GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 20, 2024

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

RE: License #:	AS250077486
Investigation #:	2025A1039009
	Stanley Road

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,

Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250077486
Investigation #:	2025A1039009
Complaint Receipt Date:	11/11/2024
Investigation Initiation Date:	11/12/2024
Report Due Date:	01/10/2025
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:	Stanley Road
Facility Address:	2162 Stanley Road Mt Morris, MI 48458
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	10/22/1997
License Status:	REGULAR
Effective Date:	06/27/2024
Expiration Date:	06/26/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 10/23/2024, during the evening, Staff Emily Taylor reportedly gave Resident A some of Staff Taylor's Percocet.	Yes

III. METHODOLOGY

11/11/2024	Special Investigation Intake 2025A1039009
11/12/2024	Special Investigation Initiated - Letter Emailed GHS ORR concerning allegations.
11/12/2024	APS Referral Sent via email.
11/12/2024	Contact - Telephone call made Phone interview with GHS ORR Kim Nguyen Forbes.
12/12/2024	Contact - Document Sent Emailed Centralized Intake to determine if complaint was assigned for investigation. I was informed that the complaint was denied.
12/12/2024	Inspection Completed On-site Interviewed Home Manager, Direct Care Worker, Resident A and Resident B.
12/12/2024	Contact - Telephone call made Attempted call with Staff Emily Taylor. No answer.
12/16/2024	Contact - Telephone call made Attempted call with Staff Emily Taylor. No Answer.
12/16/2024	Contact - Telephone call received ORR Nguyen-Forbes informed me that she planned to substantiate the investigation.
12/16/2024	Inspection Completed-BCAL Sub. Compliance
12/16/2024	Exit Conference Completed with Licensee Designee.

ALLEGATION:

On 10/23/2024, during the evening, Staff Emily Taylor reportedly gave Resident A some of Staff Taylor's Percocet.

INVESTIGATION:

On 11/11/2024, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that on 10/23/2024, during the evening, Staff Emily Taylor reportedly gave Resident A some of Staff Taylor's Percocet.

On 11/11/2024, I completed a phone interview with Genesee Health Systems Office of Recipient Rights (ORR) Worker Kim Nguyen Forbes. ORR Forbes stated that she had interviewed the resident and Staff member involved and was still working on the investigation. ORR Forbes stated that Staff Taylor informed her that she did give Resident A some medication, but it was Resident A's prescribed as needed (PRN) medication. ORR Forbes stated that she viewed the medication and the Medical Administration Record (MARs) and there was no evidence that she gave any PRN medication to Resident A. ORR Forbes stated that she would update me on her investigation once it was completed.

On 12/12/2024, Department of Health and Human Services Centralized Adult Protective Services (APS) informed me that the complaint regarding Resident A was not assigned for investigation. The allegations received in this investigation had been referred to APS.

On 12/12/2024 I completed an unannounced investigation at Stanley Road Home. I interviewed the following people: Home Manager Valerie Walton, Staff Mary Jones, Resident A and Resident B.

On 12/12/2024, I interviewed Home Manager (HM) Valerie Walton. HM Walton stated that she was aware of the allegations and that they have been in contact with Office of Recipient Rights and also completing their own internal investigation. HM Walton stated that Staff Emily Taylor has been suspended indefinitely and their final decision will not be made on her employment until after the Office of Recipient Rights has completed their investigation. HM Walton stated that she was not working at the time of the incident but that Resident A informed her the next day of the allegations and HM Walton contacted the Office of Recipient Rights concerning the situation. HM Walton stated that she spoke with Staff Taylor and Staff Taylor said that she did not give Resident A any of Staff Taylor's own medication but that she gave Resident A a Tylenol and logged it the MARs. HM Walton stated that she reviewed the medication packets and also the MARs and there did not appear to have been any medication taken out of the bubble packet or any medication administered in the MARs. HM Walton stated that Resident A is on normal programming and that Resident A did not appear to suffer any affects from the medication that she said she was given. HM Walton stated that she completed an

Incident Report, contacted Office of Recipient Rights, Resident A's guardian and their primary physician Dr. Lisa Lindsay. HM Walton stated that Dr. Lindsay stated that there was no need to take Resident A to the emergency room and to just monitor Resident A. HM Walton stated that the home has not had any past issues with Staff giving residents any medication they are not supposed to have.

HM Walton proved me with an Incident Report (IR) dated 10/24/2024, Resident A's Assessment Plan dated 12/26/2023 and GHS Face Sheet with contact information. The IR dated 10/24/2024, confirms that the incident was reported to Office of Recipient Rights and that the Guardian and Primary Physician were consulted for care.

The assessment plan for Resident A dated 12/26/2023 notes that Resident A can communicate and understands verbal communication. Resident A is able to move independently in the community but needs one person supervision. Resident A is somewhat alert to her surroundings. Resident A is able to follow instructions. Resident A requires one person staff supervision when taking medication. The face sheet notes that Resident A is diagnosed with Major depressive disorder and Intellectual disability.

