GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2025

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

RE: License #: AS330011149
Investigation #: 2025A0622012
Van Atta Rd 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended due to the quality of care and physical plant violations. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Amanda Blasius, 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS330011149
Investigation #:	2025A0622012
Complaint Receipt Date:	12/12/2024
Investigation Initiation Date:	12/12/2024
Report Due Date:	02/10/2025
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:	Van Atta Rd Home
Facility Address:	4817 Van Atta Rd Okemos, MI 48864
Facility Telephone #:	(517) 349-1244
Original Issuance Date:	03/10/1982
License Status:	REGULAR
Effective Date:	04/03/2023
Expiration Date:	04/02/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Male resident (Resident A) eloped from Van Atta AFC and was attempting to break into a neighbor's home/vehicle.	Yes
Resident B's previous roommate, Resident A, has attacked him and destroyed his personal belongings.	Yes
Resident B has had a foot injury for 6 months & has not been taken for medical evaluation.	No
Additional Findings	Yes

III. METHODOLOGY

12/12/2024	Special Investigation Intake 2025A0622012
12/12/2024	Special Investigation Initiated – Telephone call made to
12/19/2024	Unannounced onsite investigation completed.
12/30/2024	Contact - Telephone call made. Phone call with complainant.
12/30/2024	Contact - Telephone call made. Phone call to direct care workers.
01/09/2025	APS Referral- Referral came from APS denial.
01/13/2025	Contact – Telephone call made- Phone call to Guardian B1 and direct care workers.
01/14/2025	Contact – Telephone call made to direct care worker, Guardian A1 and CMH worker.
01/16/2025	Unannounced onsite investigation completed.
02/03/2025	Exit Conference with Jennifer Bhaskaran

ALLEGATION: Male resident (Resident A) eloped from Van Atta AFC and was attempting to break into a neighbor's home.

INVESTIGATION:
On 12/19/2024, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, a male

resident from Van Atta Rd. Home AFC had eloped and was trying to break into someone's house and the police were called. According to the complaint, this was not the first time the police have been called regarding concerns about Van Atta Rd Home residents.

On 12/19/2024, I completed an unannounced onsite investigation to Van Atta Rd. Home. Resident A's *Assessment plan for AFC Residents* (assessment plan) was reviewed. According to Resident A's assessment plan: *"Moves independently in community: No, staff need to monitor for safety."*

Based on a review of the FOIA request from Meridian Township Police Department, it was determined that Resident A eloped on 12/24/24. A phone call came into dispatch at 4:39am. At 4:40am, the FOIA request stated that the caller explained that someone was trying to break into their vehicle and her husband was talking to him. At 4:45am, the police arrived on scene and confirmed that the person was from Van Atta Rd. Home and identified himself as "[Resident A]". According to the FOIA request, his footprints appeared to have gone to other neighbors' homes also. The police took Resident A back to the AFC at 5am.

I reviewed an *AFC Licensing Division Incident Report* dated 12/24/24. According to the report completed by DCW Daniel Farlin it documented*, "I arrived at the home at 6am and noticed a screen on the ground. I went in asked the midnight staff if something happened. She said he went out the window."*

In the *Action Taken by Staff* section of the *AFC Licensing Division Incident/Accident Report* it documented*: "I asked if she documented it and to do an IR and she just left. At 11am Officer Megan Cole from Meridian police called. They said they were just called and he was at a neighbor's house. They returned him to Vanetta at 3am. She said they are concerned for his safety being out that late at night."*

In the *Corrective Measures Taken to Remedy or Prevent Reoccurrence* section of the *AFC Licensing Division Incident/Accident Report* it documented*: "Currently working with CEI Jacob Tipton, behavioral psychologist to come up with a BTP or guidelines for [Resident A]. We are also gathering data currently on [Resident A] to help assist with his plan. Also, staff will assure that when [Resident A] is agitated he will receive his PRN before he escalates and elopes."*

On 12/30/2024, I interviewed direct care worker, Paradise Godard via phone. She reported that she has worked at Van Atta Rd. Home for about 1.5 years and works 3rd shift. She confirmed that she was working the 3rd shift when Resident A eloped on 12/24/24. She stated that another resident has a broken foot, and she was assisting that resident with going to the bathroom, when Resident A eloped. DCW Godard explained that since 11pm on 12/24/24, Resident A was going in and out of the home and she was following him around all night. DCW Godard stated that she gave Resident A his tablet and asked him to go into his room because she needed to help the resident with the broken foot. DCW Godard stated that Resident A

returned to the home around 5am. DCW Godard stated that she did not think Resident A would go out his window and was unaware that he was gone. DCW Godard stated that she has asked management to add another staff to third shift, as she is unable to complete her required tasks and take care of the multiple residents with high personal care needs and supervision. DCW Godard reported that she did not call the police because she unaware that Resident A eloped as she was helping another resident in the bathroom at the time.

