GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 20, 2022

Kimberly Nolan
Progressive Alternatives, Inc
P.O. Box # 20054
Kalamazoo, MI 49019

RE: License #: AS390016162
Investigation #: 2023A0581004
Progressive Alternatives

Dear Ms. Nolan:

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.

A six-month provisional license is recommended due to quality of care violations. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390016162
Investigation #:	2023A0581004
Complaint Receipt Date:	10/25/2022
Investigation Initiation Date:	10/25/2022
Report Due Date:	12/24/2022
Licensee Name:	Progressive Alternatives, Inc
Licensee Address:	400 S. Second Street Kalamazoo, MI 49019
Licensee Telephone #:	(269) 207-0091
Administrator:	Kimberly Nolan
Licensee Designee:	Kimberly Nolan
Name of Facility:	Progressive Alternatives
Facility Address:	10476 West U Ave Schoolcraft, MI 49087
Facility Telephone #:	(269) 207-0091
Original Issuance Date:	02/05/1996
License Status:	REGULAR
Effective Date:	08/08/2022
Expiration Date:	08/07/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The facility's backyard fence is being kept locked to prevent Resident A from leaving.	Yes
A facility staff member used Resident B's banking card. There are no resident funds records for Resident B available in the facility.	Yes
Facility staff are overmedicating Resident A.	No
Resident A is being locked in the facility's basement.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/25/2022	Special Investigation Intake 2023A0581004
10/25/2022	Special Investigation Initiated - Telephone Interview with Integrated Services of Kalamazoo, RRO, Lisa Smith.
10/25/2022	Contact - Document Received Email from Ms. Smith.
10/25/2022	Referral - Recipient Rights ISK also received allegations and are investigating.
10/25/2022	APS Referral referral made via telephone
10/25/2022	Referral - Law Enforcement Referral made via telephone by RRO, Ms. Smith.
10/25/2022	Referral - Other Referral made to Attorney General's office for financial exploitation
10/25/2022	Contact - Face to Face Interview via MiTeams with RRO, Ms. Smith and Relative A1
10/27/2022	Contact - Document Received Received additional allegations from intake # 191318
10/27/2022	Contact - Telephone call made Interview with APS specialist, Lindsey Bickmeyer
10/28/2022	Inspection Completed On-site

	Interviewed staff and residents
11/01/2022	Contact - Telephone call made Interview with licensee designee, Kim Nolan.
11/01/2022	Exit conference with licensee designee, Ms. Nolan, via telephone.
11/29/2022	Inspection Completed-BCAL Sub. Compliance
12/02/2022	Contact – Document Sent Requested police report # 22-35457 from Kalamazoo Co. Sheriff's Dept.
12/07/2022	Contact – Telephone call received Interview with Ms. Smith.
12/19/2022	Inspection Completed On-site Interviewed staff and Resident A.
12/19/2022	Contact – Telephone call made Interview with former direct care staff, Jessica Gayle.
12/19/2022	Contact – Telephone call made Interview with direct care staff, Alex Finlayson.
12/19/2022	Contact – Document Received Email from Ms. Nolan.
12/19/2022	Contact – Document Sent Email to Ms. Nolan regarding Ms. Finlayson.
12/19/2022	Contact – Telephone call made Left voicemail with Ms. Nolan.
12/20/2022	Contact – Document Sent Email to Ms. Nolan.
12/21/2022	Contact – Telephone Received Interview with Ms. Nolan.

ALLEGATION:

The facility's backyard fence is being kept locked to prevent Resident A from leaving.

INVESTIGATION:

On 10/25/2022 and 10/27/2022, I received two complaints through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint from 10/27/2022 alleged the facility's backyard fence were being locked with chains to prevent Resident A from getting out of the backyard.

On 10/27/2022, I Interviewed Adult Protective Services (APS) specialist, Lindsey Bickmeyer. Ms. Bickmeyer stated when she went to the facility on 10/14/2022 she observed the backyard fence locked; therefore, preventing Resident A from opening the gate and leaving the fenced in area. She stated the fence is approximately four feet tall, making it possible for someone to still get over the fence in the event of an emergency. Ms. Bickmeyer indicated the fence was being locked to keep Resident A safe due to her recent behaviors and elopements.

