GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 3, 2023

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

RE: License #:	AS250304220
Investigation #:	2023A0123029
	Weston Road

Dear Ms. Bhaskaran:

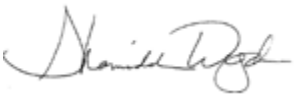
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250304220
Investigation #:	2023A0123029
Complaint Receipt Date:	03/06/2023
Investigation Initiation Date:	03/07/2023
Report Due Date:	05/05/2023
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Candy Hamilton
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Weston Road
Facility Address:	4181 Weston Drive Burton, MI 48509
Facility Telephone #:	(810) 736-2011
Original Issuance Date:	08/26/2009
License Status:	REGULAR
Effective Date:	05/21/2022
Expiration Date:	05/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Early Shackleford used a dresser to block Resident A from being able to exit his bedroom on 03/03/2023.	Yes

III. METHODOLOGY

03/06/2023	Special Investigation Intake 2023A0123029
03/07/2023	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Pat Shephard via phone.
03/15/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
03/17/2023	APS Referral APS referral completed.
03/20/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Early Shackleford.
03/20/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Rasheed Richards via phone.
03/20/2023	Contact - Telephone call made I left a voicemail requesting a return call from Resident A's case manager.
03/20/2023	Contact - Telephone call received I interviewed staff Rasheed Richards.
03/20/2023	Contact - Telephone call received I spoke with Kelley Banks, Resident A's case manager from Hope Network.
03/22/2023	Contact - Telephone call made I made a call to the facility. I interviewed staff Early Shackleford and spoke with home manager Quante Johnson.
03/22/2023	Exit Conference I spoke with licensee designee Jennifer Bhaskaran via phone.

ALLEGATION: Staff Early Shackleford used a dresser to block Resident A from being able to exit his bedroom on 03/03/2023.

INVESTIGATION: On 03/07/2023, I spoke with recipient rights investigator Pat Shephard via phone. She stated that Resident A is non-verbal. She spoke with staff Early Shackleford who admitted it. He stated that he did it to keep Resident A out of his hair, so he could pass meds. She stated that Staff Shackleford was initially making excuses. She stated that staff Rasheed Richards was the witness, as he had not left the home yet. He was waiting on his ride. Staff Richards took a video of Resident A sitting behind his dresser. Staff Shackleford told Ms. Shephard that he would not do this anymore.

On 03/15/2023, I conducted an unannounced on-site visit at the facility. I interviewed home manager Quante Johnson. Staff Johnson stated that he had spoken with staff Rasheed Richards via phone, and Staff Richards told him that Staff Shackleford blocked Resident A (in his room) with his dresser. He stated that there is a video of it. Resident A had returned home from the hospital the night before. Resident A has been having seizures and can barely walk. Staff Shackleford works from 6:00 am to 2:00 pm. Staff Shackleford admitted to the allegations and stated that he was trying to stop Resident A from “getting into his drawers.” Staff Johnson stated that he told Staff Earley that he purposefully put Resident A in his room because Resident A had been in the living room at the start of the shift. Staff Johnson stated that third shift gets the residents up, showered, and dressed for the day. He stated that the dresser was not blocking the bedroom doorway, but it was blocking Resident A from going to his door. Resident A is non-verbal and does not have the mindset to climb over his bed. He stated that Staff Shackleford did not know that Staff Richards was still in the home. Staff Shackleford has worked in the home for about four years, and sometimes works by himself.

During this on-site, I observed Resident A who was sitting in the living room, and several other residents that were present in the home. They all appeared clean and appropriately dressed. No issues were noted. Resident A could not be interviewed due to being non-verbal.

During this on-site, I reviewed the video that Staff Richards took of the dresser blocking Resident A. The video shows that the dresser was situated between the bedroom wall, and Resident A’s bed, essentially blocking the path between Resident A and the rest of the room. Resident A was situated in a chair, in the corner of his room in front of his closet door, behind the dresser used to block him. The dresser drawers were facing away from Resident A in the video.

When I observed Resident A’s bedroom during this on-site, I noticed that there is also a larger dresser that is situated against the wall on the same side of the room that Resident A was sitting in the video, that he would have had access to. This appeared to contradict what Staff Shackleford told management about his reasonings for blocking Resident A in his room.

On 03/20/2023, I interviewed staff Rasheed Richards via phone. Staff Richards stated that Resident A was in his room with his dresser turned to block him from exiting. He stated that the only person there at the time to do that was staff Early Shackleford. He stated that he and another co-worker had been waiting on another staff to arrive. Resident A has the mind of a two-year old. Staff Shackleford had gotten Resident A up and to his room without him (Staff Richards) noticing. Staff Richards stated that he went to the bathroom, then on the way out, checked Resident A's bedroom. This is when he saw Resident A sitting in the dark by himself with the dresser blocking him. He stated that Staff Shackleford was aware that he was not the only staff in the home at the time.

On 03/20/2023, I spoke with Resident A's case manager from Hope Network, Kelley Banks via phone. Ms. Banks stated that overall she has no concerns about Resident A's care, and that Staff Johnson treats Resident A like family. She stated that she was broken hearted to hear what happened. She stated that she has not observed any red flags during her in-person visits. Resident A is non-verbal, and the other residents in the home would not be able to say if something was wrong due to their mental state. She stated that Resident A was just in the hospital recently for seizures.

On 03/22/2023, I made a call to the facility. I interviewed staff Early Shackleford via phone. He stated that he took Resident A to his bedroom to calm him down, and turned Resident A's dresser around so Resident A could not take his clothes out of it. He stated that Resident A was in his room (behind the dresser) for about 35 to 45 minutes until he (Staff Shackleford) went back to Resident A's room to get Resident A for his medication. He stated that he takes Resident A to his room to calm him down because Resident A screams and hollers.

After I spoke with Staff Shackleford. I spoke with home manager Quante Johnson. He denied hearing anything about Resident A having a behavior at the time of the alleged incident.

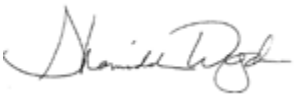
APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	Staff Early Shackleford admitted to confining Resident A in his bedroom by placing his dresser to block the pathway for Resident A to exit the room.

	Staff Rasheed Richards reported witnessing that Resident A had been confined to his room by Staff Shackleford. Resident A could not be interviewed due to being non-verbal. His case manager Kelley Banks confirmed that she was aware of Staff Shackleford confining Resident A to his bedroom. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/22/2023, I conducted an exit conference with licensee designee Jennifer Bhaskaran via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

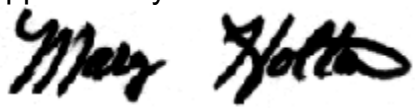
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home (capacity 1-6).



04/03/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



04/03/2023

Mary E. Holton Date
Area Manager