



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 27, 2026

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

RE: License #: AS330011149
Investigation #: 2026A0622018
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.
- 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) 335-5985.

Sincerely,

A handwritten signature in black ink, appearing to read 'Amanda Blasius', written in a cursive style.

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**

I. IDENTIFYING INFORMATION

License #:	AS330011149
Investigation #:	2026A0622018
Complaint Receipt Date:	01/16/2026
Investigation Initiation Date:	01/16/2026
Report Due Date:	03/17/2026
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:	1ST PROVISIONAL
Effective Date:	10/14/2025
Expiration Date:	04/13/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the AFC home unnoticed for up to five hours, despite three staff members working. It was later found that she traveled to Ohio with an unknown man.	No
The home has had bed bugs for many months and residents have bites.	No
Additional Findings	Yes

III. METHODOLOGY

01/16/2026	Special Investigation Intake 2026A0622018
01/16/2026	Special Investigation Initiated – Email to Guardian A1
01/21/2026	APS Referral made
01/23/2026	Additional allegations were received regarding bed bugs within the home.
01/27/2026	Contact- Telephone call to Resident A
01/28/2026	Inspection completed onsite
01/29/2026	Contact - Document Received from direct care worker, Samantha Hagerman
02/19/2026	Contact - Telephone call made to direct care workers, Caitlin Allen, Lacy Carol, Ronneshia Suggs and Nicere Lewis
02/20/2026	Contact - Telephone call made to direct care worker, Denandra Embry
02/20/2026	Inspection Completed-BCAL Sub. Compliance
02/24/2026	Contact- Telephone call made to direct care worker, Giovanni Austin
02/25/2026	Contact- Telephone call made to direct care worker, Caitlin Austin
02/27/2026	Exit Conference with licensee designee, Jennifer Bhaskaran

ALLEGATION: Resident A eloped from the AFC home unnoticed for up to five hours, despite three staff members working. It was later found that she traveled to Ohio with an unknown man.

INVESTIGATION:

On 01/16/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A walked out of the AFC at an unknown time on 12/17/2025. The complaint stated that on-call and management were called when it was noticed that Resident A was missing. According to the complaint, three direct care staff were on shift and did not notice that Resident A was missing for five hours. The complaint stated that Resident A left the home with an unknown man and headed for Ohio on 12/17/2025. The complaint also stated that the police and Guardian A1 were not informed until 12/19/2025. According to the complaint, Resident A reported that when she left, there was a staff member on the couch, another at the kitchen counter and the third was in another residents bedroom, when she left the home out the front door.

On 01/16/2026, I contacted Guardian A1 via email. Guardian A1 reported that an on-call manager went to the home on 12/17/25, found that Resident A was missing and called 911 and the on-call number for the guardian services. Guardian A1 reported that she worked with the manager, Lacy and the police to locate Resident A in Ohio and bring her back home safely. Guardian A1 stated that Resident A is planning to move to another adult foster home on 01/20/26. Guardian A1 stated that Resident A was picked up by a married couple from Ohio and as far as she knows she was not injured. Guardian A1 reported that Resident A is fully guarded and stated that she no longer has use of a cell phone. Guardian A1 provided contact information for Resident A for her new adult foster home.

On 01/27/2026, I interviewed Resident A via phone. Resident A reported that she ran away from the home. She stated that she met a couple online and was dating them. Resident A explained that the couple was from Toledo, Ohio, but had a friend in Michigan that could bring her to Ohio. She stated that the friend picked her up at the home around 10:30pm and took her to their home in Ohio. Resident A could not remember the dates or days of the week when she eloped from the facility. Resident A confirmed that three staff members were working when she left, one was in the medication room, one was in the kitchen by the window, and one was on the couch doing paperwork or reading a book. Resident A reported that she went out the front door and none of the staff members saw her. She explained that she told the friend to only pull up halfway in the driveway, so staff would not notice. She also stated that all the other residents were in their bedrooms when she left. Resident A reported that staff did not notice she was gone until 6am the following morning. She explained that a staff member Denandra Embry called her on Facebook Messenger and was then able to figure out where she was. Resident A reported that the police arrived at the home in Ohio and told her that she needed to go with them. The police then took Resident A to the Ann Arbor police station where a staff member from Van Atta picked her up. Resident A reported that she was not hurt and when she arrived in

Ohio, she spent most of the night staying up on Tik Tok and then when she did go to sleep, she was woken up as the police were there to take her back to Michigan.