Additional *AFC Licensing Division Incident/Accident Report* completed for Resident A were reviewed. An *AFC Licensing Division Incident Report* dated 12/3/2024 was reviewed. It documented the following:

In the *Explain What Happened* section of the *AFC Licensing Division Incident/Accident Report* it documented*: "[Resident A] was riding his bike in the back yard and going back and forth from his bedroom to backyard pacing. Not aggressively though, just saying mom and dad leave. Call dad, go to hospital. Staff observed him and redirected several times. Staff 1 one was counting meds, staff 2 was doing dinner prep and staff three was assisting client."*

In the *Action Taken by Staff* section of the *AFC Licensing Division Incident/Accident Report* it documented*: "In bathroom, staff 2 seen door open at end of hallway and notified all staff immediately and started looking for [Resident A]. Staff 3 went out front door to check for [Resident A] and police met staff there with [Resident A]. Police stated that he attempted to go into a neighbor's home and the neighbor called it in. Prescribe as needed given and he relaxed with IPAD."*

In the *Corrective measures taken to remedy or prevent reoccurrence section of the AFC Licensing Division Incident/Accident* it documented*: "Currently working with CEI Jacob Tipton, behavioral psychologist to come up with a BTP or guidelines for [Resident A]. We are also gathering data currently on [Resident A] to help assist with his plan. Also, staff will assure that when [Resident A] is agitated he will receive his PRN before he escalates and elopes."*

After interviews with complainants and reviewing FOIA requests, it was also determined that Resident A eloped on 12/19/24, but an incident report was not completed.

I reviewed staff schedules for Van Atta Rd. Home. The staff schedule changes depending on the day, but after reviewing staff schedules from 9/13/2024-1/30/2025, only one staff is scheduled from 10pm-6am. After reviewing the staff schedule it was found that one staff was only present for the following dates and times:

November 6th: 8am-6pm
November 7th: 6am-2pm and 6pm-6am
November 8th: 7:30am-3:30pm
November 23rd: 7:30pm-2pm
November 30th: 6am-6pm

December 1st: One staff per all shifts
December 14th: One staff per all shifts
December 15th: One staff per all shifts
December 18th: 8pm-6am
December 19th: 8pm-6am
December 20th: 4pm-6pm
December 21st: 6pm-6am
December 28th: 2pm-10pm
December 29th: 2pm-10pm

Assessment Plans for AFC Residents were reviewed for all residents.

According to Resident B's *Assessment Plan for AFC Residents,* the following was found: *"Controls aggressive behavior: no, has a BTP that staff must follow to assist with his behaviors. Exhibits self- injurious behavior: will hit, bite and roll up his shirt and bite until his gums bleed."*

According to Resident C's *Assessment Plan for AFC Residents*, the following was found: *"Controls aggressive behavior: no, if upset or anxious, especially after a seizure, he may bite others, may not always know the cause, will knock over items in the house. Gets along with others: When he is anxious, he may hit or bite others. Best to keep others away from him.*
Toileting: staff assist with post hygiene and reminders for toileting.
Bathing: Requires staff support and assistance
Grooming: requires staff support and assistance
Dressing: requires staff support and assistance
Personal hygiene: requires staff support and assistance
Walking/mobility: Unsteady gait, monitor and provide support if unsteady gait noticed. High risk of falls and bone break- noticed after seizures or tired."

According to Resident D's *Assessment Plan for AFC Residents,* the following was found:
"Communicates needs: Can verbalize some needs
Controls aggressive behavior: no, Has a positive behavior support plan guidelines by his psychologist that staff need to follow.
Exhibits self-Injurious behavior: He will bang his head, pick at his fingers and nose until it bleeds. He will rectally dig, if needs are not met right away
Toileting: staff assist, verbal reminders to be closer to toilet. Redirection from rectal digging and post toilet hygiene.
Bathing: Needs staff full assistance with all grooming
Grooming: Needs staff full assistance with all grooming
Dressing: Staff assist to assure attire is weather appropriate
Personal hygiene: Needs staff full assistance with all grooming
Walking/mobility: Staff should stay close by and assist when needed, has issues with depth perception.
Special diets: Staff need to modify all foods to chopped texture."

According to Resident E's *Assessment Plan for AFC Residents,* the following was found:

"Controls aggressive behavior: will threaten to harm herself, throw things, slam doors, yell when upset.
Toileting: Staff assist, verbally reminding her of post toileting hygiene
Bathing: staff assist due to her request of full hair care and staff verbally remind her to wash her private area when bathing
Grooming: Staff must assist and also verbally give reminders for her to complete this area."

According to Resident F's *Assessment Plan for AFC Residents,* the following was found:

"Communicates needs: no, non-verbal, can show staff/ take them to item to show staff
Controls aggressive behavior: no, has social teaching guidelines that give instructions for staff to follow. She will push down peers, pull hair and take off socks and shoes.
Gets along with others: She will scratch and pull hair
Exhibits self-injurious behavior: Will hit head and face with force. Wears a helmet for protection from herself.
Toileting: staff need to assist with reminders to use the toilet and post toileting.
Bathing: staff assist with all bathing needs
Grooming: staff assist with all grooming needs.
Dressing: staff assist to assure her clothes are on correctly and to assure she is given weather appropriate clothing options."