On 10/28/2022, I conducted an unannounced onsite inspection at the facility, as part of my investigation. I observed a four-foot chain link fence enclosing the facility's backyard that had two gates. I observed both gates to have chain locks on them; however, the gate closest to the barn was open at the time of my onsite. The facility's Human Resource employee, Katie Crosby, stated the gate was currently open because maintenance personnel had to get in the backyard for repairs. Ms. Crosby stated the locks were put on the gates approximately two weeks ago for Resident A's safety.

I informed Ms. Crosby during the inspection the fence could not be locking against egress as there was no variance approved restricting residents' freedom of movement.

On 11/01/2022, I interviewed the facility's licensee designee, Kim Nolan. Ms. Nolan stated the chain locks on the backyard gates had been removed. Her statement to me was consistent with Ms. Crosby's statement to me regarding the reason for locking the gates.

On 12/08/2022, I interviewed Resident A's guardian, Guardian A1, who confirmed the facility's backyard was fenced in and had been locked to protect Resident A as she had been eloping, going in the road, and stating she was going to kill herself.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on staff acknowledgement, APS' observations from 10/14/2022, and my own observations on 10/28/2022, the facility's backyard chain linked fence was being locked against egress and therefore, restricting residents' freedom of movement, including Resident A's freedom of movement.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **A facility staff member used Resident B's banking card.**
- **There are no resident funds records for Resident B available in the facility.**

INVESTIGATION:

The complaint received on 10/25/2022 alleged Resident B resided at the facility for approximately three years and during that entire time a direct care staff was using Resident B's personal funds.

On 10/25/2022, I interviewed Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Lisa Smith. Ms. Smith stated Resident B has not resided at the facility since August 2022 because he was moved to a nursing home; however, Resident B's guardian, Guardian B1, discovered during his transition purchases had been made using Resident B's debit card that Resident B would not have made indicating a direct care staff from the facility was misusing the card. She indicated when Resident B was residing at the facility only the facility home manager would

have access to the card. Ms. Smith indicated Resident B's card had since been turned off to prevent further misuse.

On 10/25/2022, Ms. Smith and I interviewed Guardian B1 via MiTeams. Guardian B1 indicated Resident B was admitted to the hospital on 08/09/2022 and discharged to a long-term care facility on 08/21/2022. She stated his debit card was shut off 08/17/2022 after it was discovered charges were being made on the card while he was in the hospital. She stated once it was discovered his card had been misused, she reviewed his bank statements, which indicated numerous charges had been made that Resident B would never have made, particularly DoorDash, a food delivery service.

Guardian B1 stated Resident B did not have a cell phone. She stated he only had a tablet, which he used during the Covid-19 pandemic to communicate with her and other relatives. Guardian B1 stated when she had reviewed Resident B's tablet, she did not discover any applications or any other kind of evidence to indicate his debit card was stored on the tablet in order to make the purchases or deliveries. She also indicated Resident B would not have known how to use his debit card to make online purchases and would have preferred to use cash. Guardian B1 stated Resident B did not go on many outings to where he would be purchasing large amounts of fast food and/or would not have needed the DoorDash deliver service to the facility because he was utilizing the facility's meals.

Guardian B1 stated that despite Resident B suffering from a traumatic brain injury in 1973, he still had employment and receives approximately $1,600 in social security per month. She indicated Resident B had Integrity Payee Services handle his finances, however, this changed when she became his guardian on or around August 2022. Guardian B1 stated she was able to determine Integrity Payee Services was putting money in Resident B's account every month for him to use, which was approximately $200-$300 per month. Guardian B1 indicated that due to the number of charges on the debit card, the dates and times the purchases/deliveries were made, and the length of time the purchases had been made, it appeared a current or former direct care staff from the facility had saved Resident B's debit card information in order to use any time.

Ms. Smith stated she had spoken with staff at the facility and none of them indicated Resident B was having food delivered regularly to the facility by either DoorDash or by facility staff. She stated she also reviewed Resident B's daily notes and there was no indication Resident B was leaving the facility for an exuberant number of outings other than doctor appointments or the senior center. Additionally, Guardian B1 stated she contacted Resident B weekly and never indicated he was going out a lot or making purchases.

