GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 23, 2024

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

RE: License #: AS780376324
Investigation #: 2024A0584011
Martin 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.
- 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) 284-9727.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780376324
Investigation #:	2024A0584011
Complaint Receipt Date:	01/02/2024
Investigation Initiation Date:	01/03/2024
Report Due Date:	03/02/2024
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:	Martin Home
Facility Address:	11410 Lennon Road Lennon, MI 48849
Facility Telephone #:	(810) 621-4721
Original Issuance Date:	08/17/2015
License Status:	REGULAR
Effective Date:	02/17/2022
Expiration Date:	02/16/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 12/29/23, direct care staff Sue Taylor hit Resident A on the back during his bath.	No
Additional Findings	Yes

III. METHODOLOGY

01/02/2024	Special Investigation Intake - 2024A0584011
01/03/2024	Special Investigation Initiated - Face to face interview with direct care staff Susan Taylor and Tricia Hollers.
01/03/2024	APS Referral – Verified Shiawassee Health and Wellness sent in a referral to APS.
01/24/2024	Inspection Completed On-site. Face to face interview with Resident A, B, C, D, E, F, and administrator Jeremy Hagerman.
01/29/2024	Contact- Telephone interview with direct care staff Lotta Kuchar.
02/13/2024	Exit Conference with Jennifer Bhaskaran, licensee designee.

ALLEGATION:

On 12/29/2024, direct care staff Sue Taylor hit Resident A on the back during his bath.

INVESTIGATION:

On 1/02/2024, the Bureau of Community and Health Systems (BCHS) received the above allegation via the online complaint system.

On 1/03/2023, I conducted separate face-to-face interview with direct care staff members Susan Taylor and Tricia Hollers at the Shiawassee Health and Wellness office with Recipient Rights Officer Ardis Bates. Ms. Taylor and Ms. Hollers were the only two staff on duty at the facility on 12/29/2023 at the time of the alleged incident.

Ms. Taylor confirmed that she worked at the facility on 12/29/2023 with Ms. Hollers and assisted Resident A with his bath during the shift. Ms. Taylor stated Resident A was not cooperating during his bath. Subsequently, she had to give him commands. However, Ms. Taylor denied the allegation she hit him on the back.

Ms. Hollers stated that on 12/29/2023, she worked with Ms. Taylor who was assisting Resident A with his bath. Ms. Hollers stated she witnessed Ms. Taylor directing Resident A to get in the bath and to sit using a loud and demanding tone. Ms. Hollers stated she placed Resident A's clothing in the bathroom and witnessed Ms. Taylor slap Resident A on his back. Ms. Hollers did not check Resident A for injuries and stated he did not seem scared or hurt from the incident. Ms. Hollers stated she did not feel comfortable telling the relieving shift worker what had happened. Ms. Hollers stated she felt guilty about not reporting it and eventually informed house manager Samantha Hagerman on 1/1/2024. Ms. Hollers stated that during the entire shift on 12/29/2023, she observed Ms. Taylor displaying a negative and unhappy demeanor towards Resident A.

On 1/24/2023, I conducted an unannounced investigation at the facility and observed Residents A, B, C, D, E, F, who were all unwilling or unable to answer my questions. Residents A, B, C, D, E, F all appeared in good health and were well groomed. The facility was neat, clean and in good repair.

I conducted interviews with administrator Jeremy Hagerman who verified Ms. Taylor was suspended from working at the facility, effective 1/3/2024.

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:	Based upon my investigation, which consisted interviews of direct care staff, there is not enough evidence that on 12/29/2023 Ms. Taylor hit Resident A in the back during bathing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 1/29/2024, I conducted a telephone interview with direct care staff member Lotta Kuchar. Ms. Kuchar stated she did not have any information regarding the allegation but she has worked many shifts with Ms. Taylor. Ms. Kuchar stated she recently noticed Ms. Taylor has been very "verbally negative" toward residents and to staff

when residents are present. Ms. Kuchar stated she arrived for her morning shift on 12/29/2024 to relieve Ms. Taylor and Ms. Hollers, she heard Ms. Taylor say angrily and loudly in front of another resident that she is “done and not going to do anything more with these residents”. Ms. Kuchar stated that she also heard Ms. Taylor swearing around the residents but could not provide specific words, times or dates when that 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:	Based upon my investigation, which consisted interviews of direct care staff, it has been established Ms. Taylor has not treated residents with dignity by using loud, demanding, and inappropriate language toward and around residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/13/2024, I conducted an exit conference with licensee designee Jennifer Bhaskaran and informed her of the findings of this investigation.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of this license.

2/20/2024

Candace Coburn   Date
Licensing Consultant

Approved By:

2/23/2024

Michele Streeter   Date
Area Manager