On 1/13/2025, I interviewed direct care worker, Leighanna Gnagi via phone. She reported that she mainly works third shift. DCW Gnagi stated that on 1/5/25, she was working 3rd shift and had to give CPR to another resident. She stated that she had to ask another resident to watch Resident A, so he didn't elope. DCW Gnagi also reported that often Resident A is up most of the night, which makes it difficult to complete her required cleaning tasks. DCW Gnagi stated that they were advised by CMH to give Resident A his tablet to keep him from eloping and to keep him calm, but this causes him to stay up all night and struggles to sleep. DCW Gnagi reported that Resident A has months of being physically aggressive and he sent her to the hospital. She stated that she was working the third shift alone and he hit her in the face and busted open her lip. She explained that she had to call 911 and was sent to the ER. DCW Gnagi reported that they only put two staff on third shift for a short period of time with her, but now she is back to working alone on third shift.

On 01/16/2025, I completed an unannounced onsite investigation to Van Atta Rd. Home. During my investigation, I also observed Resident A pace around the home and walk out the front and back doors multiple times and needed staff assistance for redirection. Upon leaving my investigation, Resident A followed me to my car, and I had to redirect him back into the home until a staff member came out to get Resident

A. It was apparent from my investigation that Resident A needs constant redirection and supervision from direct care staff.

On 02/03/2025, I interviewed licensee designee, Jennifer Bhaskaran via phone. She reported that their intervention to address Resident A's aggressive behaviors was to bring in behavioral psychologist, Jacob Tipton from CEI, who started working with Resident A around the end of October 2025. She also reported that towards the end of November, she noticed concerns with the manager of the home and a change was made. Licensee Bhaskaran reported that as of 01/16/25, she has added additional experienced management staff to the home to assist with training staff to work with high needs residents and to also address some of the lack of documentation completed while the previous manager was over Van Atta St. Home. As of 02/04/25, approval for alarms for Resident A's window, door and front door were in the process, but had yet to be installed.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on documentation reviewed it was determined that Resident A eloped three times from Van Atta Rd. Home and no adjustments were made to the staff schedule to provide additional protection supervision for Resident A. One elopement occurred during the 3rd shift. During another third shift on 01/5/25, another resident was asked to watch Resident A, so he would not elope while staff was giving a resident CPR. As of 01/16/2025 one staff member continues to cover the 3rd shift schedule. If one staff is working and assisting another resident, preparing medications or cooking meals, it would be impossible to constantly redirect Resident A or keep him in line of sight. Based on the information provided, Van Atta Rd. Home does not have enough staff available on all shifts to provide appropriate personal care, supervision and protection for all six high need residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(2) If an elopement occurs, staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall contact law enforcement.
ANALYSIS:	A violation was established as DCW Godard was unaware that Resident A eloped from Van Atta Rd Home on 12/24/2024, therefore no search was completed, nor was a phone call to law enforcement completed by DCW Godard. According to the FOIA request, Resident A was found at a neighbor's home and was returned to the home by the police officer.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B's previous roommate, Resident A, has attacked him and destroyed his personal belongings.

INVESTIGATION:
On 12/12/2024, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident B has been sharing a bedroom with Resident A and has been repeatedly attacked by Resident A. The complaint stated that there have been many times Resident B had injuries over the past year. Resident A has been taking Resident B's personal belongings and destroying them. According to the complaint, Resident A ripped up Resident B's family pictures and urinated on his books and other pictures. Resident B was eventually moved out of Resident A's room and staff told Complainant what occurred. Complainant is concerned that staff are unable to manage Resident A's behavior, which leaves other residents at risk.

On 12/19/2024, I completed an unannounced onsite investigation to Van Atta Rd. Home. I interviewed direct care worker, Ivvy Knowlton. DCW Knowlton reported that Resident A has been very aggressive towards staff and Resident B. She stated that his aggressive behaviors started in September 2024 through the end of November 2024. DCW Knowlton stated Resident A moved back home with his parents for about a month around Halloween due to his increase in aggressive behaviors. DCW Knowlton stated that management wanted staff members to wear a helmet when working, as Resident A was hitting staff in the head so much. Staff were also given a gym mat to protect themselves or other residents. DCW Knowlton reported that she has observed Resident A hit Resident B over 10 times. She stated that Resident A will get at least 2-3 swings on Resident B before staff can intervene. DCW Knowlton stated that she has never seen Resident A urinate on Resident B, but stated Resident A urinates on all residents' belongings. DCW Knowlton reported that she is not aware of any intervention to prevent Resident A from urinating on other

resident's belongings. DCW Knowlton explained that Resident B was eventually moved out of Resident A's bedroom.

I interviewed DCW Don Reed in person. He reported that he has observed Resident A hit Resident B and it was daily for about a week, during September 2024. DCW Reed stated that he tries to keep them separated, not allow them to be bored or sit next to each other. DCW Reed explained that Resident A has hit him a few times. DCW Reed stated that he has found Resident B's belongings and coloring books to be wet from urine. He reported that after about a month and a half of the aggressive behaviors starting, Resident B was moved out of Resident A's bedroom.

