GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 17, 2025

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

RE: License #: AS250010919
Investigation #: 2026A0779001
Maple Road Home

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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
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 #:	AS250010919
Investigation #:	2026A0779001
Complaint Receipt Date:	10/09/2025
Investigation Initiation Date:	10/10/2025
Report Due Date:	12/08/2025
Licensee Name:	Alternative Services Inc.
LicenseeAddress:	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:	Maple Road Home
Facility Address:	4341 W. Maple Avenue Flint, MI 48503
Facility Telephone #:	(810) 655-0711
Original Issuance Date:	11/05/1990
License **Status:**	REGULAR
Effective Date:	11/15/2023
Expiration Date:	11/14/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff, Alexis Lewis, was found sleeping on shift during the morning on 10/6/2025, with all residents present in the home. On 9/29/2025, staff Lakeida Whitaker, was in a car in the driveway at 3:30am instead of in the home monitoring the residents.	Yes

III. METHODOLOGY

10/09/2025	Special Investigation Intake 2026A0779001
10/10/2025	Special Investigation Initiated - Telephone Voicemail left at ORR.
10/10/2025	APS Referral Complaint was referred to APS centralized intake.
10/22/2025	Inspection Completed On-site
10/23/2025	Contact - Telephone call made Spoke with staff person, Alexis Lewis.
10/23/2025	Contact - Telephone call made Spoke with staff person, Lakeida Whitaker.
10/23/2025	Contact - Telephone call made Spoke with administrator.
11/13/2025	Exit Conference Held with licensee designee, Jennifer Bhaskaran.

ALLEGATION:

Staff, Alexis Lewis, was found sleeping on shift during the morning on 10/6/2025, with all residents present in the home. On 9/29/2025, staff Lakeida Whitaker, was in a car in the driveway instead of in the home monitoring the residents.

INVESTIGATION:

On 10/22/2025, an on-site inspection was conducted and administrator, Candy Hamilton was interviewed. Admin Hamilton stated that both Resident A and staff person,

Danisha Johnson, claimed to have witnessed staff person, Alexis Lewis, sleeping during her shift on 10/6/2025. Admin Hamilton stated that Resident A said she observed Staff Lewis on the couch at 4:45am sleeping and Staff Johnson said she observed Staff Lewis in the living room chair at 5:55am sleeping. Admin Hamilton reported that when she asked Staff Lewis about this, Staff Lewis admitted to sleeping in the chair but claimed that it was after her shift ended and when Staff Johnson had already arrived. When asked about staff person, Lakeida Whitaker, Admin Hamilton stated that on 9/29/2025, Staff Johnson arrived to work early and witnessed Staff Whitaker sitting in a car in the driveway. Admin Hamilton stated that Staff Whitaker admitted that she was outside after a friend brought her some food and that she was in the friend's car eating.

On 10/22/2025, staff person, Danisha Johnson, stated that on 10/6/2025, she arrived to work at 5:55am and observed Staff Lewis sleeping in the living room chair. Staff Johnson stated that she tapped Staff Lewis on the shoulder, but she did not wake up, so she went to check on a resident. Staff Johnson reported that no residents were awake at that time and that Staff Lewis woke up about 10-15 minutes later. When asked about what happened on 9/29/2025, Staff Johnson stated that she arrived to work very early that morning at 3:40am and observed Staff Whitaker sitting a car in the driveway with another person. Staff Johnson stated that Staff Whitaker got out of the car when she noticed her pull in and said that her friend had brought her some food. Staff Johnson stated that she has no idea how long Staff Whitaker had been outside before she arrived. Staff Johnson reported that Staff Whitaker went into the home and she stayed in her car until her shift started, so she does not know if any residents were awake at that time.

On 10/22/2025, Resident A was interviewed. Resident A stated that one night recently, she got up at around 4:45am and observed Staff Lewis sleeping on the couch. Resident A could not remember the date of this occurrence. Resident A stated that she got a drink of water and went back to bed and did not try to wake Staff Lewis. Resident A stated that no other residents were awake at this time. Resident A reported that this was the first time ever seeing Staff Lewis sleeping at work and that she has never witnessed Staff Whitaker sleeping or being outside during the night.

