GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 26, 2022

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

RE: License #: AS390250889
Investigation #: 2022A1024052
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 (616) 356-0183.

Sincerely,

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
THIS REPORT CONTAINS EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS390250889
Investigation #:	2022A1024052
Complaint Receipt Date:	08/31/2022
Investigation Initiation Date:	09/02/2022
Report Due Date:	10/30/2022
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 does not always provide protection and safety in the home.	Yes
Staff Breanna Tutt cussed at and mistreated Resident B.	No

III. METHODOLOGY

08/31/2022	Special Investigation Intake 2022A1024052
09/02/2022	Special Investigation Initiated – Telephone with recipient rights officer Michele Schiebel
09/02/2022	Contact - Telephone call made with home manager Codi Zamora, direct care staff members Michael Dwyer, and Resident A
10/04/2022	Contact - Document Received-additional allegations from intake #190715 regarding Resident B
10/04/2022	Contact - Document Received-Resident B's Assessment Plan for AFC Residents and *Behavioral Treatment Plan*
10/06/2022	Contact - Document Received-*AFC Licensing Division-Incident/Accident Report*
10/06/2022	Contact - Telephone call made via Microsoft Teams with direct care staff members Betty Lamb, Abubaker Mustafa, program director Tim Vandyke, recipient rights officer Michelle Schiebel and Resident B
10/17/2022	Inspection Completed On-site with direct care staff member Mohammed Dialo
10/17/2022	Contact-Document Received-*Resident A's Assessment Plan* and *Health Care Appraisal*
10/17/2022	Contact - Telephone call made with direct care staff member Navia Abrahams
10/18/2022	Contact - Telephone call received from direct care staff member Breanna Tutt
10/19/2022	APS Referral- made to APS

10/19/2022	Exit Conference with licensee designee Lorinda Anderson
10/19/2022	Inspection Completed-BCAL Sub. Compliance
10/19/2022	Corrective Action Plan Requested and Due on 10/19/2022

ALLEGATION:
Direct care staff does not always provide protection and safety in the home.

INVESTIGATION:

On 8/31/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged direct care staff does not always provide protection and safety in the home. This complaint further alleged Resident A eloped from the home and was in the community without staff supervision. Additional allegations were received on 10/04/2022 stating direct care staff members do not provide supervision at night because staff Muhamed Dialo and Brenna Tutt are sleeping.

On 9/2/2022, I conducted an interview with recipient rights officer Michele Schiebel who stated that Resident A has a history of walking away and direct care staff are aware he needs to be supervised closely while in the home. Ms. Schiebel stated staff reported to her Resident A was able to walk out of the facility and walk down to the fire station without staff's knowledge which took about 45 minutes. Ms. Schiebel stated she believes staff members were not providing adequate supervision required for Resident A which allowed Resident A to be able to walk away from the facility without staff supervision.

On 9/2/2022, I conducted interviews with home manager Codi Zamora, direct care member Michael Dwyer, and Resident A. Ms. Zamora stated on 8/23/2022 Resident A walked out the front door without staff's knowledge and the Fire Department reported to her that Resident A was at the fire station for about 35 minutes until staff picked him up. Ms. Zamora stated there were two staff members working during the time the incident occurred and one staff member was assigned to keep a close eye on Resident A who requires staff supervision while out in the community. Ms. Zamora stated lately Resident A has been attempting to leave out of the home without staff supervision therefore, all staff members were advised to monitor Resident A closely at least every 15 minutes to ensure his whereabouts. Ms. Zamora stated staff obviously did not check on Resident A as required on 8/23/2022 otherwise they would have known Resident A was not in the home.

Mr. Dwyer stated on 8/23/2022 Resident A walked away from the facility and walked to the fire station a few blocks from the facility. Mr. Dwyer stated Resident A does not

require 1:1 staff supervision however staff members are required to check on him every 15 minutes during the day and 30 minutes during sleeping hours as Resident A has attempted to leave the facility without staff supervision. Mr. Dwyer stated he believes Resident A was gone without staff's knowledge for at least 40 minutes until he was picked up by a staff member who was driving past and saw Resident A lying on the ground with no staff present. Mr. Dwyer stated he did not check on Resident A every 15 minutes as required because he was attending to another resident and believed the other staff member working was also attending to another resident.

I attempted to interview Resident A however was unable to due to his cognitive impairment.

On 10/06/2022, I reviewed the facility's *AFC Licensing Division-Accident/Incident Report* (report) dated 8/23/2022 and written by direct care staff member Betty Lamb. This report stated while staff was on an outing with a different resident, staff member Ms. Lamb saw Resident A at the fire station therefore Ms. Lamb stopped and talked with a police officer who informed her that Resident A had been down to the fire station alone for about 35 minutes. The report stated Ms. Lamb called the facility and the staff members did not know Resident A had left the home.

