GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 21, 2022

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

RE: License #: AS390250889
Investigation #: 2022A1030018
Transitions of Kalamazoo

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 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) 284-9730.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, 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 #:	AS390250889
Investigation #:	2022A1030018
Complaint Receipt Date:	01/06/2022
Investigation Initiation Date:	01/06/2022
Report Due Date:	03/07/2022
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:	Transitions of Kalamazoo
Facility Address:	1353 Oakland Drive Kalamazoo, MI 49008
Facility Telephone #:	(269) 743-2248
Original Issuance Date:	10/23/2002
License Status:	REGULAR
Effective Date:	08/22/2020
Expiration Date:	08/21/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff did uses appropriate physical intervention techniques and pushed Resident B.	No
Direct care staff did not follow Resident A's written Behavior Management Plan.	Yes
Additional Findings	No

III. METHODOLOGY

01/06/2022	Special Investigation Intake 2022A1030018
01/06/2022	Contact - Document Received Received new allegations from Intake 184358 regarding Resident B being mistreated
01/06/2022	Special Investigation Initiated - Telephone Interview with Complainant
01/11/2022	Contact - Face to Face Interview with Resident A
01/11/2022	Contact - Face to Face Interview with Resident B
01/11/2022	Contact - Face to Face Interview with Mamadou Boudain
01/11/2022	Contact - Face to Face Interview with Renee Lindsay
01/11/2022	Contact - Face to Face Interview with Carolyn Wilson
01/11/2022	Contact - Face to Face Interview with Traci Harris
01/11/2022	Contact - Document Received Received a reviewed document

01/11/2022	Contact - Face to Face Interview with Katie Zehner
01/11/2022	Contact - Face to Face Interview with Kristin Bauer Kristin
01/12/2022	Contact - Document Received Documents received and reviewed
01/12/2022	Contact - Face to Face Interview with Jasmine Brown
01/12/2022	Contact - Face to Face Interview with Codi Zamora
01/12/2022	Contact - Face to Face Interview with Sue Valler
01/20/2022	Exit Conference Exit Conference with licensee designee by phone

ALLEGATION:

Direct care staff did uses appropriate physical intervention techniques and pushed Resident B.

INVESTIGATION:

On 1/6/2022, I interviewed Office of Recipient Rights investigator Michelle Scheibel by telephone. Ms. Scheibel reported this incident occurred on 12/26/2021 and Resident B has a history of aggression toward staff. Ms. Scheibel reported there was one direct care staff who was a witness to the situation.

On 1/6/2022, I received and reviewed Resident B's *Behavior Management Plan* (BMP) dated 9/22/2021 and an *Incident Report* (IR) dated 12/26/2021. Resident B's BMP indicated he was diagnosed with Mild Intellectual Disability and Bipolar 1 Disorder, Unspecified. The BMP target behaviors included "verbal agitation, physical acting out against objects, physical acting out against others, self-injurious behavior and transportation dangers." Resident B's proactive strategies included "prompting calming skills" and to use "Mandt training which emphasizes the use of gradual and graded non-physical techniques" at times of physically acting out. The IR included an attached

Emergency Use of Physical Intervention form that documented the last “two minutes with 10 seconds of physical management” of the incident.

On 1/11/2022, I interviewed Resident B via Teams online video conferencing. Resident B reported he was mad because direct care staff would not take him to the hospital because he thought he had a urinary tract infection. Resident B reported he was angry at direct care staff member, Kristin Bauer. Resident B reported Ms. Bauer “pushed me” out of the staff office. Resident B reported he hit Ms. Bauer in the shoulder with his elbow but denied slapping or backhanding her in the face. Resident B reported he apologized for his behavior.

On 1/11/2022, I interviewed direct care staff member Katie Zehner via Teams. Ms. Zehner reported she has worked at the facility since October 2021 and was working on 12/26/2021 during the incident with Resident B. Ms. Zehner reported Resident B was “wound up that day and had been targeting direct care staff member, Kristin Bauer. Ms. Zehner reported she offered Resident B his PRN anxiety medication but her reused to take it. Ms. Zehner reported they tried to get Resident B to use his coping skills, but he did not respond to their prompts. Ms. Zehner reported Ms. Bauer was in the staff office/medication room when Resident B entered the room. Ms. Zehner reported she heard Ms. Bauer ask Resident B to leave the room and the saw Resident B “slap” Ms. Bauer. Ms. Zehner reported she assisted Ms. Bauer to redirect Resident B and did not hear Resident B accuse Ms. Bauer of pushing her. Ms. Zehner reported Resident B apologized to Ms. Bauer after he slapped her.