On 10/25/2022, Ms. Smith forwarded me the recent bank statements from Resident B's account. According to a list of current transactions, Resident B's debit card was used to make the following purchases in August 2022 totaling $162.15 in charges:

- 08/01/2022 – DoorDash dashpass (DoorDash monthly subscription) for $9.99
- 08/02/2022 – DoorDash delivery for McDonalds for $24.31
- 08/03/2022 – DoorDash delivery for Great Wall for $6.51
- 08/04/2022 – DoorDash delivery for McDonalds for $20.65
- 08/05/2022 – DoorDash dashpass for $9.99
- 08/07/2022 – DoorDash delivery for Taco Bell for $18.21
- 08/09/2022 – DoorDash delivery for Subway for $10.75
- 08/10/2022 – DoorDash delivery for Fiesta Burrito for $25.23
- 08/16/2022 – DoorDash delivery for Wendy's for $24.80
- 08/16/2022 – DoorDash delivery for Wendy's for $11.71

Resident B's debit card was used to make the following purchases for July 2022 totaling $350.77 in charges:

- 07/02/2022 – DoorDash delivery for Wendy's for $20.00
- 07/05/2022 – DoorDash dashpass for $9.99
- 07/05/2022 – DoorDash delivery for Great Wall for $25.00
- 07/13/2022 – DoorDash delivery for Little Caesars for $20.54
- 07/14/2022 – DoorDash delivery for Fiesta Burrito for $25.67
- 07/21/2022 – DoorDash deliver for Dollar General for $20.23
- 07/22/2022 – Walmart.com for $43.69
- 07/25/2022 – DoorDash delivery for Hungry Howies for $9.22
- 07/25/2022 – DoorDash delivery for Hungry Howies for $30.00
- 07/27/2022 – DoorDash delivery for McDonalds for $14.74
- 07/28/2022 – DoorDash delivery for Petsmart for $34.70
- 07/28/2022 – DoorDash delivery for Tender Shack for $20.61
- 07/28/2022 – Walmart.com for $45.66
- 07/30/2022 – DoorDash delivery for Petsmart for $30.72

Resident B's debit card was used to make the following purchases for June 2022 totaling $239.34 in charges:

- 06/01/2022 – DoorDash delivery for McDonalds for $33.33
- 06/04/2022 – DoorDash delivery for Wendy's for $25.80
- 06/05/2022 – DoorDash dashpass for $9.99
- 06/05/2022 – DoorDash delivery for Dollar General for $21.68
- 06/07/2022 – DoorDash delivery for Dollar General for $23.07
- 06/09/2022 – DoorDash delivery for Great Wall for $27.42
- 06/14/2022 – DoorDash delivery for Dollar General for $25.17
- 06/21/2022 – DoorDash delivery for Dollar General for $17.60
- 06/28/2022 – DoorDash delivery for Great Wall for $22.41
- 06/29/2022 – Amazon.com purchase for $32.87

The remaining bank statements provided by Guardian B1 included similar purchases for the remaining months with the following totals in charges:

- January - $32.46 in total charges
- February - $259.38 in total charges
- March - $290.40 in total charges
- April - $109.50 in total charges
- May - $337.42 in total charges

Based on my review of Resident B's bank statements, his debit card was used to make $1,781.42 in charges from January through August 2022.

When I followed up with Guardian B1 she indicated she had reviewed additional years of bank statements and believed the total amount of charges on Resident B's debit card were in excess of $3,000.

On 10/26/2022, I confirmed with APS supervisor, JD Shepherd, APS received the allegations concerning Resident B, but would not investigate the allegations because Resident B was not at a current risk of harm and Guardian B1 had closed the card. He indicated the allegations had also been referred to law enforcement.

During my onsite inspection, I interviewed home manager, Kim Crawford. Ms. Crawford stated she'd been the facility's home manager for the last four months. She stated when Resident B was residing at the facility, his debit card was kept locked in a box under a desk in the staff office. She was unable to show me the lock box because she stated Resident A had broken into the office, took the box and destroyed it. She stated receipts for purchases made using Resident B's card were kept in the lock box, but when Resident A destroyed the box, she also ripped up the receipts that were being kept in the box. Subsequently, Ms. Crawford was unable to provide me with any documentation relating to the use of Resident B's debit card that was being held in trust by the facility, including Resident B's *Resident Funds I* or *Resident Funds II* required AFC forms.