On 10/06/2022, I conducted interviews with direct care staff member Betty Lamb, program director Tim VanDyke, and recipient rights officer Michele Schiebel. Ms. Lamb stated that when she was headed back to the facility while on an outing with another resident, she saw Resident A lying on the ground screaming at the fire station. Ms. Lamb stated she stopped and spoke to a police officer who informed her Resident A had been at the fire station for about 45 minutes without any staff members present. Ms. Lamb stated she waited with Resident A for emergency medical services (EMS) to arrive to transport him to the hospital to check for injuries. Ms. Lamb stated she did not see any injuries present. Ms. Lamb stated she then called the house to speak with direct care staff members who informed her that no staff member was aware that Resident A was not in the home. Ms. Lamb stated Resident A requires staff members to check on his whereabouts every 15 minutes due to his recent issues with trying to elope from the facility. Ms. Lamb stated she has no knowledge of any staff members sleeping while working and believes Resident B is making false accusations against staff members due to being upset with specific staff members.

Mr. VanDyke stated he was made aware Resident A was able to leave the facility without staff's knowledge. Mr. VanDyke stated after his internal investigation of this incident he believes staff members failed to conduct their required 15 minute checks on Resident A because they were attending to other residents and they reportedly assumed Resident A was in the backyard of the facility. Mr. VanDyke further stated he has not had any reports made to him regarding staff members sleeping while working on shift and does not believe this accusation is true.

Ms. Schiebel stated she did not find any substantial evidence direct care staff

members Mr. Dialo and Ms. Tutt are sleeping while working and believes Resident B may be targeting these two staff members by making false complaints against them.

I also conducted an interview with Resident B regarding this allegation of staff sleeping while working. Resident B stated he believes both Ms. Tutt and Mr. Dialo sleep while they are working during night hours. Resident B stated he saw Ms. Tutt on the floor of the facility with a pillow and cover sleeping and had to wake her up. Resident B stated he believes he saw Mr. Dialo sleeping because he saw Mr. Dialo's head in a downward position, but he could not see his eyes. Resident B further stated he wakes up during the night and has observed this.

On 10/17/2022, I conducted an onsite investigation at the facility with direct care staff member Mohammed Dialo who stated that he does not sleep while working and he has no knowledge of any other staff member sleeping while working. Mr. Dialo stated he believes Resident B is targeting him and making false complaints against him. Mr. Dialo further stated that on 8/23/2022, he was made aware by a staff member who was on an outing that Resident A left the facility and walked down to the fire station reportedly for about 40 minutes. Mr. Dialo stated he was not aware Resident A had left the facility and believes the 15 minutes required checks were not conducted to ensure Resident A's whereabouts in the home which were implemented due to Resident A recent elopement issues.

On 10/17/2022, I reviewed Resident A's *Health Care Appraisal (HCA)* and *Assessment Plan for AFC Residents (assessment plan).* According to Resident A's HCA dated 9/15/2022 Resident A is diagnosed with Fragile X, ASD, Schizophrenia, and Pseudo Seizures.

According to Resident A's assessment plan dated 8/2/2022, Resident A does not move independently in the community and staff needs to be close by and available to Resident A when in the community.

On 10/17/2022, I conducted an interview with direct care staff member Navia Abrahams who stated that she has no knowledge of any staff members sleeping while on shift and there has been no reports made to her regarding this issue.

On 10/18/2022, I conducted an interview with Breanna Tutt who stated that she has never fallen asleep while working and she has not seen any other staff members sleeping while at the home. Ms. Tutt stated Resident B has been very aggressive towards her and has falsely accused her of bringing in pillows and covers to sleep while working during night hours. Ms. Tutt stated she has worked during night hours for many years and does not need to sleep during her shift.

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:	Based on my investigation which included interviews with home manager Codi Zamora, direct care staff members Michael Dwyer, Betty Lamb, Muhammed Dialo, Breanna Tutt, Navia Abrahams, program director Tim Vandyke, recipient rights officer Michelle Schiebel and Resident B, direct care staff members did not provide protection and safety measures to Resident A at all times per his assessment plan which allowed him to elope from the facility on 08/23/2022 without staff knowledge and/or supervision. Ms. Zamora, Ms. Lamb, Mr. VanDyke, Mr. Dwyer all stated that Resident A requires staff to conduct 15-minute checks on Resident A due to his past elopement issues. These checks were not conducted on 8/23/2022 when Resident A was able to walk out of the facility and walk blocks away to a fire station for at least 35 minutes without staff's knowledge. The facility's incident report stated staff member Ms. Lamb she saw Resident A at a fire station without staff present and when she called the home staff members were not aware that Resident A was out of the home. Staff did not provide adequate supervision to Resident A therefore, failed to provide protection and safety at all time times. Regarding the allegation of direct care staff members sleeping during third shift, there is no evidence to support this allegation. Both staff interviewed denied sleeping while working.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff Breanna Tutt cussed at and mistreated Resident B

INVESTIGATION:

On 10/4/2022, I received additional allegations through the BCHS online complaint system. These allegations stated staff Breanna Tutt cussed at and mistreated Resident B.