I viewed the MARs and the bubble packets of medication containing the PRN/Tylenol that Staff Emily Taylor stated that she used. It did not appear that any medication had been taken out of the bubble pack as it had no missing medication from the any of the bubbles in the pack. The MARs had not documentation of Resident A or any other resident receiving any PRNs from the bubble pack.

On 12/12/2024, I interviewed Direct Care Worker (DCW) Mary Jones. DCW Jones stated that she was familiar with the allegations as Resident A told her and HM Walton about the incident at the same time. DCW Jones stated that she was not working at the time of the alleged incident. DCW Jones stated that she has never heard of a staff giving a resident any unprescribed medication at the home before and doesn't think that it has ever happened. DCW Jones stated that she has never seen Staff Emily Taylor give any resident unprescribed medication. DCW Jones stated that she is trained to give residents medication and only gives them what they are prescribed and notes everything in the MARs. DCW Jones stated that they give the residents medication in the dining room at the table and make note of it in the MARs as soon as they verify that the residents have taken it. DCW Jones stated that she doesn't know anything that happened with Staff Emily Taylor except that she was suspended immediately and that she has not seen her since the day Resident A informed her that of the incident.

On 12/12/2024, I interviewed Resident A. Resident A was in the staff office at the time of the interview. Resident A appeared neat and clean and was able to communicate. Resident A stated that she remembers the incident and that she had a headache that day and asked Staff Emily Taylor if she could have something for her headache. Resident A stated that Staff Emily Taylor told her that she could not find her PRNs in the bin and said she had a Percocet that she could take. Resident A stated that she knew she should not have taken the medication because it was not hers, but she had a bad headache and took it anyway. Resident A stated that she took the medication, and it

made her feel better and she thinks it made her feel high. Resident A stated that Staff Emily Taylor has never given Resident A that kind of medication before and this was the first time. Resident A stated that Staff Emily Taylor told her not to tell anyone or she could get fired but she told HM Walton anyway because she felt bad about it. Resident A stated that she has not seen Staff Emily Talor since she told HM Walton what happened. Resident A stated that the residents get their medication at the dining room table and that staff mark it in the medication book (MARs). Resident A stated that she likes it at Stanley Road Home and doesn't want to leave.

On 12/12/2024, I interviewed Resident B. Resident B was in the staff office at the time of the interview. Resident B appeared neat and clean and was able to communicate. Resident B stated that she had heard about the incident but didn't know too much about the details besides Staff Emily Talor gave medication to Resident A that she wasn't supposed to have. Resident B stated that staff has never tried to give her any medication that she is not supposed to have and if they did then she would call the police and the Office of Recipient Rights. Resident B stated that the residents get their medication in the dining room at the table. Resident B stated that she never witnessed Staff Emily Taylor give any residents unprescribed medication, but she has observed Staff Taylor take medication while she has been working before. Resident B stated that she did not tell anyone about it since Resident B did not know what it was and it is not Resident B's business. Resident B stated that the staff are really good there and she does not think that any of the other staff would give residents medication they were not prescribed. Resident B stated that she has not seen Staff Emily Taylor in a little while and figured that Staff Taylor got fired or something.

On 12/12/2024 and 12/16/2024, I attempted to contact Staff Emily Taylor via phone call. Staff Emily Taylor did not answer. No return phone call has been received to this point.

On 12/16/2024, I spoke with Genesee Health Systems Office of Recipient Rights (ORR) Worker Kim Nguyen Forbes. ORR Forbes informed me that she would be substantiating on this investigation.

On 12/16/2024, I completed an exit conference with Licensee Designee (LD) Jennifer Bhaskaran. I informed LD Bhaskaran of the results of my investigation. LD Bhaskaran stated that they had suspended Staff Emily Taylor and that pending the results of their investigation and conclusion of the ORR investigation that they would most likely terminating the employment of Staff Emily Taylor.

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 S333.1101 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:	It was alleged that on 10/23/24 during the evening Staff Emily Taylor reportedly gave a Resident A some of her Percocet. I interviewed the Home Manager, Direct Care Worker, GHS Office of Recipient Rights Worker, Resident A and Resident B. I attempted to contact Staff Emily Taylor with no success. I reviewed the Incident Report, Assessment Plan for Resident A and the GHS Face Sheet. Upon conclusion of my investigation, it was determined that there is a preponderance of evidence to conclude that R 400.14312 (1) was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

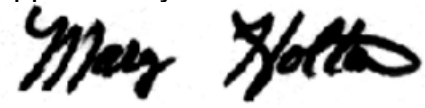
IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend not change in licensure status.

12/16/2024

Martin Gonzales Licensing Consultant	Date

Approved By:



12/20/2024

Mary E. Holton Area Manager	Date