GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 9, 2023

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

RE: License #: AS250010669
Investigation #: 2023A0779062
Marshall Group Home

Dear Jennifer 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 #:	AS250010669
Investigation #:	2023A0779062
Complaint Receipt Date:	08/23/2023
Investigation Initiation Date:	08/23/2024
Report Due Date:	10/22/2023
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Amber Harris
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Marshall Group Home
Facility Address:	1531 Cedarwood Flushing, MI 48433
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	10/07/1981
License **Status:**	REGULAR
Effective Date:	06/11/2023
Expiration Date:	06/10/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 8/20/23, 3rd shift staff, Kaneem Glaspie, was in his car leaving residents alone in the home unsupervised.	Yes
On 8/20/23, two recipients were reportedly found with feces on them at the beginning of 1st shift.	No

III. METHODOLOGY

08/23/2023	Special Investigation Intake 2023A0779062
08/23/2023	Special Investigation Initiated - Telephone Spoke to recipient rights investigator, Michelle Salem.
08/23/2023	Contact - Telephone call made Interview conducted with staff person, Kaneem Glaspie.
08/23/2023	Contact - Telephone call made Interview conducted with staff person, Latwone Hardy.
08/23/2023	Contact - Telephone call made Spoke to administrator, Amber Harris.
08/24/2023	APS Referral Complaint was referred to APS centralized intake.
08/25/2023	Inspection Completed On-site
09/26/2023	Contact - Telephone call made Spoke to APS worker, Samantha Belanger.
10/05/2023	Contact - Telephone call made Spoke to administrator, Amber Harris.
10/09/2023	Exit Conference Held with licensee designee, Jennifer Bhaskaran.

ALLEGATION:

On 8/20/23, 3rd shift staff, Kaneem Glaspie, was in his car leaving residents alone in the home unsupervised.

INVESTIGATION:

On 8/23/23, a phone conversation took place with recipient rights investigator, Michelle Salem, who confirmed that she was investigating the same allegations. Michelle Salem stated that she had already spoken to staff person, Kaneem Glaspie, who admitted that he worked 3rd shift by himself and that he went out to his car around 8:00am to smoke a cigarette, which left no staff inside the home.

On 8/23/23, a phone interview was conducted with staff person Kaneem Glaspie, who confirmed that the other staff who supposed to work 3rd shift called, that he worked the shift alone and that one person can definitely handle the duties during 3rd shift. Staff Glaspie stated that all the residents sleep during the entire shift. Staff Glaspie reported that he had spoken to staff Latwone Hardy at 7:40am, who told him that she was on her way into work. Staff Glaspie stated that after he got off the phone with Staff Hardy, he went out to his car to smoke a cigarette. He stated that he was still in his car when Staff Hardy drove into the driveway at 8:00am and that he acknowledged her and then drove away. Staff Glaspie stated that all the residents were sleeping when he went out to his car but admitted that he left the residents alone unsupervised for approximately 20 minutes.

On 8/23/23, a phone interview was conducted with staff person, Latwone Hardy, who confirmed that she was the staff who worked 1st shift on 8/20/23 and the staff that relieved Staff Glaspie from 3rd shift. Staff Hardy stated that Staff Glaspie was sitting in his car when she pulled into the home's driveway at 8:00am. Staff Hardy reported that Staff Glaspie rolled down his window to say that he had to leave and then drove off. Staff Hardy stated that all the residents of the home were sleeping in their beds when she entered the home.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Staff Kaneem Glaspie worked alone during 3rd shift on 8/20/23. Staff Glaspie admitted that he went out to his car around 7:40am, leaving all the residents in the home alone unsupervised. Staff Glaspie stated that he stayed outside in his car until Staff Latwone Hardy arrived to work at 8:00am. Staff Hardy confirmed that Staff Glaspie was sitting in his car when she arrived at the home at 8:00am and stated that all the residents were in their beds sleeping when she entered the home. There was sufficient evidence found to prove that for approximately 20 minutes during the morning of 8/20/23, there were no direct care staff present in the home and on duty for the supervision, personal care, and protection of this home's residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 8/20/23, two recipients were reportedly found with feces on them at the beginning of 1st shift.

INVESTIGATION:

On 8/23/23, recipient rights investigator, Michelle Salem, stated that she had already spoken to Staff Latwone Hardy regarding this allegation. Michelle Salem stated that Staff Hardy told her that when she arrived to work on 8/20/23, she found that Resident A's colostomy bag had exploded, and that Resident A had partially dry spots of feces on him. Michelle Salem stated that Staff Hardy told her that Resident B had wet feces in his brief and some dry feces on his sheets. Michelle Salem reported that there is nothing in Resident A or Resident B's GHS plans regarding a set requirement as to when or how often to check their briefs during sleeping hours. Michelle Salem stated that she had also already spoken to Staff Kaneem Glaspie, who told her that he had changed both Resident A and Resident B twice during third shift and that they both had diarrhea.

