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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 14, 2022

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

RE: License #: AS630305917
Investigation #: 2022A0465026
Grace Avenue

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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630305917
Investigation #:	2022A0465026
Complaint Receipt Date:	04/08/2022
Investigation Initiation Date:	04/08/2022
Report Due Date:	06/07/2022
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:	Grace Avenue
Facility Address:	1916 Grace Avenue Rochester Hills, MI 48309
Facility Telephone #:	(248) 844-2553
Original Issuance Date:	04/19/2010
License Status:	REGULAR
Effective Date:	10/19/2020
Expiration Date:	10/18/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged from the facility.	Yes

III. METHODOLOGY

04/08/2022	Special Investigation Intake 2022A0465026
04/08/2022	Special Investigation Initiated - Telephone Spoke to Complainant via telephone
04/08/2022	Contact – Telephone call made I interviewed Ascension Hospital Social Worker, Cathy DeMarco
04/08/2022	Contact - Telephone call made Spoke to LD, Jennifer Bhaskaran via telephone
04/08/2022	APS Referral Adult Protective Services (APS) referral denied.
05/06/2022	Contact – Telephone call made I spoke to Ms. DeMarco from Ascension Hospital
05/06/2022	Inspection Completed On-site Conducted walkthrough of facility, reviewed Resident A's record and interviewed direct care staff, Andrea Glenn
05/19/2022	Contact - Telephone call made Phone call with Jenny Bhaskaran
05/26/2022	Exit Conference Conducted an exit conference with Jenny Bhaskaran

ALLEGATION:

Resident A was improperly discharged from the facility.

INVESTIGATION:

On 4/8/2022, a complaint was received alleging that Resident A was improperly discharged from the facility. The complaint indicated that on 2/7/2022, Resident A

became physically aggressive towards direct care staff, Andrea Glenn. Resident A was subsequently transported to the hospital for medical and psychiatric evaluation. Resident A was evaluated and discharged from the hospital on the same day. The facility was notified by the hospital that Resident A was ready for discharge and needed to be picked up. The facility refused to pick Resident A up from the hospital and subsequently discharged him from the facility on 2/7/2022. Resident A does not have a new placement identified and has been residing at the hospital for approximately 60 days due to the facility refusing to allow him to return.

On 4/8/2022, I spoke to Complainant via telephone. Complainant confirmed that the information contained in the complaint is accurate.

On 4/8/2022 and 5/6/2022, I spoke to Ascension Hospital Social Worker, Cathy DeMarco. Ms. DeMarco stated, “Resident A was brought here by the facility on 2/7/2022 for aggressive behavior. We assessed him and he was ready for discharge within 24 hours. I spoke to Jenny Bhaskaran, and she stated that they would not pick up Resident A. I told Ms. Bhaskaran that Resident A did not meet criteria to remain in the hospital and needed to be picked up. But no one ever came to get him. Resident A remained in the hospital until 4/15/2022 because it took a long time to find a placement for him. Resident A sat in the hospital for over two months with no where to go.” Ms. DeMarco stated that the facility did not assist with finding placement for Resident A and refused to allow him to return to the facility. On 5/6/2022, I spoke to Ms. DeMarco, and she informed me that Resident A was discharged from the hospital on 4/15/2022 to an assisted living facility.

On 4/8/2022, I spoke to licensee designee and administrator, Jenny Bhaskaran, via telephone. Ms. Bhaskaran stated, “On 2/7/2022, Resident A became physically aggressive and attacked staff, Andrea Glenn. Ms. Glenn required staples in her head due to the injuries she sustained. I could not take Resident A back into the home and ensure the safety of staff and the residents. I did discharge Resident A from the facility while he was in the hospital. I did not submit an Adult Protective Services referral and I did not confirm with Resident A’s legal guardian that he had a new placement available to go to before I discharged him. I can’t take him back at this point. I have already discharged him, and he can’t come back to our facility.” Ms. Bhaskaran stated that she discharged Resident A from the facility on 2/7/2022, the same day he was transported to the hospital, without confirming that Resident A had an appropriate placement to transition to. During this phone call, I informed Ms. Bhaskaran that Resident A is still in the hospital as of today, ready for discharge and with no placement identified. Ms. Bhaskaran stated that she will not allow Resident A to return to the facility.

On 5/6/2022, I conducted an onsite investigation at the facility. I reviewed Resident A’s record and interviewed direct care staff, Andrea Glenn.

The *Face Sheet* indicated that Resident A was admitted to the facility on 1/19/2022 and discharged on 2/8/2022, and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A’s medical diagnosis as Schizophrenia, Intellectual Disability,

Intermittent Explosive Disorder, Bi-Polar and Depression. The *Assessment Plan for AFC Residents and Initial Intake Plan* indicated that Resident A has a history of domestic violence, aggressive behavior, suicide attempts and self-harm cutting behavior. I reviewed the *Discharge Notice* dated 2/8/2022, which indicated that Resident A was issued a 24-hour discharge notice due to aggressive behavior and injuries sustained by Ms. Glenn. The *Resident Registrar* indicated that Resident A was discharged from the facility on 2/7/2022, the same day he was transported to the hospital.

I interviewed direct care staff, Andrea Glenn, during my onsite investigation. Ms. Glenn stated, “On 2/8/2022, Resident A became upset with me and grabbed a metal water bottle and began hitting me in the head with it. 911 was called and he was transported by the police to the hospital. Resident A couldn’t come back here. We couldn’t take him back because we were afraid, he would hurt someone else. We discharged Resident A from our facility on 2/8/2022. I spoke to Ms. Bhaskaran, and she said the hospital was calling around to try and find a new placement for him.” Ms. Glenn acknowledged that Resident A was discharged from the facility on the same day that he was transported to the hospital, without an appropriate placement being identified prior to discharge.

On 5/26/2022, I conducted an exit conference with licensee designee and administrator, Jenny Bhaskaran. Ms. Bhaskaran is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency, of if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency, or if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:**

	(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.
ANALYSIS:	On 2/8/2022, Resident A was transported to the hospital. On this same date, according to the *Resident Registrar*, Resident A was discharged from the facility. According to Ms. Bhaskaran, she did not submit an Adult Protective Services referral and did not confirm that Resident A had an appropriate setting to transition to prior to discharging him from the home. On 4/8/2022, Ms. Bhaskaran informed me that she would not allow Resident A to return to the facility, despite being aware that he was at the hospital, ready for discharge, and with no placement to transition to. Based on the information above, there is sufficient information to confirm that the facility improperly discharged Resident A prior to determining that an appropriate setting that met his needs had been located.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

6/8/2022

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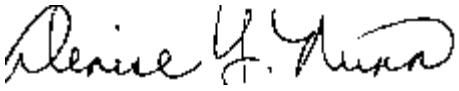
Stephanie Gonzalez Date
Licensing Consultant

Approved By:



06/14/2022

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Denise Y. Nunn Date
Area Manager