GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 15, 2022

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

RE: License #: AS150344861
Investigation #: 2022A0870022
Charlevoix House

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 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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS150344861
Investigation #:	2022A0870022
Complaint Receipt Date:	03/30/2022
Investigation Initiation Date:	03/30/2022
Report Due Date:	05/29/2022
Licensee Name:	Alternative Services Inc.
Licensee Address:	32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Tammy Stevens
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Charlevoix House
Facility Address:	203 East Garfield Charlevoix, MI 49720
Facility Telephone #:	(248) 417-4880
Original Issuance Date:	09/13/2013
License Status:	REGULAR
Effective Date:	03/13/2022
Expiration Date:	03/12/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed. Residents were left alone and unsupervised for an hour. One staff member recently supervised the residents for 72 hours straight by themself. The facility is unable to take residents to doctors' appointments due to a lack of staff.	Yes

III. METHODOLOGY

03/30/2022	Special Investigation Intake 2022A0870022
03/30/2022	APS Referral This was referred to AFC Licensing by MDHHS Adult Protective Services, Centralized Intake.
03/30/2022	Special Investigation Initiated - Telephone Telephone call to NCCMH Caseworker Samantha Kerr.
03/30/2022	Contact - Telephone call made Email referral to NCCMH ORR.
04/04/2022	Inspection Completed On-site Interview with facility staff member Amelia Swailes.
04/04/2022	Contact - Document Received Resident IPOS received from NCCMH ORR.
04/11/2022	Contact - Telephone call made Telephone interview with Home Manager Manda Bishaw.
04/12/2022	Contact - Telephone call made Telephone interview with staff Jane Thelen.
04/14/2022	Contact - Telephone call made Telephone interview with Administrator Tammy Stevens.
04/14/2022	Inspection Completed-BCAL Sub. Compliance
04/14/2022	Exit Conference Completed with Administrator Tammy Stevens.

ALLEGATION: The facility is understaffed. Residents were left alone and unsupervised for an hour. One staff member recently supervised the residents for 72 hours straight by themself. The facility is unable to take residents to doctors' appointments due to a lack of staff.

INVESTIGATION: On March 30, 2022, I contacted North Country Community Mental Health Authority (NCCMH), Office of Recipient Rights. I spoke with Amanda Dixon and provided her with the above allegations. Ms. Dixon noted she is aware of the allegations and is currently investigating the matter. She provided me with information concerning facility residents and caseworker names.

On March 30, 2022, I conducted a telephone interview with Samantha Kerr. Ms. Kerr is a caseworker for NCCMH and provides case management services to the six residents of the Charlevoix House AFC. She stated that on March 24, 2022, she found that three residents of the AFC had been left unattended and unsupervised at the home. Ms. Kerr stated that the staff on duty at the time, Amelia Swailes, had left the home after attempting to awaken staff member Jane Thelen, who was off duty and sleeping in the upstairs bedroom. She noted that Ms. Thelen did not wake up, Ms. Swailes left, and these three residents were unattended for approximately one hour until Ms. Kerr woke Ms. Thelen herself. Ms. Kerr stated that all of the facility residents require awake staffing 24 hours per day. Furthermore, Ms. Kerr stated she feels that one staff is not sufficient for the residents' needs, as the home is now unable, due to staffing issues, to transport residents to their scheduled medical appointments. Ms. Kerr also stated she had been made aware that staff member Jane Thelen had worked for 72 continuous hours over the past weekend.

On April 4, 2022, I conducted an unannounced on-site special investigation at the Charlevoix House AFC home. I met with staff member Amelia Swailes. Ms. Swailes stated the facility currently is providing care for six disabled adults. She explained that the facility was briefly down to only two staff members but recently a new home manager was hired, and she is also working shifts at the home. Ms. Swailes stated that there is no set work schedule currently since there are only two staff. She stated she works 7:00 a.m. to 7:00 p.m. on Monday, Wednesday, and Thursday and 7:00 a.m. to 1:00 p.m. on Tuesday. Ms. Swailes noted that staff member Jane Thelen works the rest of the time. She did acknowledge that Ms. Thelen worked 72 straight hours over the weekend of March 26-27, 2022. Ms. Swailes acknowledged that "a week or so ago" she had left for a short period of time and thought that Ms. Thelen was awake to care for the three residents that were in the home at the time. She explained that Ms. Thelen did not wake up and these three residents were unsupervised. Ms. Swailes further acknowledged that Resident C has an ongoing medical appointment to have blood work done every Monday. She stated that facility staff are unable to take Resident C to her appointments and that Resident C's NCCMH case worker, Ms. Kerr, takes her.

On April 4, 2022, Ms. Dixon provided me with copies of excerpts from each resident's Individualized Plan of Services. These excerpts are as follows:

"(Resident A) requires 24 hour supports both while at home and in the community." "Due to (Resident A's) DD diagnosis, she will trust almost anyone she meets... (Resident A) requires supervision and some assistance in basic self-care needs daily. (Resident A) continues to need a residential placement with structure, 24 hour availability of staff, and an appropriate peer group." "Staff will monitor (Resident A's) safety and wellbeing at all times. (Resident A) requires 24 hour supports both while at home and in the community."

"(Resident B) requires 24-hour supports for health and safety monitoring as she is a vulnerable adult at risk for exploitation." "She benefits from residing in a 24-hour staffed home to monitor her health and safety needs as this is the least restrictive setting to meet her needs." Staff to provide monitoring for (Resident B) while at home, in the community.

