



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 29, 2026

Renee Ostrom  
Residential Alternatives Inc  
124B N Saginaw Street  
Holly, MI 48442

RE: License #: AS630012774  
Investigation #: 2026A0602005  
Appomattox AIS/MR

Dear Ms. Ostrom:

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) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Cindy Berry". The signature is written in black ink and is positioned below the word "Sincerely,".

Cindy Berry, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place  
3044 West Grand Blvd  
2<sup>nd</sup> Floor Annex, Suite 2-730  
Detroit, MI 48202  
(248) 860-4475

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630012774
<b>Investigation #:</b>	2026A0602005
<b>Complaint Receipt Date:</b>	03/24/2026
<b>Investigation Initiation Date:</b>	03/25/2026
<b>Report Due Date:</b>	05/23/2026
<b>Licensee Name:</b>	Residential Alternatives Inc
<b>Licensee Address:</b>	124B N Saginaw Street Holly, MI 48442
<b>Licensee Telephone #:</b>	(248) 369-8936
<b>Administrator:</b>	Renee Ostrom
<b>Licensee Designee:</b>	Renee Ostrom
<b>Name of Facility:</b>	Appomattox AIS/MR
<b>Facility Address:</b>	10372 Appomattox Holly, MI 48442
<b>Facility Telephone #:</b>	(248) 634-5949
<b>Original Issuance Date:</b>	10/21/1992
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	12/13/2025
<b>Expiration Date:</b>	12/12/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED



**II. ALLEGATION(S)**

	<b>Violation Established?</b>
<b>Resident A's wheelchair was not properly secured during transport causing him to tip over while in the van.</b>	Yes

**III. METHODOLOGY**

03/24/2026	Special Investigation Intake 2026A0602005
03/25/2026	Special Investigation Initiated – Telephone Call made to the assigned Office of Recipient Rights worker, Sarah Rupkus.
03/30/2026	Contact – Telephone call made Spoke with the licensee designee, Renee Ostrom.
04/08/2026	Contact – Telephone call made Spoke with the home manager of Timberhill, LaShonda Lindsey.
04/10/2026	Inspection Completed On-site Observed Resident A at the Lahser Vocational Center
04/28/2026	Contact – Document received Received requested documents.
04/29/2026	Contact – Telephone call made Spoke with the home manager, Annette Thurman.
04/29/2026	Contact – Telephone call made Call made to staff member Yolanda Thornton, voicemail full.
04/29/2026	Exit Conference Held with the licensee designee, Renee Ostrum by telephone.

**ALLEGATION:**

**Resident A's wheelchair was not properly secured during transport causing him to tip over while in the van.**

## **INVESTIGATION:**

On 03/24/2026 a complaint was received and assigned for investigation alleging that Resident A's wheelchair was not properly secured during transport causing him to tip over while in the van.

On 03/30/2026 I spoke with the licensee designee, Renee Ostrom regarding the allegations. Ms. Ostrom stated on 03/17/2026 she received a call from the home manager, Annette Thurman, informing her that Resident A tipped over in the van during transport and staff member Yolanda Thornton was pulled over on the side of the road unable to lift him up. Ms. Ostrom stated she was not far from where the incident occurred and drove to the location. When she arrived at the scene, she observed Resident A still in his wheelchair but flipped backwards. The front tie downs in the van were not secured to his wheelchair but the back tie downs were. Ms. Thornton informed her that she was sure she secured the wheelchair to the van. Resident A is non-verbal and was unable to provide any information. There were also three other non-verbal residents in the van who were appropriately secure in their seats. Resident A was transported to urgent care where there were no injuries noted. Ms. Ostrom went on to state that Ms. Thornton was written up and re-in-serviced on the proper way to secure and transport residents.

On 04/08/2026 I interviewed LaShonda Lindsey who is the home manager of the Timberhill group home. Ms. Lindsey stated on 03/17/2026 staff member Sara Sundberg was scheduled to work between the hours of 7 am and 10 pm. However, she quit mid-shift on 3/16/2026 leaving Ms. Lindsey to work alone on 03/17/2026 until the afternoon staff arrived at 5 pm. Ms. Lindsey stated she contacted the home manager, Annette Thurman of the Appomattox Home (also a Residential Alternatives Inc home) and requested assistance with transport as she was unable to leave the home to pick up the residents from the workshop. Shortly after the call, Ms. Lindsey received a call from Ms. Thurman informing her that Resident A tipped over in his wheelchair during transport. Ms. Lindsey informed Ms. Ostrom and Ms. Ostrom went to the location to assist Ms. Thornton. Resident A was transported to MI-5 Urgent Care where he was evaluated and cleared of any injuries and or bruises.

