GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2023

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

RE: License #: AS630305248
Investigation #: 2023A0611012
Kingsley Trail

Dear Ms. Bhaskaran:

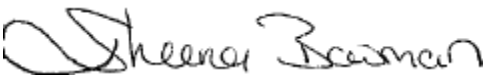
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630305248
Investigation #:	2023A0611012
Complaint Receipt Date:	01/25/2023
Investigation Initiation Date:	01/26/2023
Report Due Date:	03/26/2023
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 - 32625 W Seven Mile Rd Livonia, MI 48152
Telephone #:	(248) 471-4880
Administrator:	Jennifer Bhaskaran
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Kingsley Trail
Facility Address:	637 Kingsley Trail Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 593-9297
Original Issuance Date:	02/12/2010
License Status:	REGULAR
Effective Date:	08/14/2021
Expiration Date:	08/13/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The home Manager Breanna Smith has been locking up food in a separate fridge and cabinet. Staff reported that Breanna is filling medication cups prior to leaving shift at 2 PM, and then asking untrained staff to pass medications that evening/afternoon once the meds were prepared in a cup by Breanna.	Yes

III. METHODOLOGY

01/25/2023	Special Investigation Intake 2023A0611012
01/26/2023	Special Investigation Initiated - Letter I sent an email to the recipient rights specialist Aaron Winston regarding the allegations.
02/03/2023	Inspection Completed On-site I completed an unannounced onsite. I interviewed the home manager, Breanna Smith, staff member, Trenton Slaughter, Resident D, Resident H, and Resident V. I observed the medication cabinet, menus, the refrigerators, and pantry.
02/08/2023	Contact - Telephone call made I left a voice message for the program coordinator, Fran Hopkins requesting a call back.
02/09/2023	Contact - Telephone call made I made a telephone call to staff member, Kieonia Robinson. The allegations were discussed.
02/09/2023	Contact - Document Received I received copies of the medication trainings for three employees and the MAR for all the residents for the month of January.
02/14/2023	Contact - Telephone call made I made a telephone call to staff member, Brenda Allen. The allegations were discussed.
02/14/2023	Contact - Telephone call made I left a voice message for staff member, Oliva Jones requesting a call back.

02/14/2023	Contact - Telephone call received I received a telephone call from the licensee designee, Jennifer Bhaskaran. The allegations were discussed.
02/14/2023	Exit Conference I completed an exit conference with the licensee designee, Jennifer Bhaskaran via telephone.

ALLEGATION:

The home Manager Breanna Smith has been locking up food in a separate fridge and cabinet. Staff reported that Breanna is filling medication cups prior to leaving shift at 2 PM, and then asking untrained staff to pass medications that evening/afternoon once the meds were prepared in a cup by Breanna.

INVESTIGATION:

On 01/25/23, I received an intake regarding the abovementioned allegations. On 01/30/23, I received an email from the recipient rights specialist, Aaron Winston. Mr. Winston provided two pictures of a pad lock on the refrigerator located in the garage and another pad lock on the pantry in the kitchen.

On 02/03/23, I completed an unannounced onsite. I interviewed the home manager, Breanna Smith, staff member, Trenton Slaughter, Resident D, Resident H, and Resident V. I observed the medication cabinet, menus, the refrigerators, and pantry.

On 02/03/23, I interviewed the home manager, Breanna Smith. Regarding the allegations, Ms. Smith works from 6:00am to 2:00pm. Ms. Smith stated the residents are served three meals a day and they receive 2-3 snacks a day. The meals are prepared by staff. Ms. Smith denied any food being locked up and/or stored in a locked cabinet. There is one refrigerator in the kitchen and another refrigerator and deep freezer in the garage. Ms. Smith confirmed that none of the residents have any food restrictions. The residents who are mobile are allowed to go into the refrigerator to get food. There is only one resident who walks with a walker and; whenever he ask for additional food staff brings it to him.

Ms. Smith has been the home manager for less than a year. Ms. Smith was informed by the seasoned staff that the previous home manager use to lock up the residents food because staff members were stealing food. Ms. Smith stated she is the only staff member that does the grocery shopping. Ms. Smith stated she started noticing that food was missing in December 2022. Ms. Smith noticed that chips, milk, cookies, and food from the deep freezer was missing. Ms. Smith had a staff meeting on 01/30/23 and informed staff that the food budget has been cut and that staff can no longer eat with the residents and they will need to bring their own lunch and/or snacks. Ms. Smith stated the food budget wasn't really cut but that is what she told staff.

