



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 18, 2023

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

RE: License #: AS250350169
Investigation #: 2024A0576004
Macintosh House

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.
- 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,

A handwritten signature in cursive script, appearing to read "C. Garza".

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 #:	AS250350169
Investigation #:	2024A0576004
Complaint Receipt Date:	10/24/2023
Investigation Initiation Date:	10/27/2023
Report Due Date:	12/23/2023
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:	Macintosh House
Facility Address:	3186 Mac Avenue, Flint, MI 48506-2124
Facility Telephone #:	(810) 228-3950
Original Issuance Date:	12/23/2013
License Status:	REGULAR
Effective Date:	06/22/2022
Expiration Date:	06/21/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALL ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
A resident's wheelchair was dirty from the previous night's dinner despite an IPOS (Individual Plan of Service) requirement for daily wiping. The same resident's IPOS requires food acceptance documentation, and it was only completed 3 times for the entire month of October.	Yes

III. METHODOLOGY

10/24/2023	Special Investigation Intake 2024A0576004
10/24/2023	APS Referral
10/27/2023	Special Investigation Initiated - Telephone Left message for Complainant to return call
11/16/2023	Inspection Completed On-site Interviewed Home Manager, Dakarai Tidwell and viewed Resident A
12/12/2023	Contact - Telephone call made Left message for Guardian A to return call
12/12/2023	Contact – Telephone call made Left message for Teevia Brown, Resident A's Case manager to return call.
12/12/2023	Contact - Telephone call made Interviewed Patricia Shepard, Genesee County Office of Recipient Rights (ORR)
12/15/2023	Contact - Telephone call made Left message for Guardian A to return call
12/15/2023	Contact - Telephone call made Interviewed Teevia Brown, Resident A's Case Manager
12/18/2023	Exit Conference

ALLEGATION:

A resident's wheelchair was dirty from the previous night's dinner despite an IPOS requirement for daily wiping. The same resident's IPOS requires food acceptance documentation, and it was only completed 3 times for the entire month of October.

INVESTIGATION:

On October 27, 2023, and October 31, 2023, I left a message with the Complainant to return call.

On November 16, 2023, I completed an unannounced on-site inspection at Macintosh House and interviewed Home Manager Dakarai Tidwell regarding Resident A and the allegations. Resident A is nonverbal and requires a wheelchair to ambulate. Regarding the allegations, Resident A's Case Manager, Teevia Brown came to the home to visit with him, and Resident A had just eaten a snack. Resident A likes to play with his food and Resident A will put his hand in his mouth causing him to regurgitate. Resident A had food on his face and some on his wheelchair. Staff immediately cleaned Resident A and his chair. According to Manager Tidwell, Resident A is cleaned after he eats as is his chair.

Regarding documentation requirements, Manager Tidwell reported Resident A's individual plan of service (IPOS) requires staff to document every time Resident A eats. This document has not been completed as required due to some newer staff not completing the required documentation.

On November 16, 2023, I viewed Resident A at his home. Resident A was unable to be interviewed as he is nonverbal. Resident A appeared clean and did not appear to be under any duress. Resident A's clothing was clean, and his wheelchair was clean.

On November 16, 2023, I viewed Resident A's IPOS, which revealed Resident A is 31 years old and nonverbal. Resident A has a history of seizures and is at risk of dehydration due to regurgitation. Staff are to document Resident A's food intake daily and clean his wheel daily/weekly.

On November 16, 2023, I viewed Resident A's *Food Acceptance Record* for October 2023. The record was not completed in its entirety and there was missing documentation for Resident A's food acceptance for several meals during the month. There was no documentation as to Resident A's food acceptance for all meals (breakfast, lunch, and dinner) on October 26, 2023, October 28, 2023, October 29, 2023, and October 31, 2023

On December 12, 2023, and December 15, 2023, I left messages for Resident A's guardian, Guardian A to return call.

On December 12, 2023, I interviewed Patrica Sheppard, Genesee County Office of Recipient Rights Officer who reported she is also investigating the matter involving Resident A. According to Officer Sheppard, Resident A regurgitates and requires staff to clean his wheelchair daily, which is a requirement per his individual plan of service (IPOS). Resident A's case manager went to the home on October 19, 2023, and Resident A was eating and had not finished. The case manager informed staff that Resident A's wheelchair needed to be cleaned and they cleaned it immediately. The case manager went to the home four days later on October 23, 2023, and Resident A and his chair was clean.

On December 12, 2023, I left a message for Case Manager, Teevia Brown to return call. On December 15, 2023, I interviewed Case Manager Brown who reported she went to visit with Resident A and the home manager picked up Resident A to move him to his bed. Case Manager Brown viewed Resident A's wheelchair to be soiled as there was pieces of food in the chair. Resident A puts his hands in his mouth when he is eating and, per his IPOS, his chair is to be cleaned daily. Case Manager Brown advised she has a concern about staff not completing required documentation regarding Resident A.

APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	<p>It was alleged that Resident A's wheelchair was not cleaned, and his food acceptance documentation was not completed, both requirements specified in this plan of service. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation.</p> <p>Resident A regurgitates his food often causing him and his wheelchair to become dirty. Resident A has a requirement of daily and weekly wheelchair cleaning by staff per his IPOS. Resident A was viewed at his home and he and his wheelchair appeared clean. Resident A's Case Manager, Teevia Brown reported seeing the wheelchair dirty on a visit to the home. Home Manager Dakarai Tidwell advised Resident A had just eaten a snack and his chair had not yet been cleaned. Resident A also requires for staff to document all his food consumption. I viewed Resident A's <i>Food Acceptance Record</i> for October 2023, and noted times where this documentation was not completed.</p>

	There is a preponderance of evidence to conclude Resident A was not provided the supervision and care as outlined in his written assessment plan.
CONCLUSION:	VIOLATION ESTABLISHED

On December 18, 2023, I conducted an Exit Conference with Licensee Designee, Jennifer Bhaskaran. I advised Licensee Designee 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 to the license status is recommended.




12/18/2023

Christina Garza
Licensing Consultant

Date

Approved By:



12/18/2023

Mary E. Holton
Area Manager

Date