GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 7, 2024

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

RE: License #: AS250350169
Investigation #: 2024A0576016
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.
- 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. 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,

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 #:	2024A0576016
Complaint Receipt Date:	01/11/2024
Investigation Initiation Date:	01/16/2024
Report Due Date:	03/11/2024
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10, 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jennifer Bhaskaran
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, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
On January 6, 2024, Resident A was diagnosed with fractures in his middle and index fingers. Resident A is dependent on staff for mobility, and it is unknown how the injury occurred.	Yes

III. METHODOLOGY

01/11/2024	Special Investigation Intake 2024A0576016
01/11/2024	APS Referral
01/16/2024	Special Investigation Initiated - Telephone Interviewed Patricia Sheppard, Genesee County Office of Recipient Rights (ORR)
01/16/2024	Contact - Document Sent Sent email to Shwanda Lee, Genesee County Adult Protective Services (APS)
01/18/2024	Contact - Document Received Received email from Shwanda Lee
01/25/2024	Inspection Completed On-site Interviewed Staff Heavenly Willingham, Theresa Roberts, and Kaliah Wheeler, and viewed Resident A
01/25/2024	Contact - Face to Face Interviewed Resident B
02/15/2024	Contact - Telephone call made Interviewed Guardian A
03/01/2024	Contact - Telephone call made Unsuccessful phone contact with Teevia Brown, Case Manager
03/07/2024	Contact - Telephone call made Interviewed Home Manager, Dakari Tidwell
03/07/2024	Exit Conference

ALLEGATION:

On January 6, 2024, Resident A was diagnosed with fractures in his middle and index fingers. Resident A is dependent on staff for mobility, and it is unknown how the injury occurred.

INVESTIGATION:

On January 16, 2024, I interviewed Patricia Shepard from the Genesee County Office of Recipient Rights (ORR). Officer Shepard confirmed she is investigating this matter and stated the AFC staff are making guesses as to how Resident A was injured. Resident A may have gotten his fingers caught in his bed rails or wheelchair. Officer Shepard does not believe Resident A could have injured himself on his own given his physical limitations. Staff noticed Resident A's hand was swollen so he was taken in for examination and it was discovered he had fractured fingers. Resident A also had a red line by his wrist.

On January 16, 2024, I sent an email to Shwanda Lee, Genesee County Adult Protective Servies (APS) Investigator who confirmed she is investigating this matter. On January 18, 2024, Investigator Lee advised she will be substantiating neglect as Resident A was injured and no one at the facility knows how this happened. Investigator Lee reported she interviewed 1st shift staff, Theresa Roberts, and Kaliah Wheeler and both reported that they noticed something wrong with Resident A's arm while getting him out of bed in the morning. The staff followed protocol, contacting management, and sought medical care. Investigator Lee also spoke to Resident A's guardian, Guardian A who advised that Resident A was in the hospital and doctors determined that two of his fingers were fractured. Guardian A questioned the home manager, and it was reported that nobody knows what happened. Guardian A stated that staff must have not been paying attention to Resident A. According to Guardian A, the doctor stated that the nature of Resident A's fracture is typically if someone punches a wall or something of that nature, like riding a motorcycle and hitting a car, blunt impact. Guardian A stated that it is not possible due to Resident A's limitations.

On January 25, 2024, I conducted an unannounced on-site inspection at MacIntosh House and interviewed Staff, Heavenly Willingham. Staff Willingham has worked at the facility for 2 years. Regarding the allegations, Staff Willingham reported she came into work and Resident A's hand was swollen and purple. Home Manager, Dakari Tidwell was notified, and Resident A was taken to the hospital. According to Staff Willingham, Resident A is nonverbal, and she does not know how Resident A obtained the injury. Staff Willingham did not think the injury was the result of staff or another resident mistreating him.

On January 25, 2024, I viewed Resident A at his home. Resident A was sitting in his wheelchair and was wearing a brace on his arm. Resident A appeared well, clean, and content and did not appear to be under duress.

On January 25, 2024, I interviewed Staff Theresa Roberts who has worked at the facility for 5 years. Staff Roberts reported she and Kaliah Wheeler were working and Staff Wheeler was getting Resident A up. Staff Wheeler noticed a problem with Resident A's hand and advised Staff Roberts. Staff Roberts reported she viewed Resident A's hand, and it was swollen. The home manager was advised of the situation. Resident A was taken to the hospital, and they provided him with a ½ splint and bandaging. Staff Roberts did not know how Resident A obtained the injury to his hand and advised Resident A "touches everything" and accidents happen. Resident A cannot walk and his arms and hands "are always moving". Resident A uses a wheelchair and Resident A can move around in the wheelchair by himself although he may not go in an orderly direction. Staff Roberts reported "one day he (Resident A) was fine the next day he had a problem with his hand."