Ms. Crawford stated Resident B asked facility staff to hold onto his debit card because he did not want to misplace it. She stated staff would access Resident B's debit card if they made a medical supply purchase for Resident B like incontinence briefs. Ms. Crawford sated Resident B did not take many outings but did visit a Western Michigan University's Adult Wellness Program once a week. She stated otherwise, Resident B did not want to go on many outings. She stated he did not order food to the facility or have staff use his card to purchase food for him at the facility.

I interviewed Resident C who stated he's resided at the facility since 2017, but he hadn't seen Resident B have any packages or food delivered to the facility.

On 11/01/2022, I interviewed licensee designee, Kim Nolan. Ms. Nolan stated Resident B was admitted to the facility on 11/05/2018. She stated she had no idea who would have misused Resident B's debit card and was willing to work with police on the issue.

On 12/02/2022, I reviewed Kalamazoo County Sheriff's Department police report # 22-35457. According to the police report, Deputy Cook interviewed Guardian B1, who's statement to him was consistent with her statement to me and Ms. Smith. Guardian B1 reported to Deputy Cook that the charges on Resident B's debit card started in October 2019 and totaled over $3,600. Guardian B1 informed Deputy Cook an unknown direct care staff member accessed Resident B's card in order to purchase him clothes or medical supplies, but not DoorDash deliveries or other fast food type purchases.

On 12/07/2022, Ms. Smith stated she had contacted Kalamazoo Sheriff's Department to determine the status of their investigation. She stated to me the Sheriff's Department was still investigating and trying to determine who misused Resident B's debit card.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	Resident B was admitted to the facility on or around 11/05/2018. Based on my interview with the facility's home manager, Kim Crawford, Guardian B1, and Integrated Services of Kalamazoo Recipient Rights Officer, Lisa Smith, facility staff were entrusted with safekeeping Resident B's debit card while he resided at the facility. At some point while Resident B was residing in the facility, someone who had access to his debit card saved the debit card information to make over $3,000 in charges, which were primarily DoorDash food service deliveries. Subsequently, Resident B was financially exploited for several years while at the facility when an unknown direct care staff member misused his debit card.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee,

	and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based on my interview with the facility's home manager, Ms. Crawford and Guardian B1, and my review of Resident B's bank statements, there is evidence someone from the facility, who had access to Resident B's debit card, used the card to make over $3,000 in purchases. The purchases included an immense amount of DoorDash deliveries, which both direct care staff and Guardian B1 stated was uncharacteristic of Resident B. Additionally, Resident B didn't have the logistical capabilities of make such purchases (e.g., no cell phone or internet applications). Subsequently, someone under the direction of the licensee misused Resident B's personal funds.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Both Guardian B1 and direct care staff stated Resident B's debit card was used to make purchases like medical supplies (e.g., incontinence briefs); however, neither the *Resident Funds I* nor Resident *Funds II* forms were available for review, as required, to affirm these statements or any other purchases.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility staff are overmedicating Resident A.

INVESTIGATION:

The complaint alleged Resident A's medications are being misused. The complaint alleged Resident A is being given too many medications to make her "zombie like."

Ms. Bickmeyer stated she reviewed Resident A's medications and interviewed direct care staff but did not have concerns direct care staff were overmedicating her. She stated Resident A has a history of displaying significant behaviors that put her and/or other residents at risk. She indicated Resident A has medications to manage these behaviors, which direct care staff were administering to her, as prescribed.

Ms. Crawford stated Resident A has a PRN or as needed medication for "agitation, behavior issues, or anxiety." She stated when Resident A was exhibiting significant behavior in October 2022, like elopements, attempting to run in the road, destroying facility property, etc. direct care staff administered the PRN to her. Ms. Crawford stated she had no concerns Resident A was being overmedicated.

