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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 23, 2021

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

RE: License #: AS780376324
Investigation #: 2021A0584020
Martin 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Candace L. Pilarski

Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-8967

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780376324
Investigation #:	2021A0584020
Complaint Receipt Date:	06/25/2021
Investigation Initiation Date:	06/25/2021
Report Due Date:	08/24/2021
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jeremy Hagerman
Licensee Designee:	Jennifer Bhaskaran, Designee
Name of Facility:	Martin Home
Facility Address:	11410 Lennon Road Lennon, MI 48849
Facility Telephone #:	(810) 621-4721
Original Issuance Date:	08/17/2015
License Status:	REGULAR
Effective Date:	02/17/2020
Expiration Date:	02/16/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 6/16/2021 Resident A was able to leave the facility unattended and use a chair to get over the fence. He was discovered in the driveway by staff. Following the incident, he had scrapes and bruising on his body.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/25/2021	Special Investigation Intake 2021A0584020
06/25/2021	Special Investigation Initiated - Letter Email letter to Ardis Bates, Shiawassee Health and Wellness recipient rights case worker
07/07/2021	Contact - Face to Face With Peggy Luce, Direct Care worker
07/07/2021	Contact - Face to Face With Lyndan Tucker, Direct Care Worker
07/16/2021	Contact - Telephone call made To Guardian A-1
07/21/2021	Contact - Face to Face With Resident A
07/30/2021	Exit Conference Via email with Jennifer Bhaskaran

ALLEGATION:

On 6/16/2021 Resident A was able to leave the facility unattended and use a chair to get over the fence. He was discovered in the driveway by staff. Following the incident, he had scrapes and bruising on his body.

INVESTIGATION:

On 7/7/2021, I conducted a face-to-face interview with Peggy Luce, direct care staff. Ms. Luce was working as staff for five residents and the medication passer and stated her coworker direct care staff member Lyndan Tucker was assigned to work with Resident A. Ms. Luce stated according to Resident A's ***Functional Behavioral Assessment and Intervention Plan*** last assessed on August 25, 2020, by Shiawassee Health and Wellness, Resident A requires line of sight supervision at all times from the direct care staff assigned to him unless he is in his bedroom. I reviewed Resident A's ***Functional Behavioral Assessment and Intervention Plan*** last assessed on August 25, 2020, by Shiawassee Health and Wellness that specifies Resident A must have line of sight supervision at all times by staff unless he is in his bedroom. Line of sight supervision was defined by the plan as having the resident within the sight of the assigned staff member anytime that resident is not in their bedroom.

Ms. Luce stated that she informed her coworker, Ms. Tucker, she needed to take a five-minute break and upon returning to the living room area, Ms. Luce stated she noticed the facility front door was open. Ms. Luce stated she could see that Resident A was at a staff member's vehicle in the driveway trying to open the door. Ms. Luce stated she went outside, opened the gate, and assisted Resident A back into the home. Ms. Luce stated she offered Resident A to go on a walk, but instead he returned to the inside of the home without incident. Ms. Luce stated that there is a small table on the enclosed porch which she assumed Resident A used to climbed up and over the fence. Ms. Luce stated she did not see Ms. Tucker, who was assigned to provide line of sight supervision to Resident A, before seeing the facility door was open and finding Resident A in the driveway. Ms. Luce stated since the porch gate remained secure, she figured Resident A used a chair and the table to get over the porch wall. Ms. Luce stated upon finding Resident A, she checked over Resident A and found some scrapes and bruises from going over the porch wall. Ms. Luce stated the scrapes were minimal and bruises not large or deep. Ms. Luce stated she did minor first aid to the scrapes. Ms. Luce contacted the home manager, Nichole Frye and also telephoned Resident A's Recipient Rights office to notify of the incident.

On 7/7/2021, I conducted a face-to-face interview with Lyndan Tucker, direct care staff member. Ms. Tucker stated she is new employee at the home having only been working for a couple of months. On June 16, 2021, Ms. Tucker stated she worked 6am to 2pm. Ms. Tucker stated she was assigned to be the line-of-sight worker for Resident A. Ms. Tucker said that her coworker that day was Peggy Luce, and Ms. Luce was assigned medication passing. Ms. Tucker stated she was trained on Resident A's ***Functional Behavioral Assessment and Intervention Plan*** last assessed on August 25, 2020 by Shiawassee Health and Wellness states and understood that Resident A required line of sight unless he was in his bedroom. Ms. Tucker stated that she was giving another resident, not Resident A, a shower when Ms. Luce took a short break. Ms. Tucker stated she did not recall Ms. Luce

mentioning to her that she needed a break for a few minutes. Ms. Tucker stated that Resident A had eaten breakfast and was sitting at the dining room table when she took another resident into the shower. Ms. Tucker explained that when she got out of the shower room, she noticed the front door was open. Ms. Tucker said she looked out the window and saw Ms. Luce and Resident A standing by her car. Ms. Tucker said that Resident A came back inside the home and Ms. Luce checked the scrapes he sustained. Ms. Tucker verified that Ms. Luce called the home manager Nichole Frye and the Recipient Rights office about the incident. Ms. Tucker stated she was not able to see Resident A and provide line of sight supervision when she was showering another resident. Ms. Tucker was not aware of Ms. Luce being on a break and that left Resident A not being line of sight supervised by any on duty staff.

On 7/21/2021, I conducted a visit to the home to view Resident A. Resident A is non-verbal. I viewed exposed skin on Resident A and did not see any signs of injuries.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Resident A has an ***Functional Behavioral Assessment and Intervention Plan*** that instructs direct care staff to keep him in direct line of sight at any time he is outside of his bedroom. Two direct care staff were on duty the day Resident A left the home without staff knowledge. One direct care staff was assigned to provide Resident A with line-of-sight supervision at all times other than when Resident A is in his bedroom. This level of supervision was not provided to Resident A, per his Resident A's ***Functional Behavioral Assessment and Intervention Plan*** by Shiawassee Health and Wellness, on June 16, 2021, after Resident A eloped out of the front door of the facility, climbed over the porch wall, and walked down the facility driveway.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 7/7/21, I conducted face-to-face interviews with Peggy Luce and Lyndan Tucker. Both Ms. Luce and Ms. Tucker reported they did not complete an *AFC Incident/Accident Report* (incident report) after Resident A eloped from the facility on June 16, 2021.

On 7/16/21, I conducted a phone interview with Guardian A1. Guardian A1 stated Guardian A1 was not aware Resident A was able to leave the home without staff knowledge on June 16, 2021. Guardian A1 did not receive a verbal notice or a written report of the elopement.

On 7/21/21, I reviewed Resident A's file and did not see an incident report documenting him leaving the home without staff knowledge on June 16, 2021.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence. **(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:** **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved, and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**

ANALYSIS:	No incident report form was completed after Resident A eloped from the facility on June 16, 2021. Further, facility direct care staff members did not contact Resident A's designated representative, Guardian A1, within 24 hours of the elopement as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

After receiving an acceptable corrective action plan, I recommend no changes in the status of this license.

Candace L. Pilarski

8/13/21

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Candace Pilarski Date
Licensing Consultant

Approved By:

08/23/2021

Dawn N. Timm Date
Area Manager