On January 25, 2024, I interviewed Staff, Kaliah Wheeler who has worked at the facility for 5 years. Staff Wheeler reported she was working and noticed Resident A's hand was swollen and a little purple on top of his hand. Staff Wheeler advised Staff Theresa Roberts who called the home manager. Staff Wheeler does not know how Resident A obtained the injury to his hand. Resident A is "touchy" and maybe his hand got caught somewhere. According to Staff Wheeler, one resident at the home is "pushy" but Staff Wheeler did not think the resident did anything to harm Resident A. Staff Wheeler did not think Resident A's injury was the result of staff mistreating him. Staff Wheeler advised that there is only one verbal resident who resides at the home, Resident B.

On January 25, 2024, I interviewed Resident B who reported she has lived at her home for 4 years. Resident B was familiar with Resident A and was aware he had an injury to his hand. Resident B denied knowing how Resident A's hand was injured. Resident B did not witness any staff or residents hit or harm Resident A. Resident B knows staff well and Resident B does not believe staff would harm Resident A. Resident B confirmed she feels safe at her home and stated if she has any issues with staff, she reports them to the home manager. Resident B denied any concerns regarding Resident A or in general.

On February 15, 2024, I interviewed Guardian A regarding Resident A and the allegations. Guardian A reported Resident A has resided at the home since 2014, and is wheelchair restricted. Guardian A reported the doctor who examined Resident A reported his injury was a major accident like his hand went through a wall or a motorcycle accident. The doctor described the injury as "blunt impact and crushing". A few days after Resident A's injury, Guardian A visited Resident A at his home and noticed another resident has a wheelchair that moves up and down. Resident A often grabs other's drinks and maybe Resident A's hand was crushed in Resident B's chair when she reclined it. Guardian A also stated that Resident A could have gotten his hand in the tires of his own wheelchair. In the past, Resident A could move around in his wheelchair "but not articulately". Guardian A reported the home could not explain what happened to Resident A's hand. Guardian A was asked if he thought a staff person harmed Resident A and he stated, "I can't say that". Guardian A advised he has never noticed any residents to be mean or vicious when he visits the home.

On March 1, 2024, I called Resident A's case manager, Teevia Brown however there was no answer, and a message could not be left due to the mailbox being full. I sent a text message requesting Case Manager Brown contact me.

On March 7, 2024, I reviewed Resident A's IPOS, which revealed Resident A is 31 years old and "cannot express himself in words". Resident A has diagnosis of cerebral palsy, spastic quadriparesis, fine motor impairments and difficult walking and general muscle weakness. Resident A requires the use of a wheelchair for mobility.

On March 7, 2024, I interviewed Home Manager Dakari Tidwell, and he reported Resident A is doing well. Resident A went to the doctor on February 12, 2024, and the doctor reported Resident A's hand has healed and he no longer requires the use of a brace. Manager Tidwell denied being aware of how Resident A obtained the hand injury.

On March 7, 2024, I reviewed an Incident Report (IR) regarding Resident A. The IR is dated for January 6, 2024, and authored by Amber Harris. The IR documented that on January 6, 2024, Resident A's hand was swollen. Management was contacted and Resident A was taken to the hospital where x-rays were taken. Resident A was diagnosed with Metacarpal Bone Fracture. Management will follow up primary physician and specialist, follow discharge instructions, and seek additional medical treatment as needed.

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, who is nonverbal, obtained a fracture to his fingers and staff are not aware of how he obtained the injury. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Resident A is nonverbal and requires the use of a wheelchair to ambulate. On January 6, 2024, staff noticed Resident A's hand to be swollen and discolored. Resident A was taken to the hospital and diagnosed with a metacarpal bone fracture. The home manager and 3 staff, including the 2 who discovered the injury, were interviewed and were unable to explain how Resident A obtained the injury. Guardian A was interviewed

	and advised that staff were unable to explain how Resident A was injured likely due to not paying attention to Resident A. Resident A is nonverbal, requires the use of a wheelchair for mobility, and diagnosed with cerebral palsy and spastic quadriparesis. Resident A is dependent on staff to keep him safe from harm. Given Resident A's significant injury that is lacking explanation as to how it occurred, there is a preponderance of evidence to conclude that Resident A's protection and safety was not adhered to at all times.
, CONCLUSION:	**VIOLATION ESTABLISHED**

On March 7, 2024, 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 in the license status is recommended.

3/7/2024

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Christina Garza Date
Licensing Consultant

Approved By:

3/7/2024

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Mary E. Holton Date
Area Manager