



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 6, 2021

Ronda Freeman-McDonald
Altum Care Homes, LLC
23408 Plum Hollow
Southfield, MI 48033

RE: License #: AS630399707
Investigation #: 2021A0611026
The Strides House

Dear Ms. Freeman-McDonald:

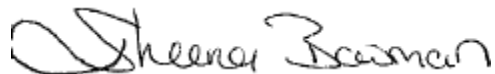
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,

A handwritten signature in dark ink, appearing to read "Sheena Bowman". The signature is fluid and cursive, with the first name "Sheena" written in a larger, more prominent script than the last name "Bowman".

Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630399707
Investigation #:	2021A0611026
Complaint Receipt Date:	07/30/2021
Investigation Initiation Date:	07/30/2021
Report Due Date:	09/28/2021
Licensee Name:	Altum Care Homes, LLC
Licensee Address:	23408 Plum Hollow Southfield, MI 48033
Licensee Telephone #:	(313) 377-3776
Administrator:	Ronda Freeman-McDonald
Licensee Designee:	Ronda Freeman-McDonald
Name of Facility:	The Strides House
Facility Address:	21380 Mada Southfield, MI 48075
Facility Telephone #:	Unknown
Original Issuance Date:	06/28/2019
License Status:	REGULAR
Effective Date:	12/28/2019
Expiration Date:	12/27/2021
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
While investigating a current special investigation for Plum Hollow House #2021A0611025, it was discovered that Resident S was taking an Uber/Lyft to Plum Hollow House after work because there wasn't any staff at the Strides House. Another incident happened in March/April 2021 where a staff member had an emergency and left the home before she received coverage.	Yes

III. METHODOLOGY

07/30/2021	Special Investigation Intake 2021A0611026
07/30/2021	Contact - Document Received On 07/29/21, I received a copy of Resident S IPOS.
07/30/2021	Special Investigation Initiated - Telephone I received a return phone call from Ms. McDonald. Ms. McDonald stated she will provide the addendum to Resident S behavioral assessment plan.
08/03/2021	Inspection Completed On-site I completed an unannounced onsite. I interviewed Resident M and Resident B. I received a copy of the resident register.
08/04/2021	Exit Conference I completed an exit conference with the licensee designee, Ronda Freeman-McDonald via email.

ALLEGATION:

While investigating a current special investigation for Plum Hollow House #2021A0611025, it was discovered that Resident S was taking an Uber/Lyft to Plum Hollow House after work because there wasn't any staff at the Strides House. Another incident happened in March/April 2021 where a staff member had an emergency and left the home before she received coverage.

INVESTIGATION:

As the result of the allegations that were reported in the special investigation of Plum Hollow House #2021A0611025 it was discovered that Resident S was taking an Uber/Lyft to Plum Hollow House after work because there wasn't any staff at the Strides House because the staff would be picking up the other residents from workshop during

this time. There was another incident that happened in March/April 2021 where a staff member had an emergency and left the home before she received coverage, a separate intake was created for The Strides House on 07/30/21.

On 07/28/21, I interviewed staff member Corvette Blunt. Regarding the allegations, Ms. Blunt denied all of the residents from the Strides House getting in an Uber/Lyft to come to Plum Hollow house. Ms. Blunt stated Resident S was the only resident from the Strides House that was allowed unsupervised community access. Resident S was allowed to utilize public transportation including Uber/Lyft to and from work and; she could take walks without staff per her assessment plan. Ms. Blunt stated there were instances where she was scheduled to work at the Strides House and she would leave to pick up the residents from workshop. During this time, Resident S would be at her job. Resident S would get off from work during the time Ms. Blunt would leave the home to pick up the other residents from workshop. Therefore, Resident S would take an Uber/Lyft to Plum Hollow house and Ms. Blunt would pick her up after she finished picking up the other residents from workshop and transport them back to the Strides House. Ms. Blunt stated Resident S would take an Uber/Lyft to Plum Hollow house to prevent her from having to wait outside of the Strides House unsupervised until Ms. Blunt returned from transport as there wasn't another staff on duty. Resident S was discharged from the Strides House on or about 07/17/21.

On 07/28/21, I interviewed staff member Shana Wilson. Ms. Walker stated as far as she knows, no residents from the Strides House have ever been transported in an Uber to the Plum Hollow house.

On 07/28/21, I interviewed the licensee designee, Ronda Freeman-McDonald. Regarding the allegations, Ms. McDonald stated around March or April 2021, a staff member at the Strides House received a phone call that her husband was shot and being rushed to the hospital. The staff member contacted Ms. McDonald to inform her of the incident. Ms. McDonald could not find coverage therefore; she called an Uber to pick up the four residents from the Strides House and transport them to the Plum Hollow house. Ms. McDonald monitored the Uber on her cell phone. The staff at the Plum Hollow House were made aware that the residents from the Strides House were coming over.

Ms. McDonald stated the two homes are one mile apart and the ride in the Uber was three minutes. Ms. McDonald met the residents from the Strides House at the Plum Hollow house. Ms. McDonald then transported the residents back to the Strides House and supervised them for the rest of the shift. Ms. McDonald stated Resident S may have been included in the total number of residents that were transported in the Uber but she is not sure. Ms. McDonald stated it is not written in the other resident's assessment plans that they can utilize Uber/Lyft without staff supervision. An incident report was not completed. Ms. McDonald stated currently there is one staff per shift due to lack of staff. Ms. McDonald also provides care at her AFC group homes to help the other staff member.