On 01/28/2026, I completed an unannounced onsite investigation to Van Atta Rd. Home. During the investigation I viewed paperwork and interviewed staff working. Resident A was no longer living at the home on 01/28/2026 and had been moved to another AFC.

On 01/28/2026, I interviewed direct care worker, Rachelle Riley in person. She reported that she was not working when Resident A walked out the front door. She stated that when she has worked an overnight shift, Resident A is usually up most of the night on her phone and comes in and out of the kitchen so it's not unusual for Resident A to be awake during the evening.

On 02/19/2026, I interviewed direct care worker, Caitlin Allen via phone. She reported that she no longer works at Van Atta, as she was told that it was not a behavioral home when she started and felt untrained or prepared to work there. DCW Allen stated that she was working at the home when Resident A eloped from the facility through the front door. DCW Allen reported that she worked 12/19/26 and came in at 10pm and worked until 7am. She stated that it was her first shift working overnight. DCW Allen reported that she did see Resident A on her shift after Resident A came out to the kitchen in regular clothes and not pajama pants but she did not think anything about it. She stated that Resident A was on her phone when she saw her. DCW Allen stated that she was probably sitting on the couch reading her book when Resident A left and she did not see her leave or hear the door open. She explained that the other two staff members were in the kitchen, one at the counter and one at the dining room table. DCW Allen reported that throughout the night, they checked on all the other residents, but were not required to check on Resident A, therefore they assumed she was sleeping. DCW Allen reported that when first shift came before 6am, they noticed that Resident A was not at the home. They then called the on-call manager and 911 after no one could find her in the home. DCW Allen reported that the worker that came in at 6am mentioned that Resident A was talking about leaving with a couple the day before and going to Ohio and that staff member told her it was not a good idea. DCW Allen stated that she is unsure if this person told second shift, but none of the information was reported to third shift.

On 02/19/2026, I interviewed direct care worker, Lacy Carol via phone. DCW Carol reported that she was on-call for Van Atta as the home manager was on vacation. DCW Carol stated that on 12/19/25 around 9:30pm/10pm, she stopped into Van Atta to check on things, but was there very briefly. During the time of her stop, Resident A was in the home. She explained that on Saturday morning 12/20/2025 around 5:45am she received a phone call from DCW Ronneshia Suggs stating that Resident A was not in the home and staff could not find her. DCW Carol stated that staff were calling the police to report Resident A missing. DCW Carol reported that she went to the home and shortly after she arrived the police arrived. DCW Carol stated that she

assisted the police in trying to find Resident A and also called Guardian A1. DCW Carol stated that another staff member was able to connect with Resident A on Facebook messenger. The other staff member was able to find out she was in Ohio and then found her location by using Snapchat. The location was shared with the police and they were able to send an officer to the home.

On 02/19/2026, I interviewed direct care worker, Nicere Lewis via phone. DCW Lewis stated that he was working on 12/19/2025 when Resident A eloped from the facility. DCW Lewis explained that he came in for his shift around 10pm and went into the medication room to count the medications. He explained that he saw Resident A in the home that night, around 12am/1am and she did have a backpack on her arm, along with her jacket on. DCW Lewis stated that now he realized he should have asked her more about why her jacket was on, but he did not question her. DCW Lewis reported that around 12am/1am, he went out to get a water from his car and he did not observe Resident A follow him out and she was not in the common areas when he came back in, therefore he assumed she went to bed. DCW Lewis stated that the other two staff members that were working were sitting in the kitchen counter and dining room. He explained that Resident A will sometimes sleep all night, but sometimes she is up on her phone and in and out of her room getting snacks. DCW Lewis stated that he thinks that it was DCW Caitlin Allen who noticed Resident A missing around 5:45am. DCW Lewis reported that they then called the on-call manager and the police.

