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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 6, 2022

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

RE: License #: AS250010919
Investigation #: 2022A0779055
Maple Road 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) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010919
Investigation #:	2022A0779055
Complaint Receipt Date:	08/22/2022
Investigation Initiation Date:	08/23/2022
Report Due Date:	10/21/2022
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:	Maple Road Home
Facility Address:	4341 W. Maple Avenue Flint, MI 48503
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	11/05/1990
License **Status:**	REGULAR
Effective Date:	11/15/2021
Expiration Date:	11/14/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was having behaviors and becoming hostile with staff. Recipient A grabbed a knife and threated to kill herself.	No
An unauthorized video recording was made of Resident A and home manager, Jacobi.	No
Additional Findings	Yes

III. METHODOLOGY

08/22/2022	Special Investigation Intake 2022A0779055
08/23/2022	Special Investigation Initiated - Telephone Spoke to Complainant.
08/23/2022	Contact - Telephone call made Interview conducted with administrator, Candy Hamilton.
08/23/2022	Contact - Telephone call made Interview conducted with staff person, Drianna Smith.
08/24/2022	Contact - Telephone call made Spoke with recipient rights investigator, Michelle Salem.
08/24/2022	Contact - Telephone call made Interview conducted with staff person, Daejaney Williams.
08/24/2022	Contact - Telephone call made Interview conducted with staff person, Destiny Willingham.
08/24/2022	Contact - Telephone call made Interview conducted with home manager, Jacobi Powells.
08/25/2022	Contact - Telephone call made Interview conducted with staff person, Lattice Price.
08/26/2022	Contact - Telephone call made Interview conducted with administrator, Candy Hamilton.
09/08/2022	Contact - Document Received Received video via text from staff person, Drianna Smith.
09/09/2022	Contact - Telephone call made Spoke with home manager, Ms. Powells.

09/14/2022	Contact - Face to Face Interview conducted with Resident A.
09/22/2022	Exit Conference Held with licensee designee, Jenny Bhaskaran.
10/06/2022	APS referral Complaint was referred to APS centralized intake.

ALLEGATION:

Resident A was having behaviors and becoming hostile with staff. Recipient A grabbed a knife and threated to kill herself.

INVESTIGATION:

On 8/23/22, a phone conversation took place with Complainant, who stated that she was told by the staff working during this incident that staff was able to take the knife away from Resident A within 2-3 seconds. She stated that no one was injured.

On 8/23/22, a phone call was made to administrator, Candy Hamilton. She stated that Resident A continues to being going through a rough time. She stated that staff were present when Resident A grabbed the knife and took it from her immediately. Ms. Hamilton reported that there is nothing in Resident A's plan of service regarding her requiring increased supervision or regarding keeping knifes or sharp objects away from her. She stated that it is the home's policy to keep all knives locked up when staff are not using them.

On 8/24/22, a phone interview was conducted with staff person, Drianna Smith, who confirmed that she one of the staff working at the time when Resident A grabbed the knife. Ms. Smith stated that Resident A was having a difficult day, was making threats to hurt staff, and actually hit staff person, Destiny Willingham. She reported that she was washing dishing and Resident A went into the sink and grabbed the knife, but she was able to take it from her immediately. Ms. Smith stated that there were no other residents present to witness the incident and that they continued to monitor Resident A closely the rest of the shift.

On 8/24/22, a phone interview was conducted with staff person, Daejaney Williams, who stated that she was present when Resident A grabbed the knife. She stated that she did not actually see where Resident A grabbed the knife from but did see it in her hands. Ms. Williams reported that resident A only had the knife for a couple of seconds when Ms. Smith took it from her. Ms. Williams stated that the whole incident took place very fast and there was no actual threat or risk of harm.

On 8/24/22, a phone interview was conducted with staff person, Destiny Willingham, who confirmed that she was present during the knife incident. She confirmed that Resident A was able to grab a knife but stated that Ms. Smith was standing right there and took it from Resident A immediately.

On 9/14/22, an in-person interview was conducted with Resident A, who confirmed that she grabbed the knife from the kitchen sink and said something about this is what she would use, referring to committing suicide. Resident A stated that Ms. Smith was standing right there and took the knife from her right away. She stated that she only had the knife for a few seconds.

