resident A had not gotten up for the day. She did not know about the bruising until she received a call from her manager around 3pm. She adds that she returned to work later that day to take Resident A to McLaren Hospital.

On 08/22/2023, I placed a call to staff, Dariesha Bobo. A message was left requesting a return call.

On 08/23/2023, I placed a call to staff, Monique Sims. She stated that on the day in question, she worked 1st shift, 6am-2pm. She recalled staff, Karisca Nolen was still there while she was on duty. She was not assigned to work with Resident A, so she did not notice the bruising until Resident A got up and began moving about for the day. As soon as she noticed, she attempted to contact the 3rd shift staff Jessica Washington and Kairisca Nolen, however both claimed they did not observe any bruising or knew how it occurred. She then spoke with home manager, Tracey McLaurin, who instructed that Resident A be transported to urgent care. She did not transport Resident A for medical care during her shift.

On 08/23/2023, I placed a call to staff, Latwone Hardy. A message was left requesting a return call.

On 08/25/2023, I spoke with Latwone Hardy. She recalled on the day in question, she was the staff assigned to work with Resident A. She recalled that Resident A did not get up that day until closer to noon, near lunchtime. She stated that she observed the bruise when she awoke, however, she does not know how it occurred. She did not report the bruise to management.

On 08/25/2023, I spoke with Staff Dariesha Bobo, who stated that when she arrived to work 2nd shift on the day in question, 1st shift staff showed her Resident A's bruising and stated that she needed to go to urgent care. She does not know how the bruising occurred.

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:	It was alleged that Resident A was found with bruises, has dementia, and does not remember how she got the bruises. Aylssa Anton, Physical Therapist at Genesee Health Systems (GHS). She stated that she observed bruising under Resident A's left eye. Staff working the day prior, 07/11/2023, stated that they did not observe any bruising. No one knows what happened. Resident A stated that she fell off the toilet. Home manager, Tracey McLaurin stated that 1st shift staff, Monique Mims called her around 3pm on 07/12/2023, informing her that Resident A had bruises. It was unknown how the bruises occurred. She instructed staff to transport her to the Urgent Care. Resident A expressed that she fell in the bathroom. Chris Ann Haven, assigned GHS case manager for Resident A. She stated that Resident A stated to her that she hurt herself on the doorframe. It is possible that she bumped into the wall. She uses a walker and is unsteady on her feet. She adds that Resident A could have also fallen while on the toilet as she stated. If so, she would have needed assistance to get up. No one has any idea how the bruising occurred. Resident A does not purposely harm herself.

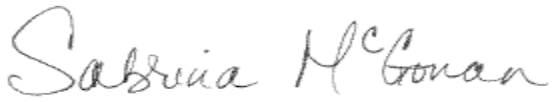
	The assessment plan for Resident A indicates that Resident A may need some assistance walking and will use a wheelchair in the community/long distances. The plan also indicates that Resident A is verbal and able to communicate her needs. Resident A also requires assistance with toileting. Staff are to assist with all her toileting needs. Staff, Kairisca Nolen stated that she toilet Resident A throughout the night at 2:am, 4am and again between 5-5:15am and no bruising was observed. She did not observe Resident A injure herself in any manner during her shift. She did not know about the bruising until she received a call from her manager around 3pm. Staff, Monique Sims stated that on the day in question, she was not assigned to work with Resident A, so she did not notice the bruising until Resident A got up and began moving about for the day. As soon as she noticed, she attempted to contact the 3rd shift staff Jessica Washington and Kairisca Nolen, however both claimed they didn't see any bruising or knew how it occurred. She then spoke with home manager, Tracey McLaurin, who instructed that Resident A be transported to urgent care. Staff, Latwone Hardy stated that she was the staff assigned to work with Resident A. Resident A got up that day until closer to noon, near lunchtime. She stated that she observed the bruise when she awoke, however, she does not know how it occurred. She did not report the bruise to management. Staff Derisha Bobo stated that when she arrived to work 2nd shift on the day in question, 1st shift staff showed her Resident A's bruising and stated that she needed to go to urgent care. She does not know how the bruising occurred. Based on the interviews conducted with Aylssa Anton, Home manager, Tracey McLaurin, Chris Ann Haven, assigned GHS case manager for Resident, staff, Jessica Washington, Monique Simms, Latwone Hardy, Karisca Nolen, Dariesha Bobo, and a review of assessment plan for Resident A, the incident report dated 07/12/2023, and the McLaren Hospital discharge summary, Resident A received bruises, and no one knows how they occurred. There is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/25/2023, I contacted the license administrator, Amber Harris, requesting an exit conference. A message was left requesting a return call.

On 08/29/2023, On 08/25/2023, I contacted the licensee designee, Jennifer Bhaskaran, requesting an exit conference. A message was left requesting a return call.

IV. RECOMMENDATION

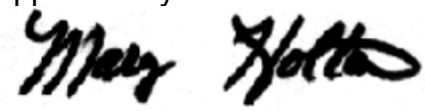
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



August 30, 2023

Sabrina McGowan — Date
Licensing Consultant

Approved By:



August 30, 2023

Mary E. Holton — Date
Area Manager