On 04/10/2026 I made an unannounced on-site investigation at the Lahser Pre-Vocational Center where I interviewed Jackie Quade who is a community skills specialist as well as observed Resident A. Ms. Quade stated when residents are picked up by their group home staff, it is the responsibility of the group home staff to secure them into the van prior to transport. She had no knowledge of Resident A tipping over in his wheelchair during transport. She went on to state that she had not observed any injuries or bruises on Resident A.

On 04/10/2029 I observed Resident A to be neat, clean, appropriately dressed and without any bruises or injuries. Resident A was unable to provide any information regarding the incident as he is non-verbal.

On 04/28/2026 I received and reviewed a copy of Residential Alternatives, INC. in home training. According to the document, all staff are provided with a copy of the employee manual, corporate policies, and procedures. Staff are trained in wheelchair use and care as well as vehicle seating, tie downs and lifts. I also received and reviewed a copy of an appointment information record for Resident A dated 03/17/2026. According to the record, Resident A was seen at the MI-5 Urgent care due to a fall in his wheelchair while in the van. There were no physical findings documented i.e. bruising or swelling of the head and back and he presented with clear breath sounds. The evaluation was listed as normal.

On 04/29/2026 I interviewed Annette Thurman who is the home manager for Appomattox. Ms. Thurman stated some of the residents from Timberhill and Appomattox attend the Lahser Pre-Vocational Center in Clarkston. On 03/17/2026 around 3:00 pm she received a call from Ms. Lindsey asking who was scheduled to pick up the residents from the workshop as she needed someone to pick her residents up. She informed her that Ms. Thornton had already left for transport, but she would call her and make sure she picked up the Timberhill and Appomattox residents. Ms. Thurman called Ms. Thornton and instructed her to pick up the Timberhill residents and drop them off at their home. Around 3:30 pm Ms. Thornton called Ms. Thurman in a panic stating Resident A tipped over backwards in his wheelchair and she was unable to get him up. Ms. Thurman was unable to leave the home to assist her as was Ms. Lindsey. Ms. Ostrom was contacted and arrived at the location and assisted Ms. Thornton. Ms. Thornton was written up and re-in-serviced on the proper procedures for securing residents in the van. Ms. Thurman went on to state that shortly after that incident, Ms. Thornton was written up again for a medication error and demoted from assistant manager to direct care worker. Ms. Thornton was not in agreement with the demotion and terminated her employment with the company on 04/26/2026.

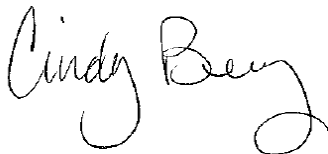
On 04/29/2026 I conducted an exit conference with the licensee designee, Renee Ostrom by telephone. I informed Ms. Ostrom of the investigative findings and recommendation documented in this report. Ms. Ostrom stated Ms. Thornton is no longer with the company and agreed to submit a corrective action plan upon receipt of this report.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

<b>ANALYSIS:</b>	<p>Based on the information obtained during the investigation, there is sufficient information to determine that on 03/17/2026 Resident A's wheelchair was not properly secured in the van, causing him to tip over backwards.</p> <p>According to Ms. Ostrom, on 03/17/2026 when she arrived at the scene, she observed Resident A tipped over backwards in the van while still in his wheelchair. Resident A's wheelchair was not secured in the van with the front tie downs but the rear tie downs were secured.</p> <p>According to Ms. Thurman, on 03/17/2026 she received a call from Ms. Thornton around 3:30 pm in a panic informing her that Resident A tipped over backwards in the van and she was unable to lift him up.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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



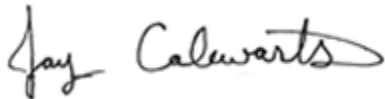
04/29/2026

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Cindy Berry  
Licensing Consultant

Date

Approved By:



For

04/30/2026

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Denise Y. Nunn  
Area Manager

Date