I reviewed Resident A's October 2022 Medication Administration Record (MAR), which confirmed Resident A has a sedative prescription consisting of Lorazepam 2 mg tablet with the instruction of "take ONE-HALF TO ONE tablet UP TO twice a DAY AS NEEDED FOR agitation SEVERE anxiety and/or SLEEP [sic]" indicating the medication is a PRN or "as needed" medication rather than a routine medication. According to the MAR, Resident A was administered this medication a total of nine times the following days with the notated reasons:

10/01/2022 – 8 pm [no reason provided]
10/02/2022 – 12 pm and 8 pm [no reason provided]
10/05/2022 – 12 pm- reason administered being "outburst"
10/09/2022 – 8 pm- reason administered being "help sleep"
10/10/2022 – 8 pm [no reason provided]
10/13/2022 – 8 pm- reason administered being "crying/anxiety"
10/20/2022 – 8 pm [no reason provided]
10/22/2022 – 8 pm – reason administered being "upset/agitated"

I also reviewed the facility's Narcotic Count sheet for Resident A's Lorazepam medication, which was consistent with the October 2022 MAR as to when the medication was administered by staff. I also counted Resident A's Lorazepam medication, which was consistent with the nine tablets left per her narcotic count sheet indicating the medication was being administered, as prescribed.

I interviewed Resident A who indicated she takes a lot of medications and expressed she did not want to take them anymore. When I tried asking Resident A more

specific medication questions, she became agitated and tearful. Subsequently, I was unable to gather additional information like if she thought direct care staff were overmedicating her with a particular medication.

Guardian A1 stated she had no concerns Resident A was being over medicated or staff were misusing her medication to drug or immobilize her. She stated she had reviewed Resident A's medications and her MARs and had no concerns staff were administering the Lorazepam inappropriately or not as prescribed.

On 12/19/2022, I interviewed direct care staff, Alex Finlayson. Ms. Finlayson stated there were direct care staff who would administer Resident A's PRN medication without indicating the reason it was being administered to her.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Based on my review of Resident A's October 2022 Medication Administration Record, her Lorazepam PRN medication Narcotic Count sheet, my count of Resident A's Lorazepam medication, and interviews with direct care staff and Guardian A1, there is no indication Resident A's Lorazepam medication was being misused or was being overly administered to her with the intention of overmedicating, immobilizing, or drugging her.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**

ANALYSIS:	Based on my review of Resident A's October Medication Administration Record, direct care staff administered Resident A's PRN medication, Lorazepam 2 mg tablet, on 10/01/2022, 10/02/2022, 10/10/2022, and 10/20/2022 without recording the reason it was administered, which is required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is being locked in the facility's basement.

INVESTIGATION:

The complaint alleged Resident A was locked in the facility's basement without a phone. The complaint alleged Resident A's guardian, Guardian A1, instructed the facility's owner, Kim Nolan, to lock her in the basement.

Ms. Bickmeyer stated during her onsite at the facility she observed the basement door locked; however, the sliding doors were not locked indicating Resident A still had a means of egress out of the basement. She indicated she interviewed direct care staff and Ms. Nolan who all indicated the basement door was being locked to provide additional safety to Resident A when she was displaying dangerous behaviors. Ms. Bickmeyer stated she interviewed Guardian A1 who stated to her Resident A's behaviors seemed to escalate when Resident A was on the facility's main level indicting this was why she was also in agreement with keeping the basement door locked. Ms. Bickmeyer stated based on her interviews, locking the basement door did not appear to be "malicious" to Resident A, but rather to protect her from harming herself or others.

The facility's home manager/direct care staff, Ms. Crawford, confirmed Resident A's bedroom was in the facility's basement. She stated the basement door was not currently locked and/or preventing Resident A from coming upstairs. She indicated if the door was currently locked it was because Resident A locked it. Ms. Crawford also indicated Resident A can exit the basement through sliding doors, which were also not locked. Ms. Crawford stated Resident A has her direct care staff assigned to her; therefore, she's not left alone or unsupervised. She indicated staff may leave her in the basement during the overnight shift when Resident A is asleep.

During the investigation, I did not observe the downstairs basement door locked preventing Resident A from being upstairs. Additionally, I observed Resident A upstairs commingling with staff and residents in the facility, as well as, outside of the facility. I observed the downstairs basement door handle to have locking against egress door hardware indicating if the doorknob was locked it would prevent Resident A from accessing the facility's main level. I observed the second means of

egress in the facility basement, which was the sliding doors to the backyard. I found these sliding doors to be functioning properly and to be non-locking against egress.