On 02/19/2026, I interviewed direct care worker, Ronneshia Suggs via phone. She reported that on 12/18/2025 she worked at the home and Resident A told her about meeting a couple from Ohio online. DCW Suggs stated that Resident A also told her that the couple had a friend in Michigan that could take her to Ohio. Resident A explained to DCW Suggs that she was not going to do it though. DCW Suggs stated that Resident A did not sound serious about this and often talks about people she meets online, therefore she didn't think there were any current safety concerns. DCW Suggs also reported that she told Resident A that it was not a good idea to go to Ohio and it would not be safe for her. DCW Suggs stated that she came into the home on 12/20/2025 for her morning shift around 5:30/5:45am. She explained that she had a funny feeling and went straight to Resident A's bedroom to see if she was there and found her to be gone. DCW Suggs stated that she asked the other direct care workers where Resident A was and they all stated that she was in her bedroom and she informed them she was not there. DCW Suggs stated that they all started to look around the home and could not locate Resident A. DCW Suggs stated that she called the on-call manager, Lacy Carol and 911 to report Resident A missing.

On 02/20/2026, I interviewed direct care worker, Denandra Embry via phone. She reported that on the morning of 12/20/25 she was contacted by the on-call manager, Lacy Carol to assist with finding Resident A. DCW Embry stated that she was not friends with Resident A on Facebook, but had seen her on there and was able to call her on messenger. DCW Embry stated that Resident A answered the call on the second or third call. DCW Embry explained that she did observe a gentleman on the

bed, therefore she tried to keep the conversation very normal and let Resident A know if she needed anything to reach out. DCW Embry stated Resident A told her that she was in Ohio but did not disclose her location. DCW Embry reported that she then sent Resident A a Snapchat request and once she approved the request, she was able to get her location and address of where she was. DCW Embry stated that she provided the address to DCW Lacy Carol, who shared it with the police.

On 02/24/2026, I interviewed direct care worker, Giovanni Austin via phone. DCW Austin stated that she was working on 12/19/2025 when Resident A eloped from the facility and went to Ohio. DCW Austin stated that he arrived at the home at 10pm and did not see DCW Lacy Carol during his shift. DCW Austin stated that he saw Resident A at least once during his shift, but she was in her room a lot. DCW Austin stated that he was sitting in the living room and the front door swung open around midnight. DCW Austin stated that he and his co-workers were confused. They checked Resident A's bedroom, and she was not there and they also checked the rest of the house and did not find Resident A. DCW Austin stated that staff were not sure what to do and had other duties such as cleaning and caring for the other residents, therefore they did not call management. DCW Austin stated that when DCW Ronneshia Suggs arrived around 5:45am and she initiated calling management and 911. DCW Austin confirmed again, that staff were confused that Resident A was gone and did not report her missing at midnight and waited until another staff member came in at 6am.

On 02/25/2026, I contacted direct care worker, Caitlin Allen via phone again. She confirmed again that she was unaware that Resident A was missing until 5:45am.

I viewed Resident A's *Assessment Plan for AFC Residents*. It stated the following: "**Moves independently within the community:** No, needs supervision for safety reasons.

Controls sexual behavior: No, history of being sexually abused. Staff need to assist with making good choices. [Resident A] has no stranger danger and could be taken advantage of.

Hobbies/Special interests: Loves to use her phone and video chat with friends.

Family/Friends: Staff encourage good choices when finding friends on the internet and has a history of inviting strangers to the home. Can be manipulating others and can be manipulated by others."

Resident A's annual treatment plan dated 05/28/2025 was reviewed. No documentation was found stating that Resident A needs hourly or staff check in's during sleeping hours.

I viewed a *Community Mental Health of Clinton, Eaton and Ingham Counties General Incident Report* was viewed. The incident report was completed by direct care worker, Nicere Lewis on 12/19/25. The incident report stated the following:

“Prior to the event, [Resident A] was talking to staff about her job. After the conversation [Resident A] went to her bedroom and said she was going to bed. At 5:45am, staff came in to relieve night staff. While doing rounds, staff noticed [Resident A’s] bed was empty. Staff began checking rooms and outside. After not locating her, staff called management and 911.”

I viewed an *AFC Licensing/Division Incident/Accident Report*. The report was dated 12/20/2025. The *AFC Licensing/Division Incident/Accident Report* stated the following:

“Explain what happened: At 3:30am [Resident A] was up talking with staff about her job and then she was going to go to her bedroom and go to bed. At 5:45am during a bed check it was discovered that [Resident A] was not in her room or bed. Staff immediately looked thru [sic] the house and did not locate her. Staff then called 911 to report the incident and then phoned management.

