



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 30, 2024

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

RE: License #: AS250010919  
Investigation #: 2025A0779010  
Maple Road 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,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

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**

<b>License #:</b>	AS250010919
<b>Investigation #:</b>	2025A0779010
<b>Complaint Receipt Date:</b>	11/18/2024
<b>Investigation Initiation Date:</b>	11/19/2024
<b>Report Due Date:</b>	01/17/2025
<b>Licensee Name:</b>	Alternative Services Inc.
<b>Licensee Address:</b>	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
<b>Licensee Telephone #:</b>	(248) 471-4880
<b>Administrator:</b>	Candy Hamilton
<b>Licensee Designee:</b>	Jennifer Bhaskaran
<b>Name of Facility:</b>	Maple Road Home
<b>Facility Address:</b>	4341 W. Maple Avenue Flint, MI 48503
<b>Facility Telephone #:</b>	(810) 655-0711
<b>Original Issuance Date:</b>	11/05/1990
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/15/2023
<b>Expiration Date:</b>	11/14/2025
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
There was no staff inside the home in the early morning on 11/14/2024 when manager Rachel White arrived. Staff Lashay Coleman was in her car sleeping at that time.	Yes

**III. METHODOLOGY**

11/18/2024	Special Investigation Intake 2025A0779010
11/18/2024	APS Referral Complaint sent to APS centralized intake.
11/19/2024	Special Investigation Initiated - On Site
11/19/2024	Contact - Telephone call made Spoke to staff person, Lashay Coleman.
11/22/2024	Contact - Telephone call made Spoke to Resident B.
12/17/2024	Exit Conference Held with administrator, Candy Hamilton.

**ALLEGATION:**

There was no staff inside the home in the early morning on 11/14/2024 when manager Rachel White arrived. Staff Lashay Coleman was in her car sleeping at that time.

**INVESTIGATION:**

On 11/19/2024, an on-site inspection was conducted and Resident A was interviewed. Resident A stated that on the night of 11/14/2024, she got up to use the bathroom at approximately 11:00pm, because she was feeling sick. In order for Resident A to get from her bedroom to the bathroom, she had to walk through the entire 1<sup>st</sup> floor. Resident A claimed that she did not see staff person, Lashay Coleman, anywhere. Resident A stated that 3<sup>rd</sup> shift staff usually sit at the staff desk during the night, which is right next to the bathroom on the 1<sup>st</sup> floor. Resident A reported that she got up again at approximately 5:30am and again did not see Staff Coleman anywhere. Resident A stated that the front door was open at that time and that when she was looking out the door, home manager, Rachel White, showed up. Resident A stated that when Manager White came in the home, she went back to bed. Resident A reported that she never saw where Staff Coleman was.

On 11/19/2024, home manager, Rachel White, stated that she arrived to work the morning of 11/14/24 at 5:30am. Manager White claims that while she was walking up to the home, she observed Staff Coleman sitting in her car with the car doors closed. Manager White stated that Staff Coleman was physically slumped over, had her eyes closed, and appeared to be sleeping. Manager White reported that when she approached the door of the home, the door was open and she observed Resident A standing in the doorway. Manager White stated that Resident A went back to bed and that she was in the home for a few minutes before Staff Coleman came back into the home. Manager White stated that Staff Coleman came in, went straight to the bathroom and then left the home at 5:45am. Manager White claimed that she did not get a chance to talk to Staff Coleman about her being out in her car, before Staff Coleman left. Manager White stated that all the other residents were still in bed at that time, as most of them usually sleep the entire night. Manager White reported that no other residents have said anything about seeing Staff Coleman out in her car during 3<sup>rd</sup> shift. Manager Coleman stated that she is not sure how long Staff Coleman was out in her car before she arrived there at 5:30am.

While still at this home on 11/19/2024, a phone call was made to staff person, Lashay Coleman, who denied that she was out sleeping in her car the morning of 11/14/2024. Staff Coleman claimed that at approximately 5:30am, she went out to start her car and that while she was out there, Manager White pulled in the driveway. Staff Coleman stated that since Manager White had arrived, she took the opportunity to clean some trash out of her car. Staff Coleman stated that Manager White went into the home without saying anything to her. Staff Coleman admitted that there was no staff present in the home when she went out to start her car but claimed that she was only outside for a total of about 3 minutes. Staff Coleman reported that she went into the home, used the bathroom, told Manager White that she was leaving and then left the home. Staff Coleman stated that Manager White never said anything to her about being out in her car. When asked where she was when Resident A got up at 11:00pm, Staff Coleman stated that she was out on the porch with Resident B. Staff Coleman reported that Resident B got up and asked for a cigarette, so she sat out on the porch with Resident B for a few minutes and then fixed Resident B a sandwich, before Resident B went back to bed. Staff Coleman claimed that Resident A must have gone to the bathroom while she was outside with Resident B.

A second brief conversation took place with Resident A on 11/19/2024. Resident A stated that she did not observe Resident B when she got up at 11:00pm on 11/13/2024. Resident A stated that no other resident was up and/or out of their rooms at either time that she was up during the night of 11/13-11/14/2024.

On 11/22/24, a phone interview took place with Resident B, who stated that she remembers getting up the night of 11/13/24 and that she remembers that because it was the last night that Staff Coleman worked. Resident B confirmed that Staff Coleman stood out on the porch with her while she smoked a cigarette, but that it was a little past 10:00pm when that happened. Resident B reported that she did get a little something to eat, before going back to bed. Resident B stated that she does not remember what

time it was when she went back to bed and that she does not remember seeing Resident A or any other resident, while she was up during that time. Resident B stated that she does not remember a time where she has observed Staff Coleman outside during 3<sup>rd</sup> shift, but that she usually sleeps all night.

On 12/17/2024, an exit conference was held with administrator, Candy Hamilton. Admin Hamilton confirmed that Staff Coleman punched out early at 5:45am the morning of 11/14/2024 and that Manager White had called her that morning to report her seeing Staff Coleman out sleeping in her car when she arrived to work that morning. Admin Hamilton stated that Staff Coleman was immediately placed on a suspension and that Staff Coleman's employment at this home has since been terminated. Admin Hamilton was informed of the licensing rule violation and that a written corrective action plan will be required.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.</b>
<b>ANALYSIS:</b>	Resident A has stated that she got up twice, once at 11:00pm and once at 5:30am, during the night and early morning on 11/13-11/14/2024 and that she did not observe staff person, Lashay Coleman, present in the home during either time. Home manager, Rachel White, stated that when she arrived to work at 5:30am on 11/14/24, she observed Staff Coleman to be out in her car and Staff Coleman appeared to be sleeping. Manager White stated that there were no other staff present in the home at that time. Staff Coleman admitted that she went outside to start her car at 5:30am but denied sleeping in her car and claims that she was only out there for about 3 minutes. Regardless, if Staff Coleman was outside once or twice during her 3 <sup>rd</sup> shift or how long she was outside for, the residents were left in the home unsupervised and the requirement of having at least 1 direct care staff present in the home was not met. There was a preponderance of evidence found to support violation of this rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Christopher A. Holvey*

12/30/2024

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Christopher Holvey  
Licensing Consultant

Date

Approved By:

*Mary Holton*

12/30/2024

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Mary E. Holton  
Area Manager

Date