Ms. Smith stated when the residents went to Golden Corral, she informed the staff that if any of the residents ask for more food when they return to the AFC group home, to give them a light snack because they ate a lot of food at the restaurant. Ms. Smith stated this is not a general rule and she only gave those instructions because the residents ate at the restaurant. Ms. Smith stated only trained staff administer medications. Ms. Smith stated there are four new staff members and three of them are fully trained. Ms. Smith did have staff member, Brenda Allen count the pills in the bubble packet during her midnight shift to ensure the count is accurate. Ms. Allen will not be trained to administer medications until 02/27/23.

On 02/03/23, I interviewed staff member Trenton Slaughter. Mr. Slaughter has worked for the AFC group home for nine years. Mr. Slaughter works from 6:00am to 2:00pm with Ms. Smith. Regarding the allegations, Mr. Slaughter stated he is fully trained to administer medications. Mr. Slaughter correctly cited the medication 5 rights. Mr. Slaughter stated the three newest staff members are Kevin, Coco (Kieonia Robinson), and Brenda and; as far as he knows they have not been trained to administer medications. Mr. Slaughter has never seen these staff members administer medications. Mr. Slaughter denied Ms. Smith prepping medications for other staff members to administer at a later time.

Mr. Slaughter stated the residents are served three meals a day and they receive snacks. Mr. Slaughter denied any food being locked up nor has he ever seen Ms. Smith lock up any food. Mr. Slaughter denied witnessing anyone steal food from the AFC group home however; it would not shock him if staff were stealing food. Mr. Slaughter stated there is always enough food in the AFC group home for the residents. Mr. Slaughter has never heard Ms. Smith say that the residents could not eat after 4:00pm. Mr. Slaughter stated Ms. Smith is good to the residents and she is one of the best managers he has ever worked with. Ms. Smith buys the kind of the food the residents ask for.

On 02/03/23, I interviewed Resident D. Regarding the allegations, Resident D has lived at the AFC group home for 15 years. Resident D stated he doesn't like living at the AFC group home because he wants to leave but he has nowhere to go. Resident D stated sometimes he likes staff, but they are not mean to him. Resident D stated the staff do not do anything that he doesn't like. Resident D is served three meals a day and snacks. There is always plenty of food in the AFC group home. Resident D stated none of the food is locked up. Resident D denied ever seeing medications in a cup unattended.

On 02/03/23, I interviewed Resident H. Regarding the allegations, Resident H has lived at the AFC group home for 4-5 months. Resident H stated he likes the staff as they treat him very well. Resident H is served three meals a day and snacks in between. There is more than enough food in the AFC group home. The only cabinet that is locked is the cabinet that contains chemicals. Resident H stated none of the food is locked up.

Resident H stated he is administered medications every day. Resident H denied ever seeing medications in a cup left unattended or off to the side.

On 02/03/23, I interviewed Resident V. Regarding the allegations, Resident V has lived at the AFC group home for nine years. Resident V stated its nice living at the AFC group home, but he would like to move because he wants his own bedroom. Resident V is served three meals a day and sometimes snacks. Resident V stated the snacks are eaten up quickly. Resident V stated he gets enough food to eat. Resident V stated he was told by the midnight staff members, Olivia Jones, and Brenda Allen that Ms. Smith locks up the snacks. Resident V stated the refrigerator and the deep freezer in the garage are locked.

Resident V stated two weeks ago, staff member Coco (Kieonia) gave him the wrong medications, but he did not swallow the medications as he spit them out in his hand. Resident V stated someone had put the medications out for Coco to administer. Resident V does not know if Coco is fully trained to administer medications. Resident V stated no other staff member was present when Coco was giving him the wrong medications. Resident V stated sometimes Mr. Slaughter or Ms. Smith put medications together for Coco when she works the afternoon shift.