Action taken by staff: DCW Lacy Carol contacted Tamie Stevens at 5:57am to report that [Resident A] was not in the home and they could not locate her. [Resident A] was last seen by staff at 3:30am. DCW Stevens instructed DCW Carol to call 911, which they have already done. DCW Stevens then asked DCW Carol if they had [Resident A’s] personal cell phone number and at the time they did not, but she was going to call staff to see if they had it. DCW Carol was able to reach DCW Denandra Embry, who did not have [Resident A’s] number but would try Facebook. At 6:20am DCW Carol called DCW Stevens and reported that staff attempted to call [Resident A] four times on messenger, but she did not answer. Staff would keep trying. At 6:32am, DCW Carol informed DCW Stevens that staff were going to drive around the local trailer park and see if they could locate [Resident A]. At 6:45am, DCW Carol informed DCW Stevens that staff could not locate Resident A at the local trailer park, but DCW Denandra Embry was able to talk with Resident A on messenger. [Resident A] told DCW Embry that she was in Ohio with a male and staff asked her to show the house and road, which [Resident A] did. DCW Embry was able to screenshot the video. At 7:12am, the Meridan Township Police arrived at Van Atta and staff provided staff with the screenshots from the call with [Resident A]. Meridan Township Police were going to contact the Toledo police department and have them go home. At 8:36am, DCW Carol contacted Guardian A1 via phone. DCW Carol provided Guardian A1 with the screenshots. Guardian A1 was able to google map the screenshot and found the address of 5106 Kellog in Ohio. At 9:05am, DCW Carol called Meridan Township Police and gave them the new address. The police stated that [Resident A] was not found at the address of 5102 Kellog, but they would relay the new address to the Ohio police department. At 9:41am, DCW Carol received a phone call from Meridan Township Police stating that they found Resident A and she was enroute to the Toledo Police department. At 9:47am, DCW Carol received a phone call from Toledo Police Department giving her an address to pick up [Resident A]. DCW Carol made arrangements for staff to pick up [Resident A] to pick up Toledo. At 10:03am, DCW Carol received a call stating that Toledo Police would meet a staff member in Ann Arbor.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based upon documentation reviewed and interviews with direct care workers, it was determined that direct care workers were providing supervision, protection and personal care in accordance with Resident A's assessment plan. Resident A did not require hourly checks and did not require constant supervision during waking or sleeping hours. All three direct care workers who were working during the overnight shift on 12/19/2025 confirmed that they viewed Resident A on their shift at some point within the evening and during rounds at 5:45am, it was determined that Resident A was not in her bedroom, nor in the home. A violation was not established as according to Resident A's <i>Assessment Plan for AFC Residents and Treatment Plan</i> staff were not required to complete hourly checks, nor provide constant supervision during sleeping hours.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.693	Incident notification, incident records.
	(2) If an elopement occurs, facility staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the initiation of the search, staff shall contact law enforcement.

ANALYSIS:	An AFC Licensing/Division Incident/Accident Report was completed and stated that once it was determined that Resident A was missing, a search of the home was conducted immediately, then followed up by calling 911 and management. During the incident, three direct care workers were on shift and all three were interviewed. Two of the three confirmed that they were not aware Resident A was missing until 5:45am, then they completed a search and called 911. One of the direct care workers reported that he was aware that Resident A was missing at midnight on 12/20/2025 and was unsure what to do and was confused, therefore the police nor management was notified until another staff member, Ronneshia Suggs arrived for her shift at 5:45am and called 911. Due to two direct care workers confirming that they were unaware that Resident A was missing until 5:45am, a violation was not established as a search was completed at 5:45am and then the police were notified within 30 minutes. There is not 51% preponderance of evidence to find a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The home has had bed bugs for many months and residents have bites.

INVESTIGATION:

On 01/23/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, bed bugs have been present within the home since October 2025. The complaint stated that the concerns have been reported to management, but bed bugs were still present as of 1/23/26. According to the complaint, Orkin has been treating the home, but residents still have bed bug bites along with staff members.

