GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 24, 2021

Lorinda Anderson
Community Living Options
626 Reed Street
Kalamazoo, MI 49001

RE: License #: AS390317402
Investigation #: 2021A1024030
Farrell

Dear Ms. Anderson:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On May 21, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390317402
Investigation #:	2021A1024030
Complaint Receipt Date:	04/30/2021
Investigation Initiation Date:	05/22/2021
Report Due Date:	06/29/2021
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(126) 934-3635
Administrator:	Lorinda Anderson
Licensee Designee:	Lorinda Anderson
Name of Facility:	Farrell
Facility Address:	805 Farrell Kalamazoo, MI 49006
Facility Telephone #:	(269) 372-5932
Original Issuance Date:	08/08/2012
License Status:	REGULAR
Effective Date:	01/16/2021
Expiration Date:	01/15/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff Angela was observed being rude to the residents.	No
Additional Findings	Yes

III. METHODOLOGY

04/30/2021	Special Investigation Intake 2021A1024030
05/03/2021	Special Investigation Initiated – Telephone with Recipient Rights Officer Michelle Schiebel
05/04/2021	Contact - Telephone call made via Microsoft Teams Conference with direct care staff members Angela Filipunas, Harrison Osborn and home manager Cam Dawson.
05/04/2021	Contact-Telephone call made with licensee designee Lorinda Anderson
05/05/2021	Contact-Document Received-email correspondence with Recipient Rights Officer Michelle Schiebel
05/10/2021	Contact - Telephone call made with direct care staff member Andy Argo
05/11/2021	Contact - Telephone call made with direct care staff member Sharon Mckenzie
05/12/2021	Contact - Telephone call made with direct care staff member Cindy Knapp
05/14/2021	Contact - Document Received *Assessment Plan for AFC Residents* and *Health Care Appraisals* for Residents A, B, C, D and E.
05/19/2021	Contact - Telephone call made with direct care staff member Kailey Lethcoe
05/19/2021	Exit Conference with licensee designee Lori Anderson
05/19/2021	Inspection Completed-BCAL Sub. Compliance

05/19/2021	Corrective Action Plan Requested and Due on 06/16/2021
05/21/2021	Corrective Action Plan Received
06/01/2021	Inspection Completed On-site with Residents A, B, C, D, E
06/02/2021	Corrective Action Plan Approved

ALLEGATION:

Staff Angela Filipunas was observed being rude to the residents.

INVESTIGATION:

On 4/30/2021, I received this complaint through the Bureau of Community and Health Systems online complaint system. This complaint alleged staff Angela Filipunas was observed being rude to residents and therefore was mistreating the residents. This complaint further alleged on 4/30/2021, Ms. Filipunas was observed to ignore Resident A when he was trying to sign (use American Sign Language) to her that he was hungry by tapping her leg while she was on her phone. Ms. Filipunas was observed to then slap Resident A's hand away when he was trying to get her attention to sign. This complaint further alleged Ms. Filpunas was also rude to Resident B by 'hip checking' him, causing him to fall and rude to Resident C by intentionally pushing Resident C when he was sitting on his knees, causing him to hit his head and bend his knees backwards. The supervisor Cam Dawson was present when Ms. Filpunas was rude to the residents.

On 5/3/2021, I spoke to Recipient Rights Officer Michelle Schiebel who stated she was also investigating this allegation and planned to interview the direct care staff members involved on 5/4/2021 through Microsoft Teams Conference.