On 1/11/2022, I interviewed direct care staff member Kristin Bauer via Teams. Ms. Bauer reported she has worked for the facility for a year and a half. Ms. Bauer reported Resident B was agitated on 12/26/2021 and was targeting her that day as he often does. Ms. Bauer reported Resident B had been following her around the house throughout the shift. Ms. Bauer reported she was sitting on the staff office which is also the medication room when Resident B came “charging” into the office asking her what she was “writing in his book.” Ms. Bauer reported she asked Resident B to step out of the office which he refused to do. Ms. Bauer reported she then “put her hands up, palms out” like she was trained to do and “placed her hands on his forearms and “guided him out of the office. Ms. Bauer reported she did not “push him out of the office” as was alleged. Ms. Bauer reported she felt that he was going to attack her as one of his fists was “balled up.” Ms. Bauer reported Resident B slapped her in the face in response to being guided out of the office and yelled “you pushed me.” Ms. Bauer reported that she tied to have Resident B take one of his PRN medications prior to this situation but he refused. Ms. Bauer reported she also asked him to use his coping skills and he responded, “I will never use my skills.” Ms. Bauer reported she spoke with direct care staff member Katie Zehner about what happened and was able to get Resident B to calm down and later he apologized.

On 1/12/2022, I received and reviewed verification of direct care staff Kristin Bauer’s Mandt training dated 12/23/2021.

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 interviews with Ms. Scheibel, staff, and Resident B combined with my review of Resident B's BMP, 12/26 IR, and staff training records I determined the staff followed their training and was able to safely manage Resident B's behavior without any mistreatment to him.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff did not follow Resident A's written Behavior Management Plan.

INVESTIGATION:

Ms. Scheibel reported Resident A eloped from Transitions during the morning of 1/5/22 and was found at Phoenix High School on one of the school buses by a school bus driver. Ms. Scheibel reported Resident A was transported to Borgess Hospital by law enforcement where hospital staff examined him and contacted Transitions for him to be picked up.

On 1/6/2022, I received and reviewed Resident A's BMP dated 6/15/2021 and an IR dated 1/5/2022. Resident A's BMP indicated he was diagnosed with Autism Spectrum Disorder, IDD Severe, Generalized Anxiety Disorder, Undifferentiated Schizophrenia Disorder and Fragile X Disorder. The BMP target behaviors included "physical acting out against objects, physical acting out against others, self-injurious behavior and anxiety-driven behaviors." Resident A's proactive strategies included "prompting calming skills." In addition, the BMP indicated "staff will provide attention and social interaction every fifteen minutes during awake hours." The IR indicated that Resident A eloped and was taken to Borgess Hospital. The IR further indicated Mr. Boudain

informed Ms. Harris that Resident A was sleeping as he had “tired himself out” by yelling and screaming all night long.

On 1/11/2022, I interviewed Resident A via Teams. It should be noted Resident A has communication deficits and was unable to fully participate with the interview. Resident A acknowledged that he walked away from Transitions and went into a school bus located at the school next door to the facility. Resident A was unable to provide the exact time he left the facility or how long he was on the school bus.

On 1/11/2022, I interviewed direct care staff member Mamadou Boudain via Teams Mr. Boudain was working third shift from 1/4 into 1/5/2022. Mr. Boudain reported he was unaware that Resident A had eloped during his shift. Mr. Boudain reported Resident A was in a “manic phase” and was up all night long yelling and going from his bedroom to the living room. Mr. Boudain stated the last time he saw Resident A was when Traci Harris reported for her shift about 6:40am and Resident A was observed leaving the living room and going to his bedroom. Mr. Boudain reported leaving the facility at end of his shift at about 7:50am. At that time Resident A was not in the living room, so he assumed Resident A had remained in his bedroom sleeping.

On 1/11/2022, I interviewed direct care staff member Renee Lindsay via Teams. Ms. Lindsay reported she left work at 7:05am and did not see Resident A either during her shift or as she was leaving the facility.