Ms. McDonald confirmed that Resident S would take an Uber/Lyft to Plum Hollow House after work and a staff from the Strides House would pick her up and transport her back to Strides House.

On 07/29/21, I received a copy of Resident S IPOS. The IPOS is dated for 09/09/20. According to Resident S IPOS, Resident S has independent community access through her behavioral plan and IPOS and she needs to be with staff at all times in the community at a 1 to 3 staff ratio. The IPOS also states that Resident S can attend the library twice a month and go walking once a week with staff supervision.

On 07/30/21, I received a return phone call from Ms. McDonald. Ms. McDonald stated there is an addendum to Resident S behavioral assessment plan which indicates she can have unsupervised access in the community and can utilize public transportation. Ms. McDonald agreed to provide a copy of Resident S's most recent behavioral assessment plan.

On 08/02/21, I received a copy of Resident S behavioral assessment plan. The behavioral assessment plan is dated for 12/03/20. According to the assessment plan, Resident S must remain within eyesight of staff when accessing the community, with the exception of when she is at work. In order for Resident S to have community access for the purpose of working, she was required to select a job that did not interfere with her medication schedule, she had to inform staff of her work schedule promptly, and she had to return to the home from work within 30 minutes of her shift ending. Resident S was also permitted to access the community when she was with her parents for four hours per week.

On 08/03/21, I completed an unannounced onsite. I interviewed Resident M and Resident B. I received a copy of the resident register.

On 08/03/21, I interviewed Resident M. Regarding the allegations, Resident M stated she likes living at the AFC group home. There are a total of three residents currently residing at the AFC group home. Resident S was discharged on 07/17/21. Resident M stated around June 2021, staff member, Lisa Gemes family was sick and she needed to leave. Resident M stated an Uber was called and Ms. Gemes waited for the Uber to arrive to the AFC group home before she left. Resident M stated she and Resident S, and Resident R got into the Uber without a staff member accompanied them. Resident M, Resident S, and Resident R were transported to Plum Hollow House around 4:00 pm and they returned to their AFC group home after 11:00 pm. Resident M stated there was one staff member at the Plum Hollow House and there were five other residents at this home.

Resident M stated there was another incident when another staff member had to leave because their daughter was sick. Resident M stated a staff member from Plum Hollow House came to the AFC group home and picked up all four residents and transported them to Plum Hollow House. The residents were taken to Plum Hollow House around 5:00 pm and they returned to their AFC group home around 11:30 pm.

On 08/03/21, I interviewed Resident B. Resident B denied any problems at the AFC group home. Resident B is not aware of any situation where any of the residents had to take an Uber to another AFC group home. Resident B stated there is always a staff member at the AFC group home and she is never left alone.

On 08/03/21, I reviewed the resident register. There are currently three residents residing in the AFC group home.

On 08/04/21, I completed an exit conference with the licensee designee, Ronda Freeman-McDonald via email. Ms. McDonald was informed that a corrective action plan will be required.

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:	<p>According to staff member, Ms. Blunt, there were instances where Resident S would have to take an Uber/Lyft to Plum Hollow House when she got off work as there would not be a staff member at the Strides House. Therefore, Resident S would take an Uber/Lyft to Plum Hollow House and Ms. Blunt would pick her up after she finished picking up the other residents from workshop and transport them back to the Strides House.</p> <p>Ms. McDonald confirmed that Resident S would take an Uber/Lyft to Plum Hollow House after work and a staff from the Strides House would pick her up and transport her back to Strides House.</p>
CONCLUSION:	VIOLATION ESTABLISHED

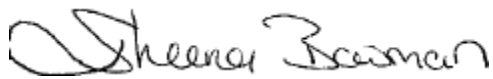
APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	<p>According to Ms. Blunt and Ms. McDonald, Resident S was permitted unsupervised community access including public transportation. However, per Resident S IPOS she needs to be with staff at all times in the community at a 1 to 3 staff ratio. The IPOS also indicates that Resident S can attend the library twice a month and go walking once a week with staff supervision.</p> <p>According to Resident S behavioral assessment plan, she must remain within eyesight of staff when accessing the community, with the exception of when she is at work. In order for Resident S to have community access for the purpose of working, she was required to select a job that did not interfere with her medication schedule, she had to inform staff of her work schedule promptly, and she had to return to the home from work within 30 minutes of her shift ending. Resident S was also permitted to access the community when she was with her parents for four hours per week.</p> <p>Resident S IPOS and behavioral assessment plan does not indicate whether or not she can utilize public transportation. However, Ms. McDonald confirmed it is not written in the other resident's assessment plans that they can utilize Uber/Lyft without staff supervision. Therefore, the other residents that were transported in an Uber/Lyft without staff supervision were not receiving the personal care in accordance with their assessment plans.</p>
CONCLUSION:	VIOLATION ESTABLISHED

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 my investigation and information gathered, the residents were not treated with dignity since they had to go to another AFC group home and wait for hours before they could return to their own home.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Sheena Bowman
Licensing Consultant

08/04/21
Date

Approved By:



08/06/2021

Denise Y. Nunn
Area Manager

Date