On 10/22/2025, home manager Rachel White, stated that all the residents of this home are quite independent and that Resident B is the only resident who might need help during the night. HM White stated that Resident B is known to lay in a wet or soiled brief and would need staff assistance to change her. HM White stated that Resident B can physically change herself but will commonly sit in a dirty brief and then ask staff for help. HM White reported that all the other residents may occasionally get up during the night to get a drink or use the bathroom but would not require any assistance to do so.

All the residents' *Assessment Plan for AFC Residents* were reviewed. The plans confirmed that all four residents are quite independent, are all mobile, able to complete all activities of daily living on their own and do not require any enhanced staff supervision. Resident B's plan states that she can physically complete her ADLs (Activities of Daily Living) but will ask staff for assistance.

On 10/23/2025, a phone interview was conducted with staff person, Alexis Lewis, who denied she has ever slept during her shift or has laid on the couch. Staff Lewis stated that on 10/6/2025, she waited until Staff Johnson arrived to the home and she then took a nap in the chair, while waiting for her ride to come. Staff Lewis stated that she does not remember Resident A or any other resident getting up during the night of 10/6/2025.

On 10/23/2025, a phone interview was conducted with staff person, Lakeida Whitaker, who stated that on 9/29/2025 she arrived to work at 10:00pm and did all her chores and paperwork for the night. Staff Whitaker stated that Resident C stayed up until almost 3:00am that night and that after Resident C went to bed, she called a friend who delivers food for Door Dash. Staff Whitaker admitted that she went outside to smoke and waited for her friend to deliver her food. Staff Whitaker stated that she was only outside for maybe 10 minutes before Staff Johnson arrived to the home and she denied that she ever sat in her friend's car. Staff Whitaker claimed that she was getting her food from her friend's car when Staff Johnson pulled up, but that she never sat down inside the car. Staff Whitaker stated that no residents were up and/or awake when she went back inside the home.

On 10/23/2025, Admin Hamilton stated that they have a no smoking on shift policy, which is in writing in the staff handbook, that staff sign acknowledging this. Admin Hamilton stated that when she questioned Staff Whitaker about this incident, Staff Whitaker told her that she was outside smoking and that she actually finished eating her food while outside. Admin Hamilton stated that Staff Whitaker said she was outside for about 20 minutes. Admin Hamilton reported that she is not aware of any residents being up and/or awake during that time.

On 11/13/2025, an exit conference was held with licensee designee, Jennifer Bhaskaran. LD Bhaskaran confirmed that they have a policy prohibiting staff from smoking while on shift and that no staff should be spending any extended length of time outside, when they are the only staff person on shift. LD Bhaskaran stated that both Staff Lewis and Staff Whitaker have been terminated and no longer are employed at this home.

Special Investigation Report #2025A0779010 dated December 30, 2024, cited this home for lack of staff on shift. It was found that the only staff on shift at the time was found sleeping in her car, leaving no staff inside the home to supervise the residents. On January 22, 2025, a corrective action plan (CAP) was submitted by licensee designee, Jennifer Bhaskaran. The CAP stated that the staff in question was terminated and that the rest of the staff was retrained on policies regarding proper supervision and protection of residents.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection

	of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	On 9/29/2025, staff person, Lakeida Whitaker, was seen by staff person, Danisha Johnson, to be sitting in a car in the home's driveway at approximately 3:40am. Staff Whitaker was the only staff person on shift at that time. Staff Whitaker told administrator Candy Hamilton that she was outside for 20 minutes eating the food she had delivered to the home. When interviewed, Staff Whitaker admitted that she went outside to smoke and to retrieve the food she had delivered to the home. Staff Whitaker admitted that she was outside the home for 10 minutes. There was sufficient evidence found to prove that Staff Whitaker was the only staff person on shift during the night of 9/29/2025 and that Staff Whitaker spend an extended length of time outside the home, leaving the residents unsupervised.
CONCLUSION:	**REPAT VIOLATION ESTABLISHED** **SIR #2025A0779010 dated December 30, 2024**

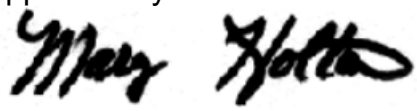
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, I recommend the status of this license remain unchanged.

11/17/2025

Christopher Holvey — Date
Licensing Consultant

Approved By:



11/17/2025

Mary E. Holton — Date
Area Manager