

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

March 14, 2024

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

> RE: License #: AS250010789 Investigation #: 2024A0779020 Dodge Road Home

Dear Jenny 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.
- 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

Christolin A. Holvey

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 #:	AS250010789
Investigation #:	2024A0779020
Complaint Receipt Date:	01/30/2024
Investigation Initiation Date:	01/30/2024
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Report Due Date:	03/30/2024
Licensee Name:	Alternative Services Inc.
Licensee Name.	Alternative Services IIIc.
Licensee Address:	Suite 10
	32625 W Seven Mile Rd
	Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
-	
Administrator:	Will Paige
Licensee Designee:	Jennifer Bhaskaran
_	
Name of Facility:	Dodge Road Home
Facility Address:	12228 W Dodge Road
r domey r dunesce	Montrose, MI 48457
Facility Talentham #	(040) 474 4000
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	10/16/1987
License Status:	REGULAR
Effective Date:	02/04/2023
Expiration Date:	02/03/2025
Capacity:	6
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Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

Violation Established?

On 1/30/24, staff Isiah Meniefield struck Resident A causing	Yes
Resident A's ear to bleed.	

III. METHODOLOGY

01/30/2024	Special Investigation Intake 2024A0779020
01/30/2024	Special Investigation Initiated - Telephone Spoke to administrator, Will Paige.
01/30/2024	APS Referral Complaint was referred to APS centralized intake.
02/05/2024	Inspection Completed On-site
02/05/2024	Contact - Telephone call made. Interview conducted with staff person, James Brezzell.
02/05/2024	Contact - Telephone call made. Interview conducted with staff person, Isiah Meniefield.
02/06/2024	Inspection Completed On-site
02/08/2024	Contact - Document Received Received police report.
02/16/2024	Contact - Document Received Received ORR summary report.
03/12/2024	Exit Conference Held with administrator, Will Paige.

ALLEGATION:

On 1/30/24, staff Isiah Meniefield struck Resident A causing Resident A's ear to bleed.

INVESTIGATION:

On 1/30/24, a phone conversation took place with administrator, Will Paige, who stated that Resident A has been taken for medical care and had to get stitches in his ear. Admin Paige stated that Resident A has clearly identified staff person, Isiah Meniefield, has the person who hit him and injured his ear. Admin Paige stated that Staff Meniefield has been suspended pending the outcome of this investigation.

On 2/5/24, an on-site inspection was conducted and home manager, Mary Schiefer, was interviewed. Manager Schiefer stated that she started work on 1/30/24 at 6:00am and that Staff Meniefield was already in his car and leaving the properly when she arrived at the home. Manager Schiefer reported that when she entered the home, staff person, James Brezzell, was holding a towel to Resident A's bleeding ear and Resident A was quite emotional and crying. Manager Schiefer stated that Resident A told her "that black man punched me" and when she asked where it happened, Resident A told her that it happened in the bathroom. Manager Schiefer stated that Staff Meniefield is the only staff that she has heard Resident A refer to as "the black man". Manager Schiefer stated that she immediately tried to contact Staff Meniefield, but he had turned his phone off. Manager Schiefer reported that she able to contact Staff Meniefield later that day and Staff Meniefield told her that he had no idea what happened to Resident A's ear.

On 2/5/24, a phone interview was conducted with staff person, James Brezzell, who confirmed that he worked 3rd shift with Staff Meniefield on 1/30/24. Staff Brezzell stated that at a few minutes prior to 6:00am, Staff Meniefield went out to his car and when he reentered the home, Staff Meniefield entered the hallway bathroom. Staff Brezzell stated that just a minute or two later he heard the bathroom door open and close again, but he could not see the bathroom from where he was in the kitchen. Staff Brezzell reported that he heard someone exit the bathroom and few seconds later, Resident A came into the kitchen with his ear bleeding, saying "He hit me". Staff Brezzell stated that a minute or two later, Staff Meniefield came into the kitchen and Resident A confronted him by saying "You hit me" and Staff Meniefield denied it by saying "No I didn't bro". Staff Brezzell stated that although he did not witness it, he believes Resident A and Staff Meniefield were in the bathroom together after Resident A walked in on Staff Meniefield. Staff Brezzell stated that he did not hear any noise in the hallway that would have suggested that Resident A had fallen. Staff Brezzell reported that Staff Meniefield never gave him an explanation for Resident A's injured ear and left quickly before Manager Schiefer arrived there at 6:00am. Staff Brezzell stated that he did not witness Staff Meniefield hit Resident A and that no other residents were awake at the time to witness anything.