Resident A's *Assessment Plan for AFC Residents* was reviewed. The plan states that Resident A is quite independent and is able to complete all her activities of daily living on her own. There is no mention in the plan regarding Resident A requiring increased supervision or the need to restrict her access to knives or other sharp objects.

On 9/14/22, administrator, Candy Hamilton, stated that Resident A has a long history of attention seeking behavior and saying that she is having suicidal threats is a part of that. She stated that she has been in the hospital multiple times over the last few months and that both local hospitals will no longer admit her. Ms. Hamilton reported that they continue to work with GHS and Resident A's psychiatrist in order to best meet Resident A's needs.

APPLICABLE RULE	
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:	It was confirmed that Resident A was able to grab a knife, but staff were present and were able to immediately take the knife from her. It appears that staff was washing dishing when Resident A grabbed the knife out of the sink. Resident A confirmed that is what happened and that she only had the knife in her hands for a few seconds. No one was injured during this
	incident. There was insufficient evidence found to prove that Resident A was not provided adequate protection and safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

An unauthorized video recording was made of Resident A and home manager, Jacobi.

INVESTIGATION:

On 8/23/22, administrator, Ms. Hamilton, stated that she was not aware that a video was taken. She stated that only one staff person, Lattice Price, claims to have seen a video with Resident A and home manager, Jacobi Powells, in it. Ms. Hamilton reported that all the other staff allegedly involved deny knowing anything about a video. When asked if an

On 8/23/22, staff person, Drianna Smith, stated that she was present when Ms. Powells had her talk with Resident A about the knife situation and suicidal thoughts. She stated that she does not know anything about a video of that conversation.

On 8/24/22, a phone conversation took place with recipient rights investigator, Michelle Salem. She stated that home manager, Ms. Powells, spoke to Resident A about her behaviors and suicidal issues and that conversation was what was allegedly recorded. Ms. Salem stated that she has spoken to Ms. Powells and that Ms. Powells claims to know nothing about a video. She reported that Resident A also claims to not know about being recorded.

On 8/24/22, staff persons, Daejaney Williams and Destiny Willingham, were interviewed. They both claim they have not seen any video of Resident A and Ms. Powells and are not aware that any video exists.

On 8/24/22, home manager, Ms. Powells, confirmed that she had a conversation with Resident A about her behaviors, suicidal thoughts, and the knife incident. She stated that she is not aware of anyone recording that conversation. Ms. Powells stated that the only other person present during that conversation was staff person, Drianna Smith.

On 8/25/22, staff person, Lattice Price, stated that staff person, Daejaney Williams, had the video on her phone and showed it to her. She stated that the video had both Ms. Powells and Resident A in it. Ms. Price stated that she believes that Ms. Williams told her that she got the video from staff person, Destiny Willingham.

On 9/8/22, a video was received via text from staff person, Drianna Smith. In the text, Ms. Smith admitted to recording the video. In the video, the back of home manager, Ms. Powells, could be seen blocking the view of a resident, who was sitting in a chair. Ms. Powells appears to be holding something in her hand, but the object was not visible. Ms. Powells told the resident to “Do what you got to do” and repeatedly told the resident to “Push”. The resident could be heard to be crying and repeatedly yelling out “No”, “No I am not going to push”. The video lasted approximately 15 seconds.

On 9/9/22, administrator, Ms. Hamilton stated that she was sent the same video. She confirmed that the staff in the video was home manager, Ms. Powells, and that although the face of the resident could not be seen, she was positive that the voice of the resident was Resident A.

On 9/9/22, Ms. Powells confirmed that she had confronted Resident A about her recent behavior and suicidal thoughts. Ms. Powells claims that she did not know that they were being recorded and that she had not seen the video. When told of the content of the video, Ms. Powells confirmed that the video was a recording of the confrontation she had with Resident A.

