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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2022

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

RE: License #: AS390250889
Investigation #: 2022A1024011
Transitions of Kalamazoo

Dear Ms. Anderson:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 #:	AS390250889
Investigation #:	2022A1024011
Complaint Receipt Date:	11/24/2021
Investigation Initiation Date:	11/24/2021
Report Due Date:	01/23/2022
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(126) 934-3635
Administrator:	Tim VanDyke
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?
Hospital recommended a change in medication for Resident A in August 2021 and no change has been made.	No

III. METHODOLOGY

11/24/2021	Special Investigation Intake 2022A1024011
11/24/2021	Special Investigation Initiated – Telephone left voicemail for Adult Protective Service Specialist (APS) Lauren Cook
11/29/2021	Contact - Telephone call received from APS Specialist Lauren Cook
12/14/2021	Contact - Telephone call made with Relative A1
01/11/2022	Contact - Telephone call made with home manager Codi Zamora
01/11/2022	Contact - Telephone call made with direct care staff member Katlyn Zehner
01/12/2022	Contact - Document Received- Medication Administration Record (MAR), AFC Licensing Division-Accident/Incident Report
01/13/2022	Contact - Document Sent with administrator Tim VanDyke
01/14/2022	Inspection Completed On-site- Reviewed *Borgess Discharge Summary, Medical Visit Form,* physician scripts
01/14/2022	Exit Conference with licensee designee Lori Anderson

ALLEGATION:

Hospital recommended a change in medication for Resident A in August 2021 and no change has been made.

INVESTIGATION:

On 11/24/2021, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged the hospital recommended a change in medication for Resident A in August 2021 but no

change was made. This complaint further stated the hospital recommended Resident A to receive Diazepam 10 mg twice daily and instead the home continues to administer Resident A, Ativan 1 mg three times per day.

On 11/29/2021, I conducted an interview with APS Specialist Lauren Cook who stated that she found no substantial evidence to support this allegation. Ms. Cook stated she observed the home to be suitable for Resident A and found that medications were changed per Resident A's medical provider and direct care staff has followed this change.

On 12/14/2021, I conducted an interview with Relative A1. Relative A1 stated she is the medical power of attorney for Resident A. Relative A1 stated Resident A has been in and out of various psychiatric hospitals over the years and has been prescribed constant medication changes due to various behaviors he has exhibited. Relative A1 stated she believes direct care staff members have followed Resident A's prescribed medication regiment and she has no concerns.

On 1/11/2022, I conducted an interview with home manager and direct care staff member Codi Zamora. Ms. Zamora stated Resident A has had constant medication changes due to his behaviors, however Resident A continues to take Diazepam which is prescribed by his psychiatrist and takes Ativan as needed. Ms. Zamora stated Resident A's primary psychiatrist is very involved in Resident A's care and conducts medication reviews immediately once Resident A is discharged from any hospital visit.

On 1/11/2022, I conducted an interview with direct care staff member Katlyn Zehner regarding this allegation. Ms. Zehner stated Resident A has been living in the AFC home since 2019 and has been in and out of the hospital for his behaviors since then. Ms. Zehner stated when he is released from the hospital, Resident A is usually seen by his primary psychiatrist within seven days of his release. Resident A's primary psychiatrist is Jennifer Richardson who is very involved in Resident A's care and prescribes all of Resident A's medications. Ms. Zehner stated Resident A is currently taking Diazepam 10 mg and has been taking this medication since the hospital stay in August of 2021. Ms. Zehner stated Ativan is a medication that is taken as needed which is also prescribed by Resident A's psychiatrist Jennifer Richardson.

On 1/12/2022, I reviewed Resident A's Medication Administration Record (MAR) for the months August 2021 through January 2022. According to the MARs, Resident A was administered Diazepam 10mg and received 1 tablet 3 times daily. The medication Ativan is prescribed 1 tablet by mouth as needed.

I also reviewed *AFC Licensing Division-Accident/Incident* Report dated 8/16/2021. According to this report, Resident A had been escalated all night and did not sleep. He refused his medications, was physically aggressive by hitting and kicking, and eventually went outside naked. This report stated Resident A would not keep any

clothes on and continued to scream. Resident A was taken to Bronson Hospital via ambulance and was medically evaluated only due to Resident A being calmed while at the hospital. The report stated Resident A was then released from the hospital and when he returned to the AFC facility, he became angry and aggressive by throwing items, flipping tables, and screaming. The report stated Resident A was then taken back to the hospital to be psychiatrically evaluated.

On 1/13/2022, I conducted an interview with administrator Tim VanDyke. Mr. VanDyke stated Resident A's psychiatrist has conducted home visits with Resident A after every hospital discharge and has made medication changes at her own discretion. Mr. VanDyke stated direct care staff members have followed all medication orders that have been prescribed by the hospital however when medication changes are made by the psychiatrist direct care staff members will follow the new orders made as well.

On 1/14/2022, I conducted an onsite investigation at the facility and reviewed *KCMHSAS Medical Visit Form* dated 8/31/2021 completed by psychiatrist Jennifer Richardson. According to this form, Resident A was seen for a medication consultation following an emergency room discharge.

While at the facility, I also reviewed *Borgess Patient Discharge* Summary dated 8/31/2021. According to his summary, Resident A was prescribed Olanzapine 5 mg to take as needed and Quetiapine 50 mg to take twice a day. The summary showed Diazepam as a medication to be continued however the discharge summary did not list Ativan as a medication to continue. It should be noted the summary stated, "if there are any medications at home that are not on the list please talk to your primary care physician."

I reviewed physician scripts dated 8/31/2021 issued by Jennifer Richardson. According to the prescriptions Resident A was prescribed the following new medications; Oxcarbazepine 300 mg twice a day, Melatonin 3 mg three times at bedtime, Trazodone 50 mg once at bedtime, Remeron 15 mg once at bedtime, and Quetiapine 25 mg twice a day.

According to the prescriptions Valium 10 mg, Ambien 10 mg, Benadryl 25 mg, Invega 1.5 mg, Zyprexa Zydis 5 mg, and Zypreza Zydis 10mg were discontinued. There was no physician's order for Resident A's Ativan to be discontinued.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**

ANALYSIS:	Based on my investigation which included interviews with APS Specialist Lauren Cook, home manager Codi Zamora, Relative A1, administrator Tim VanDyke review of Medication Administration Record (MAR), AFC Licensing Division-Accident/Incident Report, *Borgess Discharge Summary, Medical Visit Form,* and physician scripts there is no evidence to support the allegation that the hospital recommended a change in medication for Resident A in August 2021 yet the facility direct care staff members were not following those changes. Resident A's primary psychiatrist is closely involved in his treatment and conducts a follow-up medication review after each time Resident A visits the hospital ER or is admitted for in-patient treatment. Resident A's psychiatrist Dr. Jennifer Richardson makes adjustments/changes per her own discretion and direct care staff member follow the most current orders. I verified this after reviewing Resident A's medication administration records from August 2021- November 2021. Further there was no physician orders discontinuing either Diazepam and/or Ativan. The direct care staff have followed the medical provider's orders as it pertains to Resident A's medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/14/2022, I conducted an exit conference with licensee designee Lorinda Anderson. I informed Ms. Anderson of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

Ondrea Johnson

Ondrea Johnson
Licensing Consultant

01/14/2022
Date

Approved By:

Dawn Timm

01/19/2022

Dawn N. Timm
Area Manager

Date