I interviewed DCW Nicere Lewis in person. He reported that he has seen Resident A hit Resident B. He explained that he has never been hit by Resident A. He stated that he mainly works first shift and it helps if you take Resident A for walks. He reported that he has had to step in to prevent Resident A from hitting Resident B. DCW Lewis reported that Resident A has probably urinated on Resident B, but he has never observed it.

On 01/13/2025, I interviewed Guardian B1 via phone. She reported that Resident B has been assaulted by Resident A several times and staff do not communicate these concerns with her. She reported that Resident B is terrified of Resident A and would often make noises due to being stressed and afraid. Guardian B1 reported that she noticed concerns in March of 2024, when Resident A started taking things out of her hands that were Resident B's. She noticed that Resident B was more stressed. Guardian B1 stated that she asked for Resident B to not share a room with Resident A and she was told by management that other residents can't have roommates. Guardian B1 reported that she was unaware that Resident A was taking Resident B's personal belongings and destroying them. She was also unaware that Resident A was urinating on Resident B's bed and personal belongings. Guardian B1 reported when she moved Resident B out of the home, she found some of his belongings to have urine on them and found his weighted blanket on Resident A's bed. Guardian B1 stated that at the end of November 2024, facility administration finally moved Resident B out of Resident A's bedroom but she not given a reason why it finally occurred. Guardian B1 stated that Resident B was hit over the head by Resident A many times and does not understand why facility administration allowed them to stay roommates for so long. Guardian B1 reported that she moved Resident B out of the AFC because she felt they were unable to provide supervision and protection to Resident B. She stated was also concerned due to the lack of staff available as she noticed a decline in Resident B's hygiene care. Guardian B1 stated that she has noticed that Resident B has been much more happy and less stressed since moving him home.

On 12/30/2024, I interviewed DCW Leighanna Gnagi via phone. She reported that the aggressive behavior and physical assaults started in April 2024. DCW Gnagi explained that Resident A attacked her when she was working alone on third shift, and she needed to go to the ER. DCW Gnagi stated that she has seen Resident A

attack Resident B and has also had to prevent Resident A from hitting Resident B. DCW Gnagi reported that the intervention that she has been told about to prevent his aggressive behaviors is to give Resident A his tablet. DCW Gnagi explained that Resident A has urinated on Resident B and his belongings for about six months now.

On 12/30/2024, I interviewed DCW Paradise Godard via phone. She reported that Resident A often “beat on” Resident B. DCW Godard described “beat on” as Resident A often hitting Resident B on his head. DCW Godard stated Resident A and Resident B were often in their room alone and Resident A would be bothering Resident B. DCW Godard reported that Resident A would take Resident B’s belongings and urinate on them.

On 01/14/2025, I interviewed CEI Jacob Tipton, Resident A’s behavioral psychologist via phone. He stated that he was brought in to work with Resident A due to his aggressive behaviors. Mr. Tipton stated that he started working with Resident A in early October, 2024. He states that he visits Resident A in person twice a month. Mr. Tipton also confirmed that it was Resident A’s Guardians decision to bring Resident A to their personal home while they adjusted his medications. He stated that Resident A was out of the facility in October 2024 for about one to two weeks. Mr. Tipton reported that he has spent a lot of time trying to understand Resident A’s behaviors and has asked staff to track them. Mr. Tipton reported that he created a daily schedule for Resident A to decrease his aggressive behaviors. Mr. Tipton reported that he does not recommend a 1:1 direct care staff supervision as it imposes on Resident A’s personal rights.

Resident A’s daily schedule that was established by CEI Jacob Tipton, behavioral psychologist was reviewed.

Breakfast: 7-8am
Monday, Tuesday, Friday: 8am- offer to ride with another resident to work
Offer snack: 10am
Activity: 10:30am- walk in driveway, ride bike, walk on nature trail
Lunch: 12pm
Monday, Tuesday, Friday: 12:30pm offer to ride to pick up another resident from work
Quiet time activity: 1pm, movie, puzzle, tablet
Offer walk or ride bike: 2pm
Quiet time activity: 2:30pm
Offer Snack: 3:30pm
Important: If possible, Resident A needs to go for a car ride between 4-7pm. This is the period when he is most likely to be aggressive.
Dinner: 5-6pm
Offer snack: 7-7:30pm
Wind down for bed: 7:30-8:pm. This includes prompting Resident A to put away his tablet, dimming the lights and turning on a movie.

On 09/19/2024 at 1pm an incident report stated that, *"Another peer was aggressive towards [Resident B] by yelling and hitting throughout the shift. Staff was able to redirect and keep them separate. Staff continued to monitor and seen no visible injuries."*
Action taken: "Staff will continue to monitor"

On 11/08/2024 at 8:30pm an incident report stated that, *"[Resident A] started to be aggressive towards staff and residents. He was lying in his room, getting ready for bed, when he suddenly started yelling, do you want this fist motherfucker. [Resident A] then came out of his room, trying to target anyone in his sight. [Resident A] then proceed to go back into his room and destroyed his bed and ripped pictures off the wall."*
Action Taken: "Staff redirected him to his room and provided him his tablet to calm him down."