On 9/14/22, Resident A stated that she was not aware that she was recorded or in any video. She stated that she did not give staff person, Drianna Smith, or any other staff person permission to video record her.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	On 9/8/22, a video was received via text message from staff person Drianna Smith, who admitted to recording the video. The video consisted of home manager, Jacobi Powells, standing in front of a resident, who was sitting in a chair. Although the face of the resident could not be seen, it was confirmed by her voice that the resident in the video was Resident A. Ms. Powells claims to have not seen the video, but when told the content of the video, she confirmed that the description
	accurately depicted the confrontation she had with Resident A. Resident A has stated that she did not give anyone permission to video record her. The making of this video violated Resident A's right and need for privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 9/9/22, a phone interview as conducted with home manager, Ms. Powells, who admitted that she had confronted Resident A about her recent behavior and suicidal thoughts. She admitted that she told Resident A that if she wanted to kill herself, that she would have to kill her first. Ms. Powells claims that she did not know that her conversation with Resident A was recorded. She stated that she used a butterknife pointed toward herself and stood in front of Resident A, telling Resident A to push the knife into her. Ms. Powells admitted that Resident A was upset, crying, and repeatedly yelling out "No". When asked again what type of knife she used during this confrontation, Ms. Powells stated that it was a butterknife. Ms. Powells stated that the bucket of sharp knifes was out of the cabinet at the time, but that all the sharp knives remained in the bucket. She stated that this was her attempt to help Resident A deal with her suicidal thoughts.

On 9/14/22, Resident A stated that Ms. Powells wanted to talk to her about being suicidal and wanted to know which knife she had grabbed the day before. She stated that Ms. Powells got the butcher knife out and sat it on the counter next to them. She reported that Ms. Powells said to her "If you want to kill yourself, you will have to kill me first" and then grabbed the butcher knife. Resident A stated that Ms. Powells pointed the knife toward her own stomach and that she also put her hands on the knife, so both their hands were on the knife. Resident A reported that Ms. Powells then kept telling her to push the knife into her and that she was crying and yelling "No", because she did not want to hurt Ms. Powells. Resident A stated that Ms. Powells put the knife away and no one was hurt. Resident A also mentioned that Ms. Powells had the idea of them writing suicide notes, one from her to her sister and one from Ms. Powell to her kids. She stated that the notes were written but were thrown away.

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:	It was confirmed that home manager, Jacobi Powells, had a confrontation with Resident A regarding Resident A's behaviors and suicidal thoughts. The confrontation consisted of Resident A and Ms. Powells having both their hands on a butcher knife, which was pointed toward Ms. Powells, and Ms. Powells telling Resident A to push the knife into her stomach. The incident was recorded, and Resident A could be heard to be extremely upset, crying, and repeatedly yelling out "No". Ms. Powells used a specialized intervention as an attempt to address Resident A's suicidal thoughts. This intervention was not developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice. This intervention did not ensure the safety and welfare of Resident A, but in fact put the welfare and safety of both Resident A and Ms. Powells in jeopardy.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 8/24/22, home manager, Jacobi Powells, stated that she was aware of the incident involving Resident A grabbing a sharp knife. She stated that she had not seen a copy of an *AFC Licensing Division Incident/Accident Report* (IR) documenting such an incident. Ms. Powells stated that she did not ask the staff involved to complete an IR.

On 8/26/22, administrator, Candy Hamilton, was asked if there was an IR was written for the incident involving Resident A being able to grab a knife and reference suicide. Ms. Hamilton stated that she was not aware of an IR being completed addressing the Resident A knife issue.

R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative,

	responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	Resident A was recently involved in an incident where she grabbed a butcher knife and referenced suicide. It was confirmed that an *AFC Licensing Division Incident/Accident Report* (IR) was not completed documenting the facts of this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/22/22, an exit conference was held with licensee designee, Jenny Bhaskaran. She was informed of the above cited licensing rule violations and that a corrective action plan addressing those violations is required.

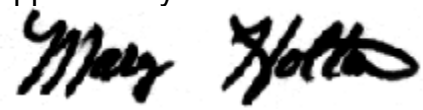
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

10/6/2022

Christopher Holvey Date
Licensing Consultant

Approved By:



10/6/2022

Mary E. Holton Date
Area Manager