GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

Renee Ostrom
Residential Alternatives Inc
P.O. Box 709
Highland, MI 48357-0709

RE: License #: AS630012774
Investigation #: 2023A0993005
Appomattox AIS/MR

Dear Ms. Ostrom:

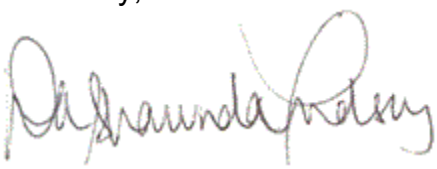
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
3026 W Grand Blvd.
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012774
Investigation #:	2023A0993005
Complaint Receipt Date:	10/31/2022
Investigation Initiation Date:	11/02/2022
Report Due Date:	12/30/2022
Licensee Name:	Residential Alternatives Inc
Licensee Address:	14087 Placid Dr Holly, MI 48442
Licensee Telephone #:	(248) 369-8936
Administrator:	Renee Ostrom
Licensee Designee:	Renee Ostrom
Name of Facility:	Appomattox AIS/MR
Facility Address:	10372 Appomattox Holly, MI 48442
Facility Telephone #:	(248) 634-5949
Original Issuance Date:	10/21/1992
License Status:	REGULAR
Effective Date:	12/13/2021
Expiration Date:	12/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 10/25/2022 staff member Markeia Wynn was sleeping during her shift and on 10/27/2022, staff member Felicia Smith was sleeping during her shift.	Yes

III. METHODOLOGY

10/31/2022	Special Investigation Intake 2023A0993005
11/02/2022	Referral - Recipient Rights Allegations forwarded to recipient rights advocate Katie Garcia
11/02/2022	Special Investigation Initiated – Letter Emailed recipient rights advocate Katie Garcia
11/02/2022	Inspection Completed On-site Conducted an unannounced onsite investigation
12/15/2022	Contact - Telephone call made Telephone call made to staff Felicia Smith. Left a message. Sent a text message.
12/15/2022	Contact - Telephone call made Telephone call made to staff Markeia Wynn
12/15/2022	Contact - Telephone call received Telephone call received from staff Felicia Smith
12/15/2022	Contact - Telephone call made Telephone call made to staff Rhonda Nichols
12/15/2022	Contact - Telephone call made Telephone call made to home manager Annette Thurman. Left a message.
12/16/2022	Contact - Telephone call received Telephone call received from home manager Annette Thurman
12/16/2022	Exit Conference Attempted to hold exit conference with licensee designee Renee Ostrom. Left a message.

12/18/2022	APS Referral Forwarded allegations to adult protective services (APS)
12/19/2022	Exit Conference Attempted to hold exit conference with licensee designee Renee Ostrom. Left a message.

ALLEGATIONS:

Per incident report, on 10/25/2022 staff member Markeia Wynn was sleeping during her shift and on 10/27/2022, staff member Felicia Smith was sleeping during her shift.

INVESTIGATION:

On 10/31/2022, I reviewed two incident reports (IR) received from the facility. The following was reported:

- On 10/25/2022, staff Markeia Wynn was sitting in the living room with her coat covering her face while sleeping.
- On 10/27/2022, staff Felicia Smith was sleep in a resident's chair throughout the shift and did not do any work.

On 11/02/2022, I conducted an unannounced onsite investigation. I interviewed home manager Annette Thurman. She stated staff Rhonda Nichols reported to her that staff Markeia Wynn and Felicia Smith were asleep during their shifts. Ms. Thurman was not sure the dates of the incidents. Per Ms. Thurman, staff are supposed to be awake during each shift, including midnight shift. Ms. Thurman acknowledged staff sleeping during the shift has been an ongoing issue in the facility. Ms. Thurman stated Ms. Smith was caught sleeping during her shift prior to Ms. Thurman becoming home manager in April 2022. This is the first time it has been reported that Ms. Wynn fell asleep during her shift.

During the unannounced onsite investigation, only Resident A and Resident B were present in the facility. I interviewed Resident A. He did not know how long he had lived in the facility. He denied ever observing staff asleep while on shift. He stated there is always staff present in the facility. I was unable to interview Resident B as he was in the bathroom during the visit. Ms. Thurman stated Resident C, Resident D, Resident E, and Resident F were at workshop at the time of the onsite.

On 12/15/2022, I conducted a telephone interview with staff Markeia Wynn. Ms. Wynn stated she began working in the facility in January 2022. She left for a few months and then returned. She stated she was terminated about two weeks ago. When she worked in the facility, she worked all shifts. Ms. Wynn denied ever falling asleep during any of her shifts. She denied ever observing other staff sleeping while on shift. Ms. Wynn described staff at the facility as "messy".

On 12/15/2022, I conducted a telephone interview with staff Felicia Smith. She stated she worked in the facility for 12½ years, but quit on 11/11/2022. When she worked in the facility, she worked the midnight shift, from 10pm to 10am. Ms. Smith stated she was wrote up in the past for not reporting that another staff was sleeping while on shift. Ms. Smith confirmed she dozed off while working with staff Rhonda Nichols. Ms. Smith could not recall the date of the incident. Per Ms. Smith, she was not feeling well and needed to sleep for an hour. She asked for permission and was denied. She went to sleep for a few minutes as she needed rest and had to do transport in the morning.

On 12/15/2022, I conducted a telephone interview with staff Rhonda Nichols. Ms. Nichols stated she has worked in the facility for four months. She works all shifts, if needed. She confirmed Ms. Smith and Ms. Wynn fell asleep while working on a shift with her. Ms. Nichols could not recall the dates of the incidents. She confirmed Ms. Smith and Ms. Wynn are no longer working in the facility. Ms. Nichols stated there are no other staff who sleep during shifts. Per Ms. Nichols, “all the sleepy people are gone”.

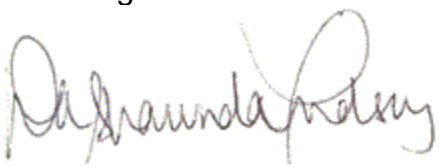
On 12/16/2022, I conducted a follow-up telephone interview with Ms. Thurman. She confirmed Ms. Smith and Ms. Wynn are no longer working in the facility. Ms. Thurman stated there are no other staff who sleep during shifts.

On 12/19/2022, I attempted to conduct an exit conference with licensee Renee Ostrom. I left a message.

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:	On 10/25/2022, staff Markeia Wynn was sitting in the living room with her coat covering her face while sleeping. On 10/27/2022, staff Felicia Smith was sleep in a resident’s chair throughout her shift and did not do any work. Ms. Thurman confirmed Ms. Smith and Ms. Wynn are no longer working in the facility. Ms. Thurman stated there are no other staff who sleep during shifts.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

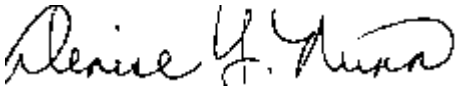
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



12/19/2022

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



12/19/2022

Denise Y. Nunn — Date
Area Manager