On 11/10/2024 at 5:30am an incident report stated that, *"[Resident A] was sitting at the dining room table asking for breakfast. Staff told him it was not ready yet. He started yelling do you want this fist. He then stood up and tried to hit another resident and then a staff member. Staff had the mat to counter the blow, but he still reached over the mat and hit the staff member in the head. She stepped back out of the way. A pillow was also picked up from a chair to protect another resident from being hit."*
Action Taken: "Redirected him by asking him if he wanted to watch a movie and he said yes. Put on what he wanted to watch and put the volume on low. He was calmer afterwards."

On 11/10/2024 at 6:15pm, an incident report stated that, *"Staff were getting ready for shift change. Staff noticed that [Resident A's] behaviors increased rapidly as the new staff arrived. Resident A instantly started yelling do you want this fist mother fucker. [Resident A] then proceed to go right into the closest resident closest to him and started hitting them. Staff redirected him to his bedroom."*
Action Taken: "After a few minutes in his room, he seemed to calm down and returned to the living room. His attitude and aggression decreased."

On 11/10/24 at 6:30pm, an incident report stated that, *"[Resident A] woke up from a nap and had dinner. He asked for his tablet many times. Staff was unable to give him his tablet right away due to finishing up dinner and assisting other residents. [Resident A] then hit another resident in the head twice. He was directed to his bedroom and reminded that hitting is not allowed."*
Action Taken: "Roommate returned to bedroom and [Resident A] was redirected to living room to watch TV. He had calmed down and seemed better."

Resident A's *Assessment Plan for AFC Residents* (assessment plan) was reviewed on 12/19/2024, during an unannounced onsite investigation. The assessment plan was completed on 01/26/2024 and there was no documentation that Resident A

needed to be supervised while in his bedroom, keeping line of sight or providing one on one supervision.

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 on interviews with direct care workers, Guardian B1 and Mr. Tipton it was confirmed that Resident A has been aggressive towards Resident B and staff. It was also confirmed through all interviews with direct care workers, that Resident A urinated on Resident B's belongings. Interviews with direct care workers confirmed that the aggressive behavior started at the latest in September, 2024 and continued through the end of November 2024. Staff reported Resident A behavior of urinating on other residents' belongings is still continuing. Van Atta Rd. Home continued to have Resident A and Resident B share a bedroom until the end of November, 2024, despite knowing and observing Resident A hit Resident B and destroy Resident B's belonging when upset or frustrated. while knowing that Resident A was consistently hitting Resident B and also destroying his personal belongings by ripping them up and urinating on them. According to my review of Resident A's *Assessment Plan for AFC Residents,* no changes were made to provide additional supervision or one on one care for Resident A to specifically address his aggressive behaviors toward Resident B and his belongings. By delaying the change in bedrooms between, Resident A and B, Resident B's dignity, personal needs and protection were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B has had a foot injury for 6 months & has not been taken for medical evaluation.

INVESTIGATION:
On 12/12/2024, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident B is nonverbal and can say one to two words. The complaint stated that over a year ago, Resident B injured his foot while at Van Atta Rd. Home and its unknown what Resident B did to injure his foot. The complaint stated that staff did not take Resident

B for medical evaluation. Guardian B1 took Resident B to the doctor for medical evaluation and his foot was determined to be broken.

On 12/19/2024, I completed an unannounced onsite investigation to Van Atta Rd. Home. During the investigation, incident reports were not available to be viewed as they were locked in an office. All direct care workers who were working, stated that they have only been employed with Van Atta Rd. Home for less than a year and were unaware of the injury to Resident B's foot.

I asked for all incident reports and medical documentation for Resident B to be sent over via email. Upon review of documentation received, no medical documentation from over a year ago was received, nor was any incident reports from over a year ago received. I reviewed a medical visit form dated 10/08/2024, which documented that Resident B visited the doctor due to left ankle pain. Resident B was prescribed Voltaren cream four times a day for pain.

An incident report was reviewed from 11/30/2024 for Resident B. According to the incident report:
"[Resident B] was walking around the dining room table, when his right foot twisted from under him. He fell and hit his head. He was taken to the emergency room and evaluated. He sprained his ankle and was prescribed Ibuprofen. [Resident B] is supposed to follow up with his physician and be given his PRN as needed."

On 01/13/2025, I interviewed Guardian B1 via phone. She reported that over a year ago, she ended up taking Resident B to the doctor due to ankle pain. Guardian B1 was unable to confirm if his ankle was broken or sprained. Guardian B1 reported that she did not have any documentation of this medical visit. She stated direct care staff did not follow up with making him wear a wrap on his ankle, which caused him to continue to sprain his ankle. Guardian B1 reported that she moved Resident B out of the AFC home on 01/10/2025 due to multiple concerns.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	A violation was not established due to the lack of documentation available from over a year ago, lack of information available from staff members and Guardian B1. Documentation was provided that Resident B was taken to the doctor and emergency room on two separate occasions in 2024, due to ankle pain and falling.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 12/19/2024, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, a male resident from Van Atta Rd. Home AFC had eloped and was trying to break into someone's house and the police were called. According to the complaint, this was not the first time the police have been called regarding concerns about Van Atta Rd Home.