"There are concerns with (Resident C) leaving the home and not communicating her whereabouts with staff, as well as not having transportation setup for her return home." She is known to be up and around during the day and night. The evenings are reported as the times where the voices become more assertive and negative. (Resident C) is known to pace the floors, smoke multiple cigarettes and has left for a walk in the middle of the night or early morning hour. (Resident C) will benefit from 1:1 staffing up to 5 hours per day to be used between day and evening. As staffing allows, it is recommended that a CSR be completed to provide this additional staffing to meet her best interests. (Resident C) enjoys walking and has had the freedom to do so for most of her life. Walking is a great tool to decrease symptoms of anxiety and alleviate the auditory hallucinations she regularly experiences. She should not be expected to stay at home all day due to low staffing levels and this is not conducive to her wellbeing. She must have regular movement and activity. Staff can use up to 2 hours per day to go for walks with her as she desires. Every effort will be made to accommodate this. (Resident C) experiences negative voices more so in the afternoons and evenings. She will benefit from having 1:1 staff up to 3 hours during these times. The simplest action, and often the most genuinely useful, is just sitting and being there with her. Having a designated staff to be available to talk with, tell stories to, and remind her that she is safe, and they are there for her will be highly beneficial both to (Resident C) and housemates.

"(Resident D) in the past has run away when she is upset. Staff will monitor (Resident D's) whereabouts especially when she is upset." "In the past, she would have meltdowns that lasted up to three hours which included crying, kicking, punching, throwing / breaking items, banging her head and making suicidal comments. It is important for (Resident D) to have adult supervision to help her work through difficult thoughts/feelings and ensure her safety when she becomes upset.

"(Resident E) currently resides in ASI Charlevoix House AFC and has since 2013. This is a 24-hour-awake-staff shifted home. It is recommended that (Resident E) continue to reside in a specialized residential placement with 24-hour staffing."

“(Resident E) benefits from ongoing staff assistance in her home. She requires monitoring, redirection, and prompting for personal care and ADL's. She is at risk of exploitation and should be monitored while in the community.” (Resident E) requires 24-hour supports for health and safety monitoring as she is a vulnerable adult at risk for exploitation.”

The IPOS for Resident F was unavailable at the time of this investigation.

On April 11, 2022, I reviewed the Charlevoix House AFC Original Licensing Study Report, dated September 13, 2013. This report specifies that the home has “awake staff during sleeping hours.”

On April 11, 2022, I conducted a telephone interview with Home Manager Amanda Bishaw. Ms. Bishaw stated she recently began working at the Charlevoix House AFC and acknowledged that the facility has been and continues to be short staffed. She noted she is working shifts herself and is working diligently to hire new staff members.

On April 12, 2022, I conducted a telephone interview with staff member Jane Thelen. Ms. Thelen stated she did work by herself for an entire weekend recently. She noted this was from Friday evening through Monday morning. Ms. Thelen noted that she did stay downstairs with the residents and “dozed” during the night. She stated she was available and would respond if needed during sleeping hours. Ms. Thelen also acknowledged that residents were recently left unattended in the home when staff member Amelia Swailes left the facility, and she was up stairs sleeping. She noted she was “off duty” at the time and Ms. Swailes was to wake her up before leaving, but she did not do that. Ms. Thelen stated that NCCMH caseworker Samantha Kerr woke her up.

On April 14, 2022, I conducted a telephone interview with Administrator Tammy Stevens. Ms. Stevens informed me that the facility had “a bunch of staff quit at the same time” in early March. She stated for a short period the facility operated with only two staff members and acknowledged that Ms. Thelen worked around the clock for several days, sleeping during the nighttime hours. Ms. Stevens stated she is aware of the incident when Ms. Swailes left the facility with three residents still in the home. She stated Ms. Thelen was not on duty at the time that Ms. Swailes departed the facility. Ms. Stevens stated she has since hired a home manager, Ms. Bishaw, who is working shifts with the residents. She further stated that the Licensee, ASI, is working diligently to recruit and hire staff.

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:	Residents A, B, C, D and E's IPOS all state they require 24-hour staffing, availability, or "awake" staff. Resident C's IPOS indicates a need for enhanced 1:1 staffing for several hours per day. Ms. Swailes and Ms. Thelen both state the residents were left unsupervised when Ms. Swailes departed the home and Ms. Thelen, while off duty, was asleep upstairs. Ms. Thelen states that she worked for 72 straight hours over a weekend and "dozed" during the nighttime sleeping hours. Resident E's IPOS specifically notes that the home has 24-hour awake staff. The Licensee does not have a sufficient number of direct care staff on duty for the supervision and protection of the residents.
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:	Residents A, B, C, D and E's IPOS all state they require 24-hour staffing, availability, or "awake" staff. Resident C's IPOS indicates a need for enhanced 1:1 staffing for several hours per day. Ms. Swailes and Ms. Thelen both state the residents were left unsupervised when Ms. Swailes departed the home and Ms. Thelen, while off duty, was asleep upstairs. Ms. Thelen states that she worked for 72 straight hours over a weekend and "dozed" during the nighttime sleeping hours.

	Resident E's IPOS specifically comments that the home has 24-hour awake staff. The Licensee did not provide supervision and protection to facility residents when Ms. Swailes departed the home and while Ms. Thelen slept while on duty during night hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

On April 14, 2022, I conducted an exit conference with Administrator Tammy Stevens. I explained my findings as noted above. Ms. Stevens stated she understood the findings and had no further questions pertaining to this investigation. She further noted that she would inform Licensee Designee Jennifer Bhaskaran of these findings and that she and Ms. Bhaskaran would develop and submit a corrective action plan which addresses the cited rule noncompliance.

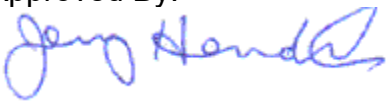
IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

April 15, 2022

Bruce A. Messer — Date
Licensing Consultant

Approved By:



April 15, 2022

Jerry Hendrick — Date
Area Manager