On 5/4/2021, I conducted interviews with direct care staff members Angela Filpunas, Harrison Osborn, and home manager Cam Dawson. Ms. Filpunas denied this allegation and stated she has never mistreated any of the residents or seen any other staff member mistreat any of the residents. Ms. Filpunas stated on 4/30/2021, she worked with Residents A, B, C while Mr. Osborn took the other residents to pick up dinner for everyone from McDonald's. Ms. Filpunas stated during this time a maintenance staff member was present and was getting agitated that the residents continued to walk near a wall that had been recently painted. Ms. Filpunas stated when Mr. Osborn returned to the home with food, Resident B attempted to walk in the kitchen near the painted wall and maintenance equipment, so Ms. Filpunas stated she walked in front of him to redirect away from that entrance by pointing to the other direction. Ms. Filpunas stated when she body positioned herself in front of

Resident B in attempts to keep him from walking near the painted wall and equipment, Resident B pushed through her and Ms. Filpunas bumped into the wall. Ms. Filpunas stated after she saw that Resident B was getting escalated, she removed herself from the situation and another staff member was able to verbally redirect Resident B away from the painted wall without incident. Ms. Filpunas stated Resident B was provided his food without any incident. Ms. Filpunas stated at no time did she “hip check” Resident B or touch him in any way. Ms. Filpunas further stated she did not slap Resident A’s hand and has never slapped his hand away. Ms. Filpunas stated Resident A will often symbolize that he is hungry by rubbing his stomach all day. Ms. Filpunas stated when Resident A wants to communicate with staff members, he will write notes or hit the wall. Ms. Filpunas denied that Resident A tapped her to get her attention and denied that she ignored Resident A while she was on her phone. Ms. Filpunas also denied that she was rude to Resident C. Ms. Filpunas stated Resident C often crawls on the floor and likes to wrestle on the floor. Ms. Filpunas stated she observed Resident C to attempt to wrestle with another resident however nothing out of the ordinary occurred. Ms. Filpunas stated at no time did she push Resident C over on the floor. Ms. Filpunas stated Resident C will roll over on his own. Ms. Filpunas stated she did not observe Resident C to hit his head while working with him and she did not have any unusual incidents with Resident C.

Mr. Dawson stated he did not observe Ms. Filpunas or any other staff member be rude to any of the residents or mistreat any of the residents. Mr. Dawson stated there are two entrances to the kitchen and maintenance was working on a wall near one of the kitchen entrances therefore chairs were positioned in this area to prevent residents from walking in this direction. Mr. Dawson stated when Mr. Harrison brought back food for dinner, all the residents walked in the kitchen away from the painted wall and maintenance equipment except for Resident B. Therefore Ms. Filpunas attempted to use body positioning by walking in front of the Resident B in attempts to redirect Resident B to walk away from the area where maintenance was working. Mr. Dawson stated Resident B pushed Ms. Filpunas against the wall to move her out the way however Resident B eventually walked to the other direction after being verbally redirected and de-escalated quickly with no further incidents. Mr. Dawson further stated all the residents were in good spirits and he has no reason to believe that they were upset about anything. Mr. Dawson stated, he believes if any of the residents were mistreated or hit, they would have shown this in their behavior by pouting or being reserved. Mr. Dawson stated, Resident A will often sign that he is hungry even when he has just eaten food and usually communicates to staff by banging on the wall or writing notes. Mr. Dawson stated he did not see Resident A tap Ms. Filpunas or get hit by Ms. Filpunas. Mr. Dawson further stated he did not see Ms. Filpunas ignore Resident A while being on her phone. Mr. Dawson also stated Resident C often crawls and rolls around on the floor therefore it is not unusual to see him on the floor and Resident C did not give indication that he hit his head. Mr. Dawson stated Ms. Filpunas is a good staff who works well with the residents and he has no concerns for Ms. Filpunas.

Mr. Harrison denied this allegation and stated he did not observe Ms. Filpunas to hit or mistreat any of the residents. Mr. Harrison stated all the residents were excited and in good spirits about getting McDonald's for dinner and everyone except for Resident B entered into the kitchen away from the area where maintenance was working to eat when the food was brought back to the home. Ms. Harrison stated Resident B attempted to walk through the kitchen entryway that was temporarily blocked off therefore Ms. Filpunas intervened by positioning herself between the wall and Resident B. Ms. Harrison stated Resident B then pushed Ms. Filpunas against the wall and Ms. Filpunas then moved out of the way. Mr. Harrison stated Resident B then walked over to the opposite kitchen entry away from the painted wall once Mr. Dawson came over to assist. Mr. Harrison stated Resident B did not seem upset and immediately got back in good spirts to eat his food. Mr. Harrison stated Resident A will often sign to staff that he is hungry even when he is not hungry. Mr. Harrison stated Resident A communicates well with direct care staff by banging on the wall or writing notes. Mr. Harrison further stated he has never seen Ms. Filpunas ignore or hit Resident A and has never seen Ms. Filpunas push Resident C. Mr. Harrison stated Resident C is often on the floor crawling and rolling around and there were no signs that Resident C hit his head while on the floor.