On 12/19/2024, I interviewed the neighbor who confirmed that she lives down the street from Van Atta Rd. Home. She confirmed that on 12/19/24 around 8:15am, her ring camera went off as a male person (Resident A) was attempting to open her slider door. He then went around her home and tried to open additional doors to her home and garage. The neighbor stated that she observed this male person walk around her backyard for an additional 5-7 minutes. She reported that she had called the police and was on the phone with the dispatch. The neighbor then stated that she observed the male walk down the road towards the adult foster home and a white car pulled up and put the male in the car. The neighbor confirmed that the male resident was on her property from 8:15am-8:40am based on viewing her ring camera. The neighbor reported that the police arrived, interviewed her and confirmed that the male was a resident from the adult foster home down the road. The neighbor stated that the police informed her that they are often called to the home for assistance.

A FOIA request was completed through Meridian Township Police Department. After reviewing documents received through the FOIA request, it was confirmed that police were called on 12/19/24 at 8:26am. Through the FOIA request it was confirmed that the male was Resident A. According the FOIA request, Resident A was picked up by a car at 8:41am.

On 12/19/2024, Resident A's *Assessment plan for AFC residents* was reviewed. According to Resident A's assessment plan: "*Moves independently in community: No, staff need to monitor for safety."*

On 12/20/2024, I emailed the licensee designee, Jennifer Bhaskaran to request incident reports for Resident A. I received a response on 12/30/2024, that there was no evidence of an elopement that occurred on 12/19/2024 and no incident report was completed.

On 01/14/2025, I interviewed Guardian A1 via phone. She reported that staff at Van Atta Rd. Home have not notified her regarding Resident A eloping from the facility. Guardian A1 stated that she received a phone call from the police about 10 days ago regarding Resident A eloping to a neighbor's home. Guardian A1 stated that in

the past Resident A would elope from her home, but until contacted by the police she was unaware that this behavior had started again.

Incident reports that were sent via email regarding Resident A were reviewed. According to the incident reports completed, Resident A eloped on the following dates: 12/3/24, 12/9/24 and 12/24/24. According to the incident reports completed on 12/3/24, 12/9/24 and 12/24/24, the guardian received a written notice. No incident report was completed for Resident A's elopement on 12/19/2024, therefore there is no documentation to determine if Resident A's guardian was notified within 48 hours. Although, the three incident reports state that they notified Guardian A1 in writing within 48 hours, Guardian A1 states she was unaware of the elopements until she was contacted by the police for the elopement on 12/24/24.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(e) Elopement from the home if the resident's whereabouts is unknown.** **(3) An incident must be recorded on a department-approved form and kept in the home for a period of not less than 2 years.**
ANALYSIS:	On 12/19/2024, it was determined that an incident report was not completed by direct care workers at Van Atta Rd. Home for the elopement of Resident A. Guardian A1 states she was not notified of any elopements regarding Resident A from staff at Van Atta Rd. Home and was only contacted by the Meridian Township Police Department after the 12/24/2024 elopement. A violation was established based on the 12/19/2024 elopement as there was no documentation to confirm Guardian A1 was notified of this elopement by the licensee or direct care staff. A violation was established as an incident report was not completed for the elopement of Resident A on 12/19/2024 and was not available to be reviewed. The elopement was confirmed through conversations with the neighbor who observed Resident A on her ring camera and called the police. It was also confirmed through the FOIA documents received through Meridian Township Police Department.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
During a phone interview with DCW Gnagi, she reported that she noticed many medication errors when completing her counts at the beginning of her shift. DCW Gnagi reported that she is concerned that the medication errors could be affecting Resident A's behaviors. She reported that she has turned in *Medication Event/Error Incident Report* to her supervisor Daniel Farlin from her weekend shift of 1/11/2025.

On 01/13/2025, I requested *Medication Event/Error Incident Reports* for Van Atta St. Home. None of the *Medication Event/Error Incident Report*s from the weekend of 01/11/2025 were received.

On 01/16/2025, I completed an unannounced onsite investigation to Van Atta St. Home and reviewed resident medication administration documentation. During the review of medications within the home, it was found that Resident A's Concerta 36mg medication was not available for administration from 01/10/2025-01/15/2025. Based on the medication count record that Van Atta Rd. Home uses, six direct care workers signed the form stating that he had zero Concerta left and there was no documented efforts of refilling the medication or obtaining an updated prescription. Based on the incident reports received from DCW Farlin, no incident reports were received regarding Resident A's Concerta 36mg not being available for administration or documentation stating why this medication was not administered from 01/10/2025 through 01/15/2025. According to a *Healthcare Chorological Log*, a call to the pharmacy was placed on 01/15/2025 at 9:15am to have Resident A's Concerta 36mg refilled. I also determined while reviewing the *Healthcare Chorological Log*, Resident C was not administered Gabapentin from 01/15/25 through the time of my onsite investigation on 01/16/25 at 1pm. Per the medication administration record, Resident C receives Gabapentin twice a day.