On 8/23/23, Staff Glaspie stated that both Resident A and Resident B had diarrhea a few times that night and that he changed both of them multiple times. Staff Glaspie claims that he checked both residents brief shortly before he spoke to Staff Hardy on the phone at 7:40am, so if they had bowel movements during that 20-30 minute span before Staff Hardy arrived to work at 8:00am, he was not aware of that. Staff Glaspie insisted that he would never leave any resident lay in feces on purpose and if he knew they had soiled their brief.

On 8/23/23, Staff Hardy confirmed that she arrived to work that morning at 8:00am and stated that the home smelled like feces when she walked in. Staff Hardy stated that all the residents were in their beds sleeping when she arrived. When asked to be specific as to the condition of what Resident A and Resident B were in, Staff Hardy stated that both residents had a combo of wet and dry feces on them and that she could tell that it was diarrhea.

On 8/23/23, a phone conversation took place with administrator, Amber Harris, who stated that the other staff person who was supposed to work with Staff Glaspie during 3rd shift that night was a no-call no-show. Administrator Harris stated that all the residents of this home sleep the entire night and that she is confident that one staff can provide adequate care to the residents during 3rd shift. Administrator Harris reported that Resident A has a colostomy bag that is supposed to be changed when 1/3 full of feces and/or gas, but that the bag can build up gas rather quickly and it is not uncommon for it to explode.

The Assessment Plans for AFC Residents were reviewed for the all the residents. All the other residents besides Resident A and Resident B seem to be fairly independent in regard to physically being able to complete their activities of daily living (ADL's).

Resident A's assessment plan stated he is non-verbal, has a colostomy bag and catheter, wears adult briefs, requires full assistance with all ADL's and utilizes a wheelchair. Resident A is able to self-propel in his wheelchair.

Resident B's assessment plan stated that he is non-verbal, legally blind, wears adult briefs and requires minimal physical assistance with his ADLs for thoroughness.

On 8/25/23, an unannounced on-site inspection was conducted. Resident A and Resident B were both viewed to be clean and well-groomed and appeared to be doing well. Due to them both being non-verbal, neither of them was able to be interviewed. All other residents of this home were also viewed to be clean and well-groomed.

On 9/26/23, a phone conversation took place with APS worker, Samantha Belanger. She stated that she was at this home on 8/25/23 and 9/22/23 and viewed Resident A and Resident B both times to be clean and well-groomed and that they both appeared well cared for. APS Belanger stated that she will not be substantiating that any neglect of Resident A or Resident B took place.

On 10/5/23, Administrator Harris confirmed that there was nothing in either Resident A or Resident B's GHS plan addressing how often they are to be checked during sleeping hours. Administrator Harris stated that the home's policy is for 3rd shift staff to put eyes on each resident about every 15 minutes and to change any briefs when visibly necessary. She stated that there is no current documentation required by staff when conducting those checks. Administrator Harris reported that Resident A and Resident B's GHS plans since changed to reflect that their briefs are to be physically checked once nightly and at the end of 3rd shift.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was confirmed that both Resident A and Resident B had soiled briefs when 1st shift staff Latwone Hardy arrived to work at 8:00am on 8/20/23. Third shift staff Kaneem Glaspie stated that both residents had diarrhea throughout the night and that he had changed both their briefs multiple times that night. Staff Glaspie claims that he changed Resident A and Resident B's briefs approximately 30 minutes before Staff Hardy's arrival to the home and that he was not aware that the residents had another bowel movement. Staff Hardy confirmed that Resident A and Resident B both had what appeared to be diarrhea and that it was a combination of wet and dry feces that she had found on them. There was no way to know when the residents had their bowel movements or prove how long they sat in soiled briefs; therefore, there was insufficient evidence found to prove that Resident A and Resident B were not provided adequate personal care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/9/23, an exit conference was held with licensee designee, Jennifer Bhaskaran. She was informed of the licensing rule violation and that a written corrective action plan is required.

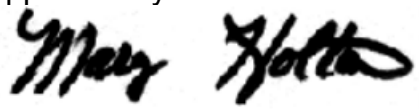
IV. RECOMMENDATION

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

10/9/2023

Christopher Holvey Date
Licensing Consultant

Approved By:



10/9/2023

Mary E. Holton Date
Area Manager