STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 8, 2022

Karen LaFave
Adult Learning Systems - UP, Inc
Suite-4
228 West Washington
Marquette, MI 49855

RE: License #: AS520299825
Investigation #: 2022A0873002
Life Options

Dear Ms. LaFave:

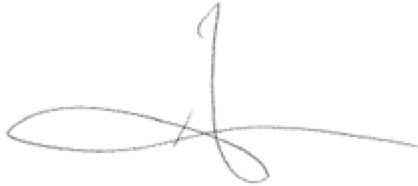
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 284-9700.

Sincerely,



Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 250-9318

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520299825
Investigation #:	2022A0873002
Complaint Receipt Date:	05/16/2022
Investigation Initiation Date:	05/18/2022
Report Due Date:	07/15/2022
Licensee Name:	Adult Learning Systems - UP, Inc
Licensee Address:	Suite-4 228 West Washington Marquette, MI 49855
Licensee Telephone #:	(906) 250-9365
Administrator:	Cole Lindberg
Licensee Designee:	Karen LaFave
Name of Facility:	Life Options
Facility Address:	2632 Moran Marquette, MI 49855
Facility Telephone #:	(906) 273-1414
Original Issuance Date:	03/23/2009
License **Status:**	REGULAR
Effective Date:	12/05/2021
Expiration Date:	12/04/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A, diagnosed with pica, was able to access a staff member's medications from that staff member's personal belongings. Resident A ingested approximately 15 pills and was subsequently hospitalized.	Yes

III. METHODOLOGY

05/16/2022	Special Investigation Intake 2022A0873002
05/18/2022	Special Investigation Initiated - Telephone
05/18/2022	Inspection Completed On-site
05/18/2022	Contact - Face to Face Interview with home manager Kyle Darcy
05/18/2022	Contact - Face to Face Interview with Resident A
05/18/2022	Contact - Document Received Received copies of Resident A's Assessment Plan and Resident Care Agreement
06/02/2022	APS Referral
07/07/2022	Inspection Completed-BCAL Sub. Compliance
07/08/2022	Exit Conference Spoke with Kelsey Williams about SIR findings

ALLEGATION: Resident A, diagnosed with pica, was able to access a staff member's medications from that staff member's personal belongings. Resident A ingested approximately 15 pills and was subsequently hospitalized.

INVESTIGATION: On May 13, 2022, I received an incident report detailing an event that occurred on May 5, 2022, in which Resident A told a home manager Kyle Darcy that he had gone into the personal belongings of staff member Elijah Claucherty, grabbed prescription pills out of Mr. Claucherty's bag, and ingested approximately 15 of the pills. According to the incident report Mr. Darcy then told Mr. Claucherty what had happened and Mr. Claucherty called poison control. Poison control recommended told Mr. Claucherty that Resident A had to be taken to the emergency department. Resident A was then taken to the emergency department. The incident report details that all staff of Life Options, including Mr. Claucherty, are aware that personal medications cannot be accessible to any residents in the home at any point. According to the incident report, Resident A has been diagnosed with pica and "this incident should never have occurred." Resident A was under hospital care until May 7, 2022 so hospital staff could monitor Resident A for any effects of ingesting the medication. Once cleared by hospital staff, Resident A returned home later that afternoon.

On May 18, 2022, I initiated a special investigation and conducted an onsite inspection at Life Options to interview home manager Kyle Darcy. During the course of the interview I obtained a copy of Resident A's resident care agreement as well as Resident A's assessment plan. It was confirmed by Mr. Darcy that Resident A is diagnosed with pica, an eating disorder in which the individual ingests items not considered food. Mr. Darcy explained that on May 5, 2022, once Resident A admitted to staff to having ingested the pills, staff called poison control immediately. I was informed by Mr. Darcy that poison control suggested taking Resident A to the emergency department. Mr. Darcy explained to me that Resident A had ingested approximately 15 pills of Mirtazapin, an anti-depression medication. Mr. Darcy also reported that Resident A's pica is well-known to staff and there have been incidents in the past in which Resident A has attempted to and successfully ingested physical objects. Because of Resident A's condition, staff have modified their behavior. For instance, staff know not to have bottle caps or loose change around when at the home. Further, Mr. Darcy explained that Resident A has very few items in his room to prevent him from ingesting anything that would cause him harm. Staff are also aware of Resident A's tendency to break objects, such as plates and cups with the intention to ingest them. Mr. Darcy explained that this incident was the first time Resident A had ever gone into a staff member's personal belongings.

On May 18, 2022, I obtained a copy of Resident A's resident care agreement as well as Resident A's assessment plan. It was confirmed by these documents that Resident A is diagnosed with pica. According to Resident A's assessment plan, Resident A exhibits several self-injurious behaviors, including pica, but also scratching and biting. Resident A requires a higher level of supervision due to these conditions, but also due to having difficulty controlling aggressive behavior.

Also on May 18, 2022, I interviewed Resident A regarding the incident. As outlined in Resident A's assessment plan, Resident A's communication is, at times, difficult to understand. However, Resident A was able to communicate that he is aware of his pica diagnosis, that he has been diagnosed since a child, and it is something that he does when he becomes overly stressed. Resident A communicated to me that although he acts out at times and can become aggressive and swallow things, he feels safe and secure at the home.

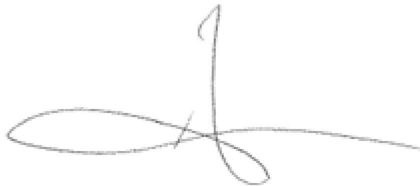
While conducting the onsite inspection on May 18, 2022, although I did not speak to any other residents, I was able to observe several as they sat in the main room. There were several other staff also on duty as this home is known to house individuals with difficult behaviors. I observed that the home's residents appeared to be receiving both adequate care and supervision from staff.

On July 8, 2022, I conducted an exit conference with Kelsey Williams explaining to her the findings of the report, specifying the specific rule that was found to have been violated, how and why I determined the rule to have been violated, and the need for a corrective action plan to be submitted within 15 days. Ms. Williams agreed that she understood the need for the finding and will discuss the matter with her staff and supervisor to develop an adequate corrective action plan.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Staff were aware of Resident A's pica. Resident A was able to access unsecured prescription medications belonging to a staff member. Once informed by Resident A of what he had done, staff immediately called poison control and were referred to the emergency department at the local hospital. The incident report detail**s** that all staff of Life Options, including Mr. Claucherty, are aware that personal medications cannot be accessible to any residents in the home at any point. Resident A ingested about 15 of these pills and had to be hospitalized for several days.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the submission of an approved corrective action plan, no changes to the status of the license is recommended.



July 8, 2022

Garrett Peters Date
Licensing Consultant

Approved By:

July 8, 2022

Mary E Holton Date
Area Manager