Resident A stated the basement door at the bottom of the stairs had not been locked for “several days,” She stated there were times when the door would be locked without staff in the basement with her. It was difficult to ask additional questions of Resident A or interview her more thoroughly as she became tearful; expressing she did not want to reside in the facility and did not want to take the medications she was prescribed.

I interviewed Resident C who stated Resident A is often on the main level of the facility. He indicated when she is in the basement staff are with her.

Ms. Nolan stated the downstairs door leading to the upstairs was only locked for a short time while Resident A was experiencing significant behaviors and appeared in crisis, but staff were with her and she stated it was to keep Resident A safe. She stated when Resident A was experiencing significant behaviors she came upstairs and engaged in property destruction and attempted to hurt herself by getting into locked cabinets or closets where cleaning products were being kept.

Upon review of the facility’s electronic file, Ms. Nolan contacted me on 10/07/2022 to report Resident A’s significant behavior issues. She reported to me at that time Resident A had been expressing suicidal thoughts and running into the road. She stated law enforcement recently took Resident A to the local Emergency Room (ER); however, the hospital wouldn’t admit her to the psychiatric hospital. She indicated Resident A was admitted to the psychiatric hospital the previous week for only one or two nights before being discharged back to the facility. She indicated she would continue providing appropriate and adequate staffing; however, she was frustrated with the local medical facilities not admitting Resident A due to her behaviors. I discussed with Ms. Nolan the possibility of issuing a discharge if the placement was no longer appropriate or safe for Resident A.

Ms. Nolan expressed interest in wanting to lock the facility’s basement door and make the area an unlicensed apartment space. I provided Ms. Nolan with the information on how to make this space separate from the licensed area of the facility, which would include it having its own address, its own separate entrance and not utilizing any of the licensed space (e.g. meal preparation, bathing facilities, etc.), the basement door would need to be locked to prevent residents from entering unlicensed space and vice versa, the resident in the unlicensed space would need to be re-evaluated from an outside professional agency or individual to determine if not residing in an AFC was an appropriate setting. Ms. Nolan acknowledged an understanding the downstairs of the facility could not be utilized as a locked setting.

Guardian A1 stated Resident A was not being locked in the facility basement without being able to get out of the facility. She stated the basement door leading to the upstairs was only locked when Resident A was in the basement with direct care

staff, and it was due to the significant behaviors she was displaying. She stated if Resident A was asleep, and staff went upstairs then the door was left unlocked. Guardian A1 stated the sliding door in the basement was never locked; therefore, Resident A was still able to get out of the facility. She denied Resident A was ever denied egress from the facility.

On 12/19/2022, I conducted a follow up onsite investigation and interviewed direct care staff members Tonette Sigsbee and Dominique Whitaker. Ms. Sigsbee stated the basement stairs door was being locked by direct care staff on or around October 2022; however, she stated it was not being locked anymore. She indicated staff locked the door to prevent Resident A from coming upstairs when she was experiencing behaviors that were assaultive or destructive. She indicated during that time, staff were not always with her in the basement, but the door was still locked. She also confirmed the gates were locked during that time. Ms. Sigsbee didn't indicate Resident A was only confined to that area while she was experiencing a behavior or what needed to occur before Resident A was allowed upstairs. She stated that currently, there was nothing preventing Resident A from coming upstairs. Ms. Sigsbee stated Resident A has a staff assigned to work with her while the facility's second staff works with the remaining residents.

Mr. Whitaker stated he had just started working more frequently at the facility; despite working for the licensee for several years. He denied being aware of staff locking Resident A in the basement or confining her to one area of the facility. He also denied locking her in the basement.

I re-interviewed Resident A during the investigation. Resident A confirmed facility staff were locking the basement stairs door in October to prevent her from accessing the upstairs. She couldn't recall why staff were locking the basement stairs door. She had no information as to when staff would unlock the basement stairs door or how long they would lock it. She also stated the fence gates were locked as well. Resident A stated they would lock the basement stairs door for the entire day without staff being in the basement with her. She stated the locks on the gates had been removed and staff were no longer locking the basement stairs door. She indicated she can now access the upstairs and the rest of the facility.

