GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 4, 2024

Kayonna Ferguson
Alternative Community Living, Inc.
P. O. Box 190179
Burton, MI 48519

RE: License #: AS250274209
Investigation #: 2024A0779017
Westwood

Dear Kayonna Ferguson:

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 (517) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250274209
Investigation #:	2024A0779017
Complaint Receipt Date:	01/22/2024
Investigation Initiation Date:	01/23/2024
Report Due Date:	03/22/2024
Licensee Name:	Alternative Community Living, Inc.
Licensee Address:	P. O. Box 190179 Burton, MI 48519
Licensee Telephone #:	(989) 482-7039
Administrator:	Paul Smyth
Licensee Designee:	Kayonna Ferguson
Name of Facility:	Westwood
Facility Address:	2820 Westwood Flint, MI 48503
Facility Telephone #:	(810) 424-9030
Original Issuance Date:	05/09/2005
License **Status:**	REGULAR
Effective Date:	11/06/2023
Expiration Date:	11/05/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Debbie Haas forcefully pushed Resident A's head back while she was taking her medication.	Yes

III. METHODOLOGY

01/22/2024	Special Investigation Intake 2024A0779017
01/23/2024	Special Investigation Initiated - Telephone Spoke to ORR.
01/23/2024	APS Referral Complaint was sent to APS centralized intake.
01/29/2024	Inspection Completed On-site
02/02/2024	Contact - Telephone call made Interview conducted with staff person, Debbie Haas.
02/28/2024	Contact – Document received. Received report summary from ORR.
03/04/2024	Exit Conference Held with administrator, Paul Smyth.

ALLEGATION:

Staff Debbie Haas forcefully pushed Resident A's head back while she was taking her medication.

INVESTIGATION:

On 1/23/24, a phone conversation took place with recipient rights investigator, Pat Shepard, who confirmed that she was investigating the same allegations. Pat Shepard stated that she had interviewed Resident A, who claims that staff person, Debbie Haas, pushed her head back while giving her medication and that it hurt her neck. Pat Shepard reported that she had already spoken to Staff Haas, who said that she was having a rough morning and may have been too rough while passing Resident A her medications. Pat Shepard stated that Staff Haas claimed that Resident A had pills on her lips so she had her hands under Resident A’s chin and over her mouth to prevent

the pills from falling onto the floor. Pat Shepard stated that she had spoken to 3 different residents of this home and that one resident said nothing happened, Resident B and Resident C said they saw Resident A's head go backwards and that Resident B felt that Staff Haas was to rough when giving Resident A medications.

On 1/29/24, an on-site inspection was conducted and Resident A was interviewed. Resident A stated that Staff Haas used a medication cup to put pills into her mouth and then put her hand on her mouth and pushed her head back. Resident A claimed that it hurt her neck. Resident A stated that she does not require any physical help to take her medication. Resident A admitted that she has on-going back issues and that her neck and back hurt daily. Resident A stated that the incident did not cause any lasting pain or injury and that it was a one-time thing. Resident A admitted that she does not like Staff Haas and wished that she would stop working there.

On 1/29/24, administrator, Paul Smyth, stated that Resident A has made several complaints against Staff Haas, has made it clear that she does not like Staff Haas and has wanted to get Staff Haas fired for some time now. Admin Smyth stated that Resident A will says things like that and then be quite nice and hug Staff Haas. Admin Smyth reported that Resident A's behavior toward Staff Haas goes back and forth quite often. Admin Smyth stated that Staff Haas has worked at this home for 12 years and that he is not aware of any issues regarding Staff Haas ever abusing or neglecting any resident. Admin Smyth stated that Resident A has a rod in her back and has daily pain, but that Resident A did not complain of pain the day of the alleged incident or any lasting injury as a result of the incident. Admin Smyth stated that Resident A can physically take her own medications. Admin Smyth reported that Staff Haas was the only staff working at that time and that Resident B and Resident C were reported to have witnessed the incident, but that Resident C no longer lives at this home. Admin Smyth stated that Resident B and Resident A appear to be close, but that Resident B has schizophrenia, can be delusional, and is not always the most credible source. Admin Smyth stated that none of Resident A, Resident B, or Resident C reported this alleged incident to him.

On 1/29/24, Resident B was interviewed and stated that she remembers that medication passing and seeing Resident A's head go backwards but could not provide any further details. Resident A stated that she likes Resident B very much and will stand up for Resident A about anything. Resident B reported that Staff Haas is normally very nice and that she likes her. The interview with Resident B was somewhat difficult, as Resident B keep changing the topic of conversation and did not appear to be making much sense.

On 2/2/24, a phone interview was conducted with staff person, Debbie Haas, who stated that she has been thinking about that particular medication passing a lot. Staff Haas stated that Resident A has a habit of not wanting to open her mouth enough during medication passing and the pills fall out onto the floor. Staff Haas reported that when she attempted to put the pills into Resident A's mouth, the pills stayed on Resident A's lips, so she put her hands under Resident A's chin to prevent the pills from

falling out. Staff Haas admitted that she may have used her hand to lift Resident A's chin up and head back a little, but that she was not intentionally rough and that Resident A did not say anything about it hurting her neck. Staff Haas reported that Resident A did not say anything during the medication passing but did come back a few minutes later and said that she was going to report her for choking her and hurting her neck. Staff Haas stated that Resident A threatens to make a complaint against her almost daily. Staff Haas stated that Resident A has told her that she reminds her of her grandmother, who she did not have a good relationship with. Staff Haas stated that she knows Resident B was present during the medication passing, but she is not sure if any other resident was present. Staff Haas claimed that she would never intentionally hurt a resident.

On 2/28/24, a summary report was received from recipient rights investigator, Pat Shepard. In the report, Pat Shepard, indicates that she found enough evidence during her investigation to substantiate that Staff Haas used unreasonable force while administering medication to Resident A.

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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Resident A stated that Staff Haas put pills into her mouth and then put her hand on her mouth and pushed her head back, which hurt her neck. Resident A stated that she does not require any physical help to take her medication. Staff person, Debbie Haas, admits that she put her hand under Resident A's chin and may have lifted Resident A's chin up and head back to prevent the pills from falling off Resident A's lips and onto the floor. During the interview with this licensing consultant, Resident B reported seeing Resident A's head go backwards during the medication passing but could not provide any further details. During the interview with recipient rights investigator,

	Pat Shepard, Resident B said that she thought Staff Haas was being rough while giving Resident A her medications. Staff Haas was well aware of Resident A's history of having back surgery and having daily back pain and should have known that pushing Resident A's head backwards would result in pain. There was sufficient evidence found to prove that Staff Haas used inappropriate force while administering medication to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/4/24, an exit conference was held with administrator, Paul Smyth. Paul Smyth was informed of the outcome of the investigation and that a corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

3/4/2024

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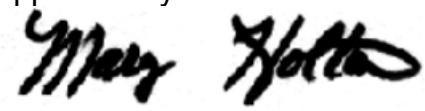
Christopher Holvey Date
Licensing Consultant

Approved By:



3/4/2024

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Mary E. Holton Date
Area Manager