On 01/16/2025, I reviewed medications for Resident A to confirm the counts were correct. Resident A's prescribed medication bubble packs were viewed as staff are to initial and date next to the pill they pop. The following errors regarding Resident A's medications were found:

- Vitamin D 200 ID, 8pm- The count was off, and he did not receive a dose on 01/12/2025.
- Quetiapine 200mg, 8pm- The count was off and he did not receive a dose on 01/6/25, 01/10/25 and 01/12/2025. He received two pills on 01/11/2025 and the order states only one pill at 8pm.
- Quetiapine 200mg 11am- The count was off and he did not receive a dose on 12/27/24, 12/28/24 and 12/29/24. He received two pills at 11am on either 1/11/25 or 1/12/25. The order states only one pill is to be given at 11am.
- Quetiapine 200mg 7am- The count was off and he received two pills on 01/10/2025 for 7am. The order states only one pill is to be given at 7am.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on review of the medication logs and resident medications, Resident A and Resident C did not receive medications as prescribed on multiple dates in January 2025. It was found that direct care workers are not getting residents medications filled on time, which is causing residents to go days without their prescribed medications. It was also found that direct care workers are not giving medication as it should be given pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
During a phone interview with DCW Gnagi, she reported that she has noticed many medication errors when completing her counts at the beginning of her shift. DCW Gnagi reported that she is concerned that the medication errors could be affecting Resident behaviors. She reported that she has turned in *Medication Event/Error Incident Report*s to her supervisor Daniel Farlin from her weekend shift of 1/11/2025.

On 01/13/2025, I requested *Medication Event/Error Incident Report*s for Van Atta St. Home. None of the *Medication Event/Error Incident Report*s from the weekend of 01/11/2025 were received.

On 01/16/2025, I completed an unannounced onsite investigation to Van Atta St. Home and reviewed resident medication administration documentation.

After reviewing the Medication Administration Record for all residents, it was found that the medication administration record was left blank for the following residents, medications and dates. Therefore, I am unable to determine if the resident missed their medication, was given the wrong medication or was gone from the facility. It should also be noted that I only reviewed medication administration records for January 2025. Resident B's medication record was not reviewed, as it had already been removed from the medication book, as he was discharged on 01/10/2025.

Medication administration record was left blank for Resident A on the following dates:

- *January 5th, 2025 for 11am, Quetiapine*
- *January 5th, 2025 for 11am, Hydroxyzine*
- *January 6th, 2025 for Clonidine HCL*
- *January 3rd and 10th, 2025 for Vitamin D2*
- *January 10th, 2025 for Amantadine 50*

- *January 3rd-9th, 11th, 13th, 14th and 15th for 8pm, Melatonin 5mg*

Medication administration record was left blank for Resident C on the following dates:

- *January 1st, 2nd, 3rd, 7th and 9th, 2025 for 7am, Docusate Sodium*
- *January 9th, 2025 for 8pm, Aption 800mg, Atorvastatin 10mg, Quetiapine 100mg, Epidiolex 100mg, Oyster Shell 500mg, Lamotrigine 150mg, Famotidine 20mg*
- *January 10th, 2025 for 8pm, Epidiolex 100mg, Oyster shell 500mg*
- *January 12, 2025 for 7am, Famotidine 20mg*

Medication administration record was left blank for Resident D on the following dates:

- *January 6th, 2025 for 8pm, Carbidopa-Levodopa, Gabapentin*
- *January 7th, 2025 for 7am, Atenolol, Loratadine, Magnesium, Pantoprazole, Tab-avite, Divalproex, Gabapentin.*

Medication administration record was left blank for Resident E on the following dates:

- *January 9th, 2025 for 8pm, Docusate 100mg, Gemfibrozil 600mg, Loratadine 10mg*
- *January 14th, 2025 for 8pm Gemfibrozil 600mg, Trazadone, Loratadine 10mg, Ferrous sulfate, Docusate*
- *January 15th, 2025 for 8pm, Gemfibrozil 600mg, Trazadone, Loratadine 10mg, Ferrous sulfate, Docusate*
- *January 15th, 2025 for 3pm, Omeprazole*

Medication administration record was left blank for Resident F on the following dates:

- *January 6th, 2025 for 7am, Lisinopril 10mg*
- *January 8th, 2025 for 7am, Lisinopril 10mg*
- *January 8th, 2025 for 3pm, Chlorhexidine*
- *January 10th, 2025 for 7am, Linzess 72.*
- *January 10th, 2025 for 8pm Gabapentin, Temazepam*
- *January 11th, 2025 for 3pm, Clonazepam, Lactulose*
- *January 12th, 2025 for 7am, Divalproex, fish oil, lacosamide*

On 01/16/2025, I interviewed three DCW in person, Ivvy Knowlton, Don Reed and Nicere Lewis. All three reported that there should be no reason why a medication administration record would be left blank as there is a code system to follow if the resident refuse, was gone from the home, etc..

