

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

January 29, 2021

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

RE: License #: AS390011418

Lovell Street Home 710 West Lovell Kalamazoo, MI 49007

Dear Ms. Anderson:

Attached is the Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and rules. Your license is renewed. It is valid only at your present address and is nontransferable.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (517) 284-9730.

Sincerely,

Ondrea Johnson, Licensing Consultant Bureau of Community and Health Systems

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427 East Alcott

Kalamazoo, MI 49001

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS BUREAU OF COMMUNITY AND HEALTH SYSTEMS RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #: AS390011418

Licensee Name: Community Living Options

Licensee Address: 626 Reed Street

Kalamazoo, MI 49001

Licensee Telephone #: (269) 343-6355

Licensee Designee: Lorinda Anderson

Administrator: Lorinda Anderson

Name of Facility: Lovell Street Home

Facility Address: 710 West Lovell

Kalamazoo, MI 49007

Facility Telephone #: (269) 343-6653

Original Issuance Date: 12/11/1986

Capacity: 6

Program Type: DEVELOPMENTALLY DISABLED

MENTALLY ILL

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 1/29/2021	
Date of Bureau of Fire Services Inspection if applicable: N/A	
Date of Health Authority Inspection if applicable: N/A	
Insp	pection Type: ☐ Interview and Observation ☐ Worksheet ☐ Combination ☐ Full Fire Safety
No. of staff interviewed and/or observed No. of residents interviewed and/or observed No. of others interviewed 0 Role: 0	
•	Medication pass / simulated pass observed? Yes \boxtimes No \square If no, explain.
•	Medication(s) and medication record(s) reviewed? Yes \boxtimes No \square If no, explain
•	Resident funds and associated documents reviewed for at least one resident? Yes \boxtimes No \square If no, explain. Meal preparation / service observed? Yes \boxtimes No \square If no, explain.
•	Fire drills reviewed? Yes ⊠ No □ If no, explain.
•	Fire safety equipment and practices observed? Yes \boxtimes No \square If no, explain.
•	E-scores reviewed? (Special Certification Only) Yes \(\subseteq \text{No} \subseteq \text{N/A} \subseteq N/
•	Incident report follow-up? Yes ⊠ No ☐ If no, explain.
•	Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s: N/A ☒
•	Number of excluded employees followed-up? N/A ⊠
•	Variances? Yes ☐ (please explain) No ☐ N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was determined to be in substantial compliance with rules and requirements.

IV. RECOMMENDATION

I recommend issuance of a 2-year regular adult foster care license.

Ondrea Johnson

Licensing Consultant

1/29/2021

Date