On 2/5/24, a phone interview was conducted with Staff Meniefield, who confirmed that he worked 3rd shift on 1/30/24, that he went outside to warm his car up and then went into the hallway bathroom. Staff Meniefield claimed that he was out of the bathroom when Resident A came out of his room and went into the bathroom. Staff Meniefield first stated that he observed Resident A come out of the bathroom and fall and hit his head on the floor, then he changed his story to that he heard Resident A fall in the hallway, helped him up off the floor and assisted Resident A to his bed. Staff Meniefield reported that Resident A got up off his bed right away and went into the kitchen to see Staff Brezzell. Staff Meniefield denied that he hit Resident A and claims that Staff Brezzell is coaching Resident A to say that he hit him. Staff Meniefield claimed that he left the home before he could tell Manager Schiefer what happened because he was worried that the weather was getting bad outside.

On 2/6/24, a second on-site inspection was conducted and Resident A was interviewed. Resident A confirmed that he remembers when his ear got hurt and stated that "the black man" hit him and that he fell down. Resident A indicated that the incident took place in the bathroom. When asked if he walked in on the staff in the bathroom, Resident A said "Yes". When asked if he had fallen in the hallway that morning, Resident A said "No, bathroom". That was all the detailed information Resident A could provide regarding his ear injury.

On 2/6/24, Manager Schiefer stated that Resident A has stuck his story that "the black man", who he refers to Staff Meniefield as, hit him in the bathroom. Manager Schiefer stated that the bathroom door shuts quite hard and can easily be heard from the kitchen area. Manager Schiefer reported that Staff Meniefield and Staff Brezzell were the only staff working at the time of Resident A's injury, that Resident A seems to really like Staff Brezzell and that Resident A was crying on Staff Brezzell's shoulder when she arrived at the home that morning. Manager Schiefer claimed that Staff Meniefield's story of how Resident A's ear was injured has changed a few times.

This home provided a copy of an *AFC Licensing Division Incident/Accident Report (IR)* regarding this incident, which was written by Manager Schiefer. The IR stated that on 1/30/24 at 6:00am, Resident A told Manager Schiefer that staff person, Isiah Meniefield, had punched him in his ear. The IR stated that Resident A had sustained a cut behind his left ear and was taken to a local urgent care clinic, where he received stitches. The corrective measures listed on the IR was to suspend Staff Meniefield until an investigation could be completed and to follow any recommendation made by the medical clinic.

On 2/8/24, a police report was received via email from the Montrose Township police Dept. The report stated that Officer Eric Abbey had went to the home on 1/30/24 regarding an assault complaint. The report stated that Resident A told Officer Abbey several times that Staff Meniefield punched him in the head for no reason. The report stated that Officer Abbey interviewed Staff Brezzell, who told Officer Abbey that he believes Resident A and Staff Meniefield were in the bathroom together and that Resident A told him that Staff Meniefield had punched him.

On 2/16/24, an ORR summary report was received from recipient rights officer, Matt Potts. The report stated that Matt Potts had concluded his investigation into these same allegations and has substantiated that Resident A was physically abused by Staff Meniefield.

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 confirmed that on the morning of 1/30/24, Resident A and staff person, Isiah Meniefield were in the bathroom of this home together alone. Resident A has told multiple sources that Staff Meniefield punched him in the head while in the bathroom. Staff James Brezzell has stated that Resident A and Staff Meniefield were the only two persons, to be in the bathroom and/or hallway at the time of Resident A's injury to his ear. Resident obtained a cut to his ear that required multiple stiches. There was sufficient evidence found to prove that Staff Meniefield physically hit and injured Resident A, therefore failing to provide Resident A with adequate dignity, safety, and protection.	
CONCLUSION:	VIOLATION ESTABLISHED	

On 3/12/24, an exit conference was held with administrator, Will Paige. Admin Paige was informed of the outcome of this 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.

3/14/2024

Christopher Holvey Licensing Consultant

Christolin A. Holvey

Date

Approved By:

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3/14/2024

Mary E. Holton Area Manager Date