On 01/23/2026, I obtained more information from Complainant. She reported that she was unsure which room the bed bugs were in, but Residents B and C were getting bites. Complainant reported that Orkin has been out to the home a few times, but the bites were still occurring for the residents. She also reported that she has received bites from the bed bugs and that all staff were aware that bed bugs were in the home.

On 01/28/2026, I completed an unannounced onsite investigation to Van Atta. During the unannounced onsite investigation, I viewed the beds of all four residents within the home. No bed bugs were observed within the home.

On 01/28/2026, I interviewed direct care workers during the unannounced onsite investigation. Residents were unable to be interviewed as they were all non-verbal.

On 01/28/2026, I interviewed direct care worker, Eric Seadorf in person. He reported that the bed bugs have been present for at least six months. He reported that he ended up getting bites and brought them to his personal home. DCW Seadorf stated that he is aware that the home has been treated three times by Orkin. He reported that the first treatment, the residents and staff had to be out of the home for 4-6 hours. The second treatment, they sprayed just one bedroom and the third time they came was to check and confirmed no bugs were present in the home.

On 01/28/2026, I interviewed direct care worker, Brittany Harper in person. She reported that she saw a bed bug about two weeks ago. She stated that bed bugs have been present in the home for many months. DCW Harper explained that she assumes a guest of a resident brought the bed bugs into the home, as she has only seen them in two bedrooms and only two residents have received bites. DCW Harper stated that Orkin has completed a spray treatment.

On 01/28/2026, I interviewed direct care worker, Rachelle Riley in person. She reported that she has been employed since the end of November and bed bugs were present then. DCW Riley explained that bed bugs were presents in Resident B and Resident C's bedrooms. DCW Riley stated that Orkin just recently treated the home.

On 01/29/2026, direct care worker, Sam Hagerman provided documentation from Orkin regarding their bed bug treatments. According to the documentation from Orkin the following treatments occurred:

1. October 1st, 2025: investigated and treated all areas of concern with crossfire bed bug concentrate with a compressed sprayer.
2. October 15th, 2025: Investigated/treated all areas. Noticed a significant amount of bed bug activity. Treated with phantom termiticide insecticide with a compressed sprayer in the bedrooms and common areas.
3. December 29th, 2025: preventative and treatment provided with crossfire bed bug concentrate with a compressed sprayer to common area
4. January 13th, 2026: treatment provided with crossfire bed bug concentrate with a compressed sprayer to bedroom, bed and common areas.
5. January 28th, 2026: Inspection completed and no bed bug activity was found.

On 01/29/2026, direct care worker Sam Hagerman, who identifies as the home manager stated that bed bugs were reported to her on 9/27/25. She reported that Orkin came out on 09/29/25 and confirmed that bed bugs were in the home. On 10/01/25, Orkin completed its first treatment for bed bugs. DCW Sam Hagerman stated that staff reported in December that bed bugs were still present, therefore she called them to come back out for treatment.

APPLICABLE RULE	
R 400.645	Environmental Health
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.
ANALYSIS:	Based on the interviews with direct care workers and documentation reviewed, it was determined that Van Atta Rd. Home has had a pest control program effective since September and has been effectively following the recommendation of Orkin, as they treated for bed bugs within the home. As of 01/28/2026, Orkin, a pest control program confirmed that the home has no bed bug activity. No violation was established, as Van Atta Rd. Home has maintained a pest control program to treat bed bugs within the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/29/2026, I completed an unannounced onsite investigation to Van Atta Rd. Home. During the unannounced onsite investigation, I viewed all beds to inspect for bed bugs. During the inspection, I viewed Resident C's bedding. His mattress cover was viewed to have multiple stains near the head of bed and foot of the bed. The mattress cover had large circles that appeared in the color of brown/red.

APPLICABLE RULE	
R 400.669	Linens.
	(1) A licensee shall provide all of the following: (a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed. (b) At least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident. (c) Bath towels and washcloths.

ANALYSIS:	During the unannounced onsite investigation, all bedding was viewed due to the allegations of bed bugs. During the inspection of bedding, it was found that Resident C's mattress cover had multiple stains near the head and foot of the bed. The mattress cover did not appear clean, nor in good condition, therefore a violation was established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same which is a provisional status.



02/26/2026

Amanda Blasius
Licensing Consultant

Date

Approved By:



02/27/2026

Dawn N. Timm
Area Manager

Date