On 5/4/2021, I conducted an interview with licensee designee Lorinda Anderson. Ms. Anderson stated a concerned staff member reported this allegation to her on 4/30/2021. Ms. Anderson stated this staff member has mentioned to her in the past about participating in trainings so he can feel more comfortable and have a better understanding of the residents in the home. Ms. Anderson believes this maintenance staff member may have misinterpreted what he observed when he was working at the home and she has no reason to believe that Ms. Filpunas would mistreat any of the residents.

On 5/14/2021, I reviewed Resident A's *Assessment Plan for AFC Residents* dated 10/5/2020. According to this plan, Resident A communicates by reading lips, ASL and written communication.

On 6/1/2021, I conducted an onsite investigation at the facility. I observed Residents A, B, C, D, and E to be clean with no concerns. I also observed the home conditions to be clean and appropriate.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or

	physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Angela Filipunas, Harrison Osborn and home manager Cam Dawson, licensee designee Lorinda Anderson and review of Resident A's Assessment Plan for AFC Residents there is no evidence to support the allegation staff Angela Filpunas was observed to be rude by mistreating the residents. This complaint further alleged Mr. Dawson has also witnessed Ms. Filpunas be rude to the residents and Ms. Filpunas was rude by ignoring Resident A and slapping his hand away, "hip checking" Resident B and knocking down Resident C causing him to hit his head. This alleged incident occurred on 4/30/2021. Ms. Filpunas, Mr. Osborn, and Mr. Dawson all denied this allegation and stated they have never seen Ms. Filipunas mistreat or hit any of the residents. Mr. Osborn and Mr. Dawson both stated the residents were in good spirits on 4/30/2021 and there was no indication that Residents A, B, and C were mistreated. Ms. Filpunas, Mr. Dawson, and Mr. Harrison all stated Resident B pushed Ms. Filpunas when Ms. Filpunas tried to prevent Resident B from entering into a kitchen entryway where maintenance staff was working by stepping in between Resident A and the kitchen entryway wall. Resident A was able to quickly be de-escalated on his own after verbal redirecting without further incident. Ms. Filpunas, Mr. Dawson, and Mr. Harrison also all stated Resident C often likes to crawl and roll around on the floor and there was no indication that Resident C hit his head or was pushed over by anyone. Mr. Dawson and Ms. Anderson has no reason to believe that Ms. Filpunas mistreated any of the residents. The residents have not been mistreated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/14/2021, I reviewed the facility's *Health Care Appraisal* for Residents A, B, C, D. I reviewed Resident B's Health Care Appraisal to be dated for 8/27/2019.

On 5/19/2021, Ms. Anderson stated Resident B's most current Health Care Appraisal was dated for 8/27/2019 and Resident B has an appointment to get an updated appraisal conducted on 5/24/2021.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	I reviewed Resident B’s Health Care Appraisal to be dated for 8/27/2019. Ms. Anderson stated Resident B’s most current Health Care Appraisal was dated for 8/27/2019 and Resident B has an appointment to get an updated appraisal conducted on 5/24/2021 therefore a written health care appraisal was not completed at least annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/5/2021, I spoke to Recipient Rights Officer Michelle Schiebel who stated that an anonymous staff member contacted her and reported that certain staff members are using inappropriate behavior intervention techniques when working with Resident C and Resident D.