On 1/11/2022, I interviewed direct care staff member Carolyn Wilson via Teams Ms. Wilson reported she was working third shift with Renee Lindsay on the North side of the facility. Ms. Wilson reported she could hear Resident A yelling and screaming throughout her shift. Ms. Wilson reported she went to the South side of the building at about 6:00am and made visual contact with Resident A. Ms. Wilson reported she later had direct care staff Traci Harris from the South side fill in for her as she went to get coffee at around 7:20am. Ms. Wilson did not see Resident A leave the facility.

On 1/11/2022, I interviewed direct care staff member Traci Harris via Teams. Ms. Harris reported she worked first shift on the North side of the facility and arrived at about 6:40am. Ms. Harris spoke with Mr. Boudian who informed her that Resident A was awake all night long. Ms. Harris reported she went to the South side of the facility to cover as Ms. Wilson went to get coffee. Ms. Harris reported she returned to her side of the facility after Ms. Wilson returned and at no time did she see or hear Resident A. I asked Ms. Harris again about seeing Resident A when she arrived at work as I was told that she did in fact see Resident A in the living room. Ms. Harris reported again that she did not see or hear Resident A and was informed by Mr. Boudian that he was sleeping. Ms. Harris reported she did not check to confirm that he was sleeping. Ms. Harris reported she received a phone call from the main office sometime shortly after 8:00am that Resident A was at Borgess Hospital and was ready to be picked up.

On 1/12/2022, I interviewed direct care staff member Jasmine Brown via Teams. Ms. Brown reported she was working first shift on the North side of the building, however,

was running late and called to informed Mr. Boudian of her late arrival. Ms. Brown reported she arrived at 7:20am and noted Ms. Harris was cooking breakfast so she and Mr. Boudian went into the staff office to talk about the night shift and count medications. Ms. Brown reported Mr. Boudian informed her at least three times that Resident A was sleeping in his bedroom because he had been up all night in a manic episode. Ms. Brown reported she was getting Resident A's medication ready when they received a phone call a few minutes after 8:00am that Resident A was at Borgess hospital. Ms. Brown denied seeing or hearing Resident A that day until they went to pick him up at Borgess Hospital. Ms. Brown reported she went into Resident A's bedroom before going to Borgess Hospital and noted Resident A's bedroom window was closed and doubted that he jumped out of his window.

On 1/12/2022, I made an on-site visit at Transitions AFC at 1353 Oakland Drive. I toured the facility and observed Resident A's bedroom which is on the first floor and contains a window large enough for him to climb out. I interviewed home manger, Codi Zamora regarding Resident A and how he eloped from the facility. Ms. Zamora reported that she walked around the home on the morning Resident A eloped and observed fresh footprints in the snow walking away from Resident A's bedroom and toward the driveway of the facility.

On 1/12/2022, I spoke with Phoenix High School principal, Sue Valler. Ms. Valler reported the school buses drop off students between 7:00am and 7:30am. Ms. Valler reported she had no knowledge of Resident A getting onto one of the buses and subsequently being taken to Borgess Hospital.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A eloped and was missing from the facility for an unknown length of time. Based on my interviews of staff and review of the 1/6 IR, Resident A was last seen at the facility at 6:40am. While there are inconsistencies between staff interviewed, Resident A was experiencing a manic episode all night and was periodically seen and heard moving about the facility. Review of Resident A's BMP reveals staff responsibility to interact with him every 15-minutes during awake hours. However, based on what appears to be an assumption beginning with Mr. Boudain, staff did not actually go to Resident A's room and verify that he was in fact sleeping when they no longer saw or heard him. It was during this time that Resident A opened his window and left unnoticed. While staff could not have anticipated Resident A eloping by means of his window, they could have verified he was in fact sleeping and did not require the frequent monitoring called for in his BMP during his awake hours. As such, Resident A was not provided supervision and protection according to his BMP.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/20/2022, I shared the findings of this report with licensee designee, Lori Anderson by phone. Ms. Anderson acknowledged and agreed with the findings.

IV. RECOMMENDATION

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

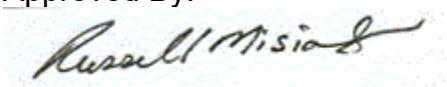
Nile Khabeiry, LMSW

1/21/2021

_____

Nile Khabeiry Date
Licensing Consultant

Approved By:



1/25/22

Russell Misiak Date
Area Manager