During my follow-up investigation, I did not find the basement stairs door locked; however, it continued to have locking against egress hardware on it.

I reviewed the facility's staff schedules again, which confirmed Resident A has her own assigned staff.

On 12/19/2022, I interviewed former direct care staff, Jessica Gayle, via telephone. Ms. Gayle Ms. Gayle's statement to me was consistent with Ms. Sigsbee's statement to me.

On 12/19/2022, I interviewed direct care staff, Alex Finlayson. Ms. Finlayson denied locking Resident A in the basement but stated other direct care staff confined her to the basement by locking the bottom basement stairs door. She stated she did not talk to staff about why they did this but indicated it could have been to deal with Resident A's behaviors because some staff seemed to have a more difficult time redirecting Resident A and handling her behaviors. Ms. Finlayson stated staff were expected to be in the basement with Resident A, but indicated staff were not always down there with her when the basement door was locked.

I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan), dated 05/13/2022, which indicated Resident A is unable to control aggressive behaviors and does not get along with others; otherwise, there was no information about her being confined to one area of the facility as a means of managing Resident A's behavior.

On 12/19/2022, Ms. Nolan forwarded me Resident A's *Behavior Supports Plan*, dated December 2022, which was created by therapist, Kimberly Mateus, and Resident A's "Interaction Guidelines", which were created in conjunction with the licensee and Ms. Mateus; however, these guidelines were not dated. Upon my review of the BSP, I determined it only addressed Resident A's cigarette usage.

Resident A's interaction guidelines indicated they were "to be used by rehabilitation aids and behavioral technicians while providing [Resident A] with assistance and supervision in order to support her health and safety". The guidelines had a section specifically addressing Resident A's "Apartment and Access to Upstairs Portion of Residence". According to this section of the guidelines, Resident A is "not to be confined to her apartment, rather encouraged to respect her housemates' personal space by avoiding going into their bedroom". It also indicated Resident A is "allowed access to the upstairs at any time. However, staff are to encourage her to sleep in her own bedroom."

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**

ANALYSIS:	Based on my investigation, which included interviews with APS specialist Lindsay Bickmeyer, licensee designee Kim Nolan, home manager Kim Crawford, Guardian A1 and multiple direct care staff, the facility's basement door was being locked to prevent Resident A from accessing the facility's main area when her behaviors escalated, which would put herself and others at risk of being harmed. Subsequently, Resident A was being confined to the facility's basement during the time she was experiencing significant behaviors (e.g., elopements, assaulting staff, etc.) during October 2022. This was in direct opposition to Resident A's Behavior Support Plan Interaction Guidelines which restricted her from being confined to the basement area.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	Based on my observations, the facility's basement door located at the bottom of the basement stairs had locking against egress hardware.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 10/28/2022, I observed a plethora of medical equipment in front of the facility's barn, which is located on the left side of the facility's garage. These items were accessible to residents if the residents were to walk around the facility's yard. The plethora of medical equipment included a medication cart, Hoyer lifts, and wheelchairs. Additionally, there was an inoperable van observed near the medical equipment.

The facility's HR person indicated the van had just been pulled out of the woods and the plan was to remove it from the premises.

Ms. Nolan stated she was in the process of cleaning out the barn on the facility property and removing the van. She indicated she would clean up the area, as required.
On 12/19/2022, I again observed the same inoperable van and plethora of medical equipment in the same locations as my initial onsite inspection establishing the van and medical equipment had not been addressed or moved from the area.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.
ANALYSIS:	The facility's yard was observed with an inoperable vehicle and refuse in the form of unused medical equipment. Subsequently, the facility's yard area was no being kept free of hazards and nuisances, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 12/07/2022, I received an Employment Disqualification Notice through Michigan's Workforce Background Check for applicant/employee, Alex Finlayson, at the facility. The disqualification notice stated Ms. Finlayson was "NOT ELIGIBLE" to work in a job involving direct services to a patient or resident in an adult foster care facility before 11/06/2023.