On 5/10/2021, I conducted an interview with direct care staff member Andy Argo who stated he has not observed any staff members mistreat any of the residents in the home however he has heard reports that some staff members have filled up a water bottle and will squirt water at Resident D to get him to comply with following directions or change a behavior. Mr. Argo stated he has not seen this practice used however he has seen water bottles throughout the home which he believes are used by staff members for drinking not as a behavior intervention. Mr. Argo stated he has not actually heard any staff member admit to using this behavior technique.

On 5/11/2021, I conducted an interview with direct care staff member Sharon McKenzie. Ms. McKenzie stated she has never seen any staff member squirt Resident D with water, however Ms. Mckenzie stated she has shown Resident D a bottle full of water when she wants him to follow directions such as going to his room. Ms. Mckenzie stated this technique is helpful because Resident D is afraid of water, therefore Resident D will comply with any direction after he is shown a water bottle. Ms. Mckenzie further reported that she has also used other innovative behavior techniques with Resident C to get him to comply with directions. Ms. Mckenzie stated although she is not trained to pull residents to assist with guiding them, she has found that pulling Resident C by the wrist is a quick way to get Resident C to move in the direction you need him to go. Ms. Mckenzie stated she will pull Resident C by the wrist when she is in the kitchen cooking meals to keep Resident C from touching the stove. Ms. Mckenzie stated she understands that she is trained to used "body positioning" as a behavior technique to keep residents safe however she chooses to pull Resident C by the wrist as an alternative technique. Ms. Mckenzie stated she is unsure if any other staff members use alternative behavior techniques that have not been approved on the residents. Ms. Mckenzie stated she understands that she used behavior techniques that are not authorized or that she is formally trained to use with either Resident C or Resident D.

On 5/12/2021, I conducted an interview with Cindy Knapp who stated she has no knowledge of any unapproved behavior techniques being used by staff members to manage resident behavior. Ms. Knapp further stated she has not seen any water bottles used as a behavior intervention with any resident in the home and has no knowledge of any staff members pulling Resident C's wrist or arms. Ms. Knapp stated Resident C is easily guided by allowing Resident C to grab on staff's arm and walk simultaneously together.

On 5/14/2021, I reviewed Resident C's and D's *Assessment Plan for AFC Residents*. According to Resident C's and D's plan, there are no specified interventions to address unacceptable behaviors by Resident C or Resident D.

On 5/19/2021, I conducted an interview with Kailey Lethcoe who stated direct care staff member Cindy Knapp informed her that water could be squirted on Resident D with a water bottle to intimate Resident D to change his behavior because Resident D is afraid of water. Ms. Lethcoe stated she has not seen any staff member squirt water on Resident D or any other residents. Ms. Lethcoe further stated she has seen Ms. Mckenzie pull and drag Resident C out of the kitchen on numerous occasions which is not an approved behavior intervention.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address

	unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Ms. Schiebel reported that she was informed by an anonymous staff member that certain staff members are using inappropriate behavior intervention techniques when working with Residents C and Resident D. Ms. Mckenzie stated she has unapproved behavior techniques on Residents C by pulling him by the wrist to guide him out of the kitchen and has intimidated Resident D with a water bottle to make him comply with following directions. Ms. Lethcoe stated she has also observed Ms. Mckenzie drag and pull Resident C out of the kitchen. There are no specified behavior techniques written in Resident C's and Resident D's *Assessment Plan for AFC Residents*. Ms. Mckenzie stated she understands that she used behavior techniques that she has not been trained or authorized to used therefore interventions to address unacceptable behavior was used not in accordance with the resident's assessment plan or in consultation with a licensed certified professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/19/2021, I conducted an exit conference with licensee designee Ms. Lorinda Anderson. I informed Ms. Anderson of my findings and allowed her an opportunity to ask questions and make comments.

On 6/2/2021, an acceptable corrective action plan was approved.

IV. RECOMMENDATION

An acceptable corrective action plan was approved; therefore, I recommend the current license status remain unchanged.

6/21/2021

Ondrea Johnson
Licensing Consultant

Date

Approved By:

06/24/2021

Dawn N. Timm
Area Manager

Date