On 02/03/23, I observed the menu posted and dated accurately on the refrigerator in the kitchen. The medication cabinet is located near the kitchen, and I did not observe any medications left out. There was plenty of food observed in the refrigerator and freezer in the kitchen. I observed latches that fasten on the pantry to keep it closed but the pantry is not locked. The only pad lock observed was the cabinet that contains the cleaning supplies in the kitchen. The refrigerator and deep freezer in the garage also have latches on them but they are not locked.

On 02/09/23, I made a telephone call to staff member Kieonia (Coco) Robinson. Regarding the allegations, Ms. Robinson started working for the AFC group home in September 2022. Ms. Robinson works from 2:00pm to 10:00pm. Ms. Robinson is not fully trained as she has only completed the recipient rights training and CPR. Ms. Robinson stated she is in the process of being trained online through MORC. However, she is waiting for her training classes to become active in order to complete them. Ms. Robinson is not trained to administer medications. Ms. Robinson stated she did administer medications one time in the middle of January 2023 because her co-worker who was supposed to administer the medications called off from work. Ms. Robinson stated when she arrived to work, Ms. Smith prepared the residents medications in cups that were labeled with the time that they are supposed to be given. Ms. Smith instructed Ms. Robinson to administer the residents medications during her shift. The prepared medications were locked in a cabinet until it was time for Ms. Robinson to administer them. Ms. Smith was not present when Ms. Robinson administered the medications.

Ms. Robinson admitted that she mistakenly gave Resident V the wrong medications. Ms. Robinson inadvertently gave Resident T’s medications to Resident V. Resident V put the medications in his mouth, but he did not swallow the medications because he

knew those medications were not his. Resident V spit the medications out. Ms. Robinson placed the medications in a grocery bag and threw them away. Ms. Robinson stated she took the trash out to prevent anyone from having access to the medications. As a result, Resident T did not receive his evening medications because the rest of the medications were locked away. Ms. Robinson stated she did not complete the medication administration record (MAR) as she does not know what that is. Ms. Robinson stated Ms. Smith did not advise her to complete any paperwork after she administered the residents their medications.

Ms. Robinson did not inform Ms. Smith or any supervisor that she gave Resident V the wrong medications. Ms. Robinson does not know if there are any other staff members who administer medications who are not trained.

Ms. Robinson stated the residents are served three meals a day. Ms. Robinson prepares dinner and provides a snack for the residents during her shift. The residents are never denied food and they can eat whenever they are hungry. Ms. Robinson stated in January she observed a pad lock on the pantry. The pad lock was on the pantry for a few days. Ms. Robinson does not know why the pantry was locked but she assumed either the lock was needed to keep the doors close, or Ms. Smith had just went grocery shopping and didn't have time to put the food away.

On 02/09/23, I received copies of the medication trainings for staff member, Ciera Bevelle dated 03/18/21, staff member, Breanna Smith dated 09/22/22, and staff member Trenton Slaughter dated 03/18/21. I also received a copy of the MAR for all six residents. I observed a staff initial documented each day on the MAR for every resident. Although Ms. Smith works the morning shift from 6:00am to 2:00pm, I observed her initials on every MAR for each resident on 01/16/23 through 01/20/23 for 8:00pm medications. Furthermore, Resident T's MAR indicates that he received all of his medications every day during the month in January however; Ms. Robinson admitted during the middle of January Resident T did not receive his 8:00pm medications because she gave them to Resident V.

On 02/14/23, I made a telephone call to staff member, Brenda Allen. Regarding the allegations, Ms. Allen stated she started working at the AFC group home in November 2022. Ms. Allen has completed recipient rights training, bloodborne pathogens, documentation and basics, working with people, environmental emergencies, nutrition, and introduction to human services and meeting special needs. Ms. Allen stated she is not trained to administer medications however; she did complete a medication refresher. Ms. Allen was trained in first aid and CPR prior to working for the AFC group home. Ms. Allen stated she was instructed today to participate in a virtual meeting to be trained on administering medications.

Ms. Allen stated in November 2022, she was instructed by Ms. Smith to administer Resident D's inhaler. Ms. Allen stated she administered Resident D's inhaler one time, and she has not administered any other medications to any of the residents. Ms. Smith informed Ms. Allen that it was allowed for her to administer an inhaler per company policy but nothing else. Ms. Allen denies observing any untrained staff member administering medications. Ms. Allen stated she works the midnight shift, and she works alone. Ms. Allen provides snacks and light meals to the residents. The residents receive three meals a day during the morning and afternoon shift. Ms. Allen cannot attest to if the residents actually receive three meals a day because she is only present during the midnight shift. Ms. Allen stated there was a pad lock on the refrigerator in the garage and on the pantry until around December 2022. Ms. Allen does not know why there was a lock on the pantry and the refrigerator in the garage.