On 12/07/2022, I contacted the facility's licensee designee, Kim Nolan, and informed her an exclusion notice had been received by the Department. She stated Ms. Finlayson was not hired to work in any of her facility's due the exclusion notice; despite her appearing to be a good employee. Licensee designee Kim Nolan confirmed she also received the exclusion notice and will not have her work in any licensed facility.

On 12/19/2022, I requested Ms. Nolan send me a staff list with staff phone numbers for the facility. Ms. Nolan provided the list, which included Ms. Finlayson's contact information indicating she was a staff member at the facility.

During my 12/19/2022 unannounced onsite investigation, I reviewed the facility's staff schedule for Resident A. According to this schedule, Ms. Finlayson was scheduled to work with Resident A on 12/25/2022 from 10 am until 11 pm.

I interviewed Ms. Finlayson via telephone after the onsite inspection and she confirmed she's worked for the licensee since approximately July 2022. She stated

she had worked with Resident A in October 2022. I asked Ms. Finlayson when she last worked at the facility and she stated, “early December”, meaning early December 2022. She confirmed her next scheduled work date at the facility was 12/25/2022. I informed Ms. Finlayson the Department had received an employment disqualification notice for her determining she was not able to work in an AFC. She stated she was aware of the notice and was going to talk to her attorney about the issue but indicated she did not know why she was excluded to work in an AFC until November 2023. I informed Ms. Finlayson she could appeal the decision; however, she was unable to work until that determination was made. I informed her I had spoken to Ms. Nolan about her exclusion notice when it was received, but I would speak to her again due to her still working and being scheduled to work.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or

	offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	On 12/07/2022, I received an Employment Disqualification Notice through Michigan's Workforce Background Check for applicant/employee, Alex Finlayson, which stated Ms. Finlayson was "NOT ELIGIBLE" to work in a job involving direct services to a patient or resident in an adult foster care facility before 11/06/2023. Ms. Nolan confirmed on 12/07/2022 that Ms. Finlayson would not work in the facility; however, during my 12/19/2022 onsite inspection I confirmed she was on the facility staff schedule to work 12/25/2022. Additionally, Ms. Finlayson stated she was aware of the exclusion notice and confirmed she was scheduled to work 12/25/2022. Despite Ms. Nolan receiving an employment disqualification notice for Ms. Finlayson she continued to employ her at the facility and put her on the schedule to work future shifts.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/01/2022, I conducted my exit conference with the licensee designee, Kim Nolan, via telephone. Ms. Nolan stated in conjunction with Guardian A1, she did what she had to do to keep Resident A safe from harming herself or others. She stated the basement doors were no longer being locked and the locks were taken off the fence, so it was no longer locking against egress. Ms. Nolan also stated she was looking into obtaining a smaller or lower energy dog for Resident A to help prevent behaviors as her previous dog had to be removed from the facility due to getting aggressive towards staff. Ms. Nolan also indicated she was pursuing making the lower portion of the facility into Resident A's own apartment and was currently working with the township on getting the apartment its own address.

On 12/19/2022, I attempted to conduct a follow up exit conference with Ms. Nolan; however, I was unable to reach her via telephone, but I did email her my findings. I reiterated to Ms. Nolan in my email that the person living in the basement needs to be able to meet his or her own needs and Resident A does not currently meet those criteria. I stressed to Ms. Nolan that if Resident A has to be confined to an area to keep herself and the other residents safe then that would indicate she cannot live independently.

On 12/21/2022, I interviewed Ms. Nolan via telephone. Ms. Nolan stated she had spoken to the police regarding the charges made using Resident B's debit card. She stated the police informed her they had individuals on camera relating to the use of the card; however, these individuals did not appear to be current or former direct care staff, per Ms. Nolan. Ms. Nolan stated Resident A was a harm to herself and confining her to a smaller space with staff was to protect her. She stated she was unable to get medical attention for Resident A; despite attempts to get her admitted to hospitals and psychiatric facilities in October. Ms. Nolan stated she recalled taking Ms. Finlayson off the schedule and believed Ms. Finlayson was only taking Resident A outside of the facility on 12/25/2022 to visit the homeless shelter.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend a provisional license due to the willful and substantial quality of care violations cited in the report.

12/20/2022

_____

Cathy Cushman Date
Licensing Consultant

Approved By:

12/20/2022

_____

Dawn N. Timm Date
Area Manager