GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 27, 2024

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

RE: License #:	AS250077486
Investigation #:	2024A1039044
	Stanley Road

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.
- 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,

Martin Gonzales, 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 #:	AS250077486
Investigation #:	2024A1039044
Complaint Receipt Date:	07/09/2024
Investigation Initiation Date:	07/10/2024
Report Due Date:	09/07/2024
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Candy Hamilton
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Stanley Road
Facility Address:	2162 Stanley Road Mt Morris, MI 48458
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	10/22/1997
License Status:	REGULAR
Effective Date:	06/27/2024
Expiration Date:	06/26/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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II. ALLEGATION(S)

	Violation Established?
Resident A was taken out on an outing on 7/4/24 and staff did not take her walker as required. Resident A fell on her face, and it is swollen. Resident A's eye was also red.	Yes

III. METHODOLOGY

07/09/2024	Special Investigation Intake 2024A1039044
07/10/2024	Special Investigation Initiated - Letter emailed aps referral.
07/10/2024	APS Referral sent in via email.
07/10/2024	Contact - Document Sent emailed GHS ORR Michelle Salem.
07/10/2024	Contact - Document Received APS denied complaint.
07/10/2024	Contact - Document Received received email from GHS ORR Patricia Shepard.
08/08/2024	Inspection Completed On-site Interviewed Resident A, Home Manager and DCW.
08/08/2024	Contact – Phone Call Attempted phone call with Resident A's guardian. No answer, left message.
08/13/2024	Contact - Document Received Received email from Program Coordinator Candy Hamilton containing Resident information.
08/20/2024	Contact - Document Received Received email from GHS ORR Patricia Shepard that she substantiated on her complaint.
08/20/2024	Contact – Phone Call

	Attempted phone call with Resident A's guardian. No answer, left message.
08/23/2024	Exit Conference completed with Licensee Designee.
08/23/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was taken out on an outing on 7/4/24 and staff did not take her walker as required. Resident A fell on her face, and it is swollen. Resident A's eye was also red.

INVESTIGATION:

On 07/09/2024, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Resident A was taken out on an outing on 7/4/24 and staff did not take her walker as required. Resident A fell on her face, and it is swollen. Resident A's eye was also red.

On 07/10/2024, Department of Health and Human Services Centralized Intake denied the complaint regarding Resident A.

On 08/08/2024, I completed an unannounced on-site investigation at Stanley Road concerning the allegations regarding Resident A. I interviewed the following people: Home Manager Valerie Walton, Direct Care Worker Mary Jones and Resident A.

On 08/08/2024, I completed an in-person interview with Home Manager (HM) Valerie Walton concerning the allegations regarding Resident A. HM Walton stated that she was aware of the allegations and that they were true. HM Walton stated that she was not present when the incident occurred but on 07/04/2024, staff took the residents to go see the fireworks and forgot to take Resident A's walker. HM Walton stated that Resident A fell while they were on the outing. HM Walton stated that staff did not take Resident A to urgent care. HM Walton stated that she was notified of the incident after they had returned to Stanley Road. HM Walton stated that she had Resident A taken to Clio Urgent Care and that she had x rays done. HM Walton stated that Resident A did not break anything and all that she was just swollen and had some scrapes from falling down. HM Walton stated that the staff involved did not believe that Resident A needed to be taken to Urgent Care. HM Walton stated that the staff involved were disciplined and are on a performance plan. HM Walton stated that she has gone over with staff what needs to happen when an incident occurs so that this does not happen again.

I reviewed an Incident Report (IR) that HM Walton completed on 07/05/2024. The incident report is consistent with the allegations. The incident report notes that on 07/04/2024, Resident A fell out of her chair when she was getting up to leave after the fireworks were

completed. Staff examined Resident A after she fell and provided basic care. Resident A was not taken to Clio Urgent Care until 07/05/2024.

I reviewed Clio Urgent Care discharge paperwork dated 07/05/2024. The discharge paperwork confirms that there were scrapes to the left cheek, localized swelling and lump on Resident A. The x ray completed showed that Resident A was negative for any fractures.

I reviewed an assessment plan developed for Resident A that was signed on 05/20/2024. The assessment plan shows that Resident A needs staff supervision in the community and requires a walker when walking as she has weakness on her left side and has an unsteady gait.

On 08/08/2024, I completed an in-person interview with Direct Care Worker (DCW) Mary Jones concerning the allegations regarding Resident A. DCW Jones stated that she was aware of what happened, and that staff is supposed to ensure that all of the residents have everything they need if they go out into the community. DCW Jones stated that she was not on the outing when Resident A fell but believes that staff probably just forgot Resident A's walker. DCW Jones stated that she always ensures that Resident A has her walker as it is identified in her care plan. DCW Jones stated that management reviewed with them what happens in case there is an incident with a resident and who they contact.

On 08/08/2024, I completed an in-person interview with Resident A regarding the allegations. Resident A appeared neat and clean at the time of her interview and was interviewed in the home managers office. Resident A is diagnosed with the following: Bipolar disorder and Posttraumatic stress disorder. Resident A requires a walker when walking as she has weakness on her left side and has an unsteady gait. Resident A stated that she remembers the incident from 07/04/2024. Resident A stated that they were going to see the fireworks and the staff got them all in the van and forgot to load up her walker. Resident A stated that she was okay until after the fireworks when she tried to get out of the lawn chair and fell forward on to her face. Resident A stated that staff gave her basic first aid and checked her over to make sure she was ok after she fell. Resident A stated that they did not take her to urgent care right away after the fall. Resident A stated that when she goes into the community the staff ensure that she has her walker. Resident A stated that she went to the urgent care the next day and got some x rays completed. Resident A stated that she did not break anything, and they she had a few scrapes on her cheek from falling.

On 08/20/2024, I received an email from Genesee Health Systems Office of Recipient Rights (ORR) worker Patricia Shepard concerning the allegations regarding Resident A. ORR Shepard informed me that she completed her investigation and that she substantiated the allegations for neglect.

On 08/23/2024, I completed an exit conference with Licensee Designee Jennifer Bhaskaran. I informed LD Bhaskaran of findings of my investigation. LD Bhaskaran

had some concerns regarding Resident A not wanting to use her walker all the time but understood that the walker is required for Resident A.

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 Resident was taken out on an outing on 7/4/24 and staff did not take her walker as required. Resident fell on her face, and it is swollen. Her eye was also red. I interviewed the Home Manager, Direct Care Worker, GHS ORR and Resident A. Attempted contact with Resident A's guardian with no success. I reviewed Resident A's assessment plan and urgent care discharge paperwork. Upon completion of my investigation, it was determined that there was a preponderance of evidence to conclude that R. 400.14305 (3) was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

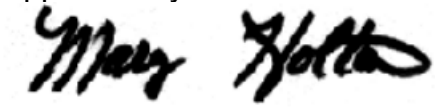
IV. RECOMMENDATION

Upon approval of corrective action plan, I recommend no change in the license status.

08/26/2024

Martin Gonzales Licensing Consultant	Date

Approved By:



08/27/2024

Mary E. Holton Area Manager	Date