On 02/14/23, I received a telephone call from the licensee designee, Jennifer Bhaskaran. Regarding the allegations, Ms. Bhaskaran stated there are four new staff members who have not been trained to administer medications. Ms. Bhaskaran asked Ms. Smith if any of the new staff members have administered medications. Ms. Smith response was no. Ms. Bhaskaran looked at the staff schedule and observed at least one staff member who was not trained to administer medications was working alone. Ms. Bhaskaran confronted Ms. Smith again and Ms. Smith admitted to prepping medications in a cup for an untrained staff member to administer. Ms. Smith stated she only did this one time. Ms. Bhaskaran believes that Ms. Smith may have prepped medications more than once.

Ms. Bhaskaran suspended Ms. Smith. However, Ms. Smith resigned from her position but shortly after her resignation she asked Ms. Bhaskaran if she could be re-hired. Ms. Bhaskaran did not allow Ms. Smith to return. Ms. Bhaskaran stated there was eight staff members employed at the AFC group home, including Ms. Smith. Currently, there are seven staff members and four of them are not trained to administer medications. The new staff members are Brenda Allen (conditional job offer 10/31/22), Kieonia Robinson (conditional job offer 9/12/22), Kevin James (conditional job offer 12/9/22), Olivia Jones (conditional job offer 11/10/22). Ms. Bhaskaran stated she is working franticly to get the new staff trained. Ms. Smith was responsible for signing the new staff up for training.

Ms. Bhaskaran was made aware of Ms. Smith locking the refrigerator in the garage either the same day or the same week she received the recipient rights complaint regarding the allegations in January 2023. Ms. Bhaskaran was informed by the program coordinator, Fran Hopkins that Ms. Smith locked the refrigerator because staff were stealing food. Ms. Bhaskaran instructed Ms. Smith to remove the lock from the refrigerator.

I completed an exit conference with Ms. Bhaskaran. Ms. Bhaskaran was informed on which licensing rules will be cited and that a corrective action plan will be required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information gathered, there is sufficient information to support the allegations as Ms. Robinson admitted that Ms. Smith removed the resident's medications from their original pharmacy-supplied container and prepared the medications in cups that were labeled with the time that they are supposed to be given. Ms. Smith also admitted to Ms. Bhaskaran that she had prepped medications in a cup for an untrained staff member to administer.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Ms. Robinson admitted that she is not trained to administer medications. However, Ms. Robinson did administer evening medications to the residents during the month of January. Ms. Allen admitted to administering Resident D's inhaler without being trained to administer medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information gathered, there is not sufficient information to confirm the allegations as the residents confirmed that they are served three meals a day. During the onsite, I observed an adequate amount of food in both refrigerators and the pantry.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Ms. Robinson admitted that Resident T did not receive his evening medications on one day in January because she inadvertently gave his medications to Resident V.
CONCLUSION:	**VIOLATION ESTABLISHED**

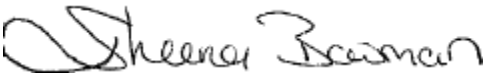
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**

ANALYSIS:	A medication error occurred when Ms. Robinson inadvertently gave Resident T's medications to Resident V. Ms. Robinson admitted that she did not notify the home manger or any supervisor about the medication error nor did she document the error on the MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	When Ms. Robinson administered the wrong medications to Resident V, he spit the medications out. Ms. Robinson placed the medications in a grocery bag and threw them away. Therefore, the medications were not properly disposed of.
CONCLUSION:	**VIOLATION ESTABLISHED**

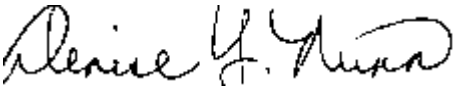
IV. RECOMMENDATION

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



Sheena Bowman — 02/15/23
Licensing Consultant — Date

Approved By:



Denise Y. Nunn — 02/15/2023
Area Manager — Date