On 10/04/2022, I reviewed Resident B's *Behavioral Support Plan (plan)* dated

3/10/2022. According to this plan, Resident B has a history of making false or inaccurate statements against peers, staff and family members with the apparent intent of deliberating getting them “in trouble.” Resident B also has a history of not allowing staff to properly clean or check his ostomy bag. Resident B will try to manipulate his schedule or activities to get who he wants to work with him or take him places. The plan also stated Resident B is known to make complaints of malfunctions related to his ostomy bag then allege staff don’t properly clean the bag. Resident B has been known to frequently call his mother to complain about the care provided by staff for his ostomy bag, make complaints about individuals in the home, and other physical complaints.

On 10/06/2022, I conducted interviews with direct care staff members Betty Lamb & Abubaker Mustafa, program director Tim VanDyke, recipient rights officer Michelle Schiebel and Resident B. Ms. Lamb stated she has never heard Ms. Tutt mistreat Resident B. Ms. Lamb stated recently Resident B repeatedly told staff something was wrong with his ostomy bag and made threats to remove his clip to get his ostomy bag to leak. Ms. Tutt state she tried to instruct Resident B to keep his clip on but Resident B began cussing at her about his bag. Ms. Lamb stated staff including Ms. Tutt always try to accommodate Resident B however Resident B is very hostile towards staff members and will use his bag as a weapon to get staff to do things. Ms. Lamb stated Resident B makes threats to remove his clip from his bag so urine can leak out of the bag then will demand staff to clean him up. Ms. Lamb stated Resident B tends to be more disrespectful towards female staff members and will regularly cuss and yell at female staff. Ms. Lamb further stated she has not seen any staff member mistreat Resident B however Resident B will make false complaints against any staff member that he is upset with in attempts to get them in trouble.

Mr. Mustafa stated he has not seen or heard any staff member mistreat Resident B. Mr. Mustafa stated Resident B often targets staff members who he is upset with and will make false complaints against them. Mr. Mustafa stated Resident B can become aggressive towards others if he does not get his way however Mr. Mustafa has not had issues with Resident B as of lately.

Mr. VanDyke stated he has not seen any staff member mistreat Resident B. Mr. VanDyke further stated Resident B has a history of making false complaints against staff members with whom who he is upset.

Ms. Schiebel stated Resident B tends to make false complaints against staff members and as of lately she has seen an increase in false complaints made by Resident B when he gets upset. Ms. Schiebel further stated Resident B will use his ostomy bag as a weapon against staff members and threatened to leak his bag in order to get staff members to clean it up.

Resident B stated he woke up at 6am and asked Ms. Tutt to drain his ostomy bag and Ms. Tutt responded and yelled, “shut the fuck up.” Resident B stated Ms. Tutt is

snotty and rude to him and he tries to be nice to her. Resident B further stated he does not like Ms. Tutt because when he wants to go out on outings, Ms. Tutt will not take him therefore he will begin to scream and yell at her.

On 10/17/2022, I conducted an onsite investigation at the facility with direct care staff member Mohammed Dialo who stated that he has not seen any staff member mistreat Resident B and believes Resident B targets staff members who he is upset with and tries to get them in trouble by making false complaints against them. Mr. Dialo stated he has seen Resident B act hostile towards staff members and then Resident B will report the staff member was hostile towards him.

On 10/17/2022, I conducted an interview with direct care staff member Navia Abrahams who stated she has not seen any staff member mistreat Resident B however Resident B often mistreats staff members and will yell, cuss and make derogatory remarks against staff members. Ms. Abrahams further stated Resident B has a history of making false complaints against staff in the home.

On 1018/2022, I conducted an interview with Breanna Tutt who stated that she has never yelled or cussed at Resident B nor has she seen any other staff member mistreat him. Ms. Tutt stated Resident B has been making false complaints against her lately and has been targeting her by acting hostile towards her. Ms. Tutt stated Resident B will make verbally abusive statements towards staff members then will make a complaint with Recipient Rights stating that the staff member made verbally abusive statements to him.

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 Betty Lamb, Abubaker Mustafa, Muhammed Dialo, Breanna Tutt, Navia Abrahams, program director Tim Vandyke, recipient rights officer Michelle Schiebel and Resident B, there is no evidence direct care staff member Breanna Tutt was verbally inappropriate toward Resident B and/or mistreated Resident B in any way. Ms. Tutt denied mistreating Resident B and denied observing or any other staff member mistreat Resident B. Ms. Tutt stated Resident B has been targeting her lately by making false complaints against her and being hostile towards her. Ms. Lamb, Ms. Schiebel, Mr. Mustafa, Mr. VanDyke, Ms. Abrahams, and Mr. Dialo all stated Resident B has a history of making false complaints against staff members with whom is upset. According to Resident B's behavioral support plan Resident B has a history of making false or inaccurate statements against peers, staff and family members with the apparent intent of deliberating getting them "in trouble." No staff member interviewed reported observing Ms. Tutt mistreat Resident B or speak to him in an inappropriate manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/19/2022, 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

Upon an acceptable corrective action plan, I recommend the current license status remain unchanged.

Ondrea Johnson
Licensing Consultant

10/19/2022
Date

Approved By:

Dawn Timm

10/26/2022

Dawn N. Timm
Area Manager

Date