On 01/13/2025, I interviewed DCW Daniel Farlin via phone and he also reported that there should be no reason why a medication administration record would be left blank, as there is a code system to follow, if the medication was not given.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	A violation was established as all residents were missing the initials of the person who administered their medication on multiple days and for multiple medications. I was unable to determine if Residents missed their medication or if the medication administration record was not completed by direct care workers as required. Based on review of the medication administration record, it was determined direct care workers are not properly completing the medication log as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
During a phone interview on 01/13/2025, I was informed through Guardian B1 and a direct care worker, that mouse droppings have been observed in the AFC home. Guardian B1 reported that she observed mouse droppings in a drawer in the kitchen and when moving her son out of the home, a living mouse was observed in the garage. Direct care worker, Leighanna Gnagi reported via phone that she has reported to management that there has been a mouse concern, and she observed a dead mouse in the garage over her weekend shift of 1/11/25.

On 01/16/2025, I completed an unannounced onsite investigation to Van Atta Rd Home. During my walk through of the home, bags of rodent repellant were observed on the floors of the kitchen; therefore, it was apparent that staff were aware that mice were present in the kitchen. The dead mouse that was discussed during a

phone call on 1/13/25 was still present in the garage. Mouse droppings were observed throughout ten cupboards/drawers in the kitchen.

On 01/16/2025, I interviewed three direct care workers (DCW) in person. DCW Ivvy Knowlton reported that she has had two mice jump out at her while working. She reported that she has informed staff of the concern and provided verification of this communication. DCW Knowlton denied knowing about the dead mouse in the garage. She reported that she has not observed a professional rodent control company at the home. I interviewed DCW Don Reed in person. He reported that he does not go into the garage and was unaware of the dead mouse. DCW Reed reported that he has heard other staff talk about mice but has not observed any mice. He has observed traps being laid out but has not seen a professional rodent control company at the home. I interviewed DCW Nicere Lewis in person. He reported that he has not seen any mice and was unaware that mice droppings were in the kitchen. He denied knowing that a dead mouse was in the garage. DCW Lewis stated that he has not observed a professional rodent company at the home.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	During my unannounced onsite investigation, it was apparent that Van Atta Rd Home is not effectively using a rodent control program that is protecting the health of the residents due to the mouse droppings found in ten kitchen cupboards/drawers, along with a dead mouse that has been in the garage for at least five days.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 01/16/2025, I completed a second unannounced onsite investigation to Van Atta Rd. Home. During the on-site investigation, I inspected the kitchen and found the oven to be in disrepair. The oven door was missing a screw, and the glass door was separating from the inside of the oven door on the left side. The oven was also observed to be dirty with crusted on food on the oven door and bottom on the oven.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(6) Household and cooking appliances shall be properly installed according to the manufacturer's recommended safety practices. Where metal hoods or canopies are

	provided, they shall be equipped with filters. The filters shall be maintained in an efficient condition and kept clean at all times. All food preparation surfaces and areas shall be kept clean and in good repair.
ANALYSIS:	The oven was observed on 01/16/25, and the appliance door was broken and appeared to be missing a screw to hold the oven door together. The oven which is used to prepare food was observed to be dirty with crusted food and needing to be cleaned.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 01/16/2025, during an unannounced onsite investigation, I walked through the home. During the walk through, a dead mouse was observed on the floor of the garage, along with two piles of human feces. A puddle of water was next to the human feces, which could have been human urine, as it was located next to the human feces. The dead mouse and two piles of human feces with located in the middle of the garage when entering from the home and should have been observable to any staff who entered the garage. One of the piles of human feces was located on the rug located just inside the garage. I asked direct care worker, Daniel Farlin why human feces were in the garage, and he reported that it must be from a resident.

On 01/16/2025, I also walked through the kitchen and observed all the cupboards/drawers. I opened all the cupboards and drawers and found mouse droppings in ten of the drawers/cupboards. The mouse droppings were mixed in with utensils, food and cooking supplies.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	During my unannounced onsite investigation on 01/16/2025, I walked through the home and observed a dead mouse and human feces in the garage that is accessible and used by residents. In the kitchen I observed mouse droppings in ten of the kitchen cupboards/drawers. Some of the cupboards had food items and the drawers had cooking utensils and cooking supplies. The Van Atta Rd Home did not display adequate housekeeping standards, nor was it observed to be clean during my unannounced onsite investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 01/16/2025, I completed a second unannounced onsite investigation to Van Atta Rd. Home. During the unannounced onsite investigation, I viewed all Resident bedrooms. During the investigation, I viewed Resident C's bedroom, which she shares with another resident. During my observations, Resident C's sheets and comforter were not fully covering her mattress. I did view a sheet and comforter on top of her mattress, but no mattress cover was observed. Resident C's mattress was exposed and was observed to be stained, dirty and worn out.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a waterbed is not prohibited by this rule.
ANALYSIS:	During my unannounced onsite investigation, I viewed Resident C's mattress to be unprotected, dirty, stained and in poor condition, therefore a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license due to the quality of care violations and physical plant violations.

02/04/2025

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Amanda Blasius Date
Licensing Consultant

Approved By:

02/04/2025

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Dawn N. Timm Date
Area Manager