GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 6, 2023

Lorinda Anderson
Community Living Options
626 Reed Street
Kalamazoo, MI 49001RE: License #

: AS390092832
Investigation #: 2023A1024016
CLO/Cliffwood Home

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

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott Kalamazoo, MI 49009

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

I. IDENTIFYING INFORMATION

License #:	AS390092832
Investigation #:	2023A1024016
Complaint Receipt Date:	01/10/2023
Investigation Initiation Date:	01/10/2023
Report Due Date:	03/11/2023
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:	CLO/Cliffwood Home
Facility Address:	127 Cliffwood Avenue Portage, MI 49002
Facility Telephone #:	(269) 323-7257
Original Issuance Date:	06/30/2000
License Status:	REGULAR
Effective Date:	12/26/2021
Expiration Date:	12/25/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
Residents have been without water for a week.	No
Resident A was given the wrong medications by staff member.	Yes
Resident B ingested 37 tablets of aspirin found in the facility's vehicle that was unlocked.	Yes
Residents are not treated with dignity.	No

II. METHODOLOGY

01/10/2023	Special Investigation Intake 2023A1024016
01/10/2023	Special Investigation Initiated – Telephone with Relative A1
01/10/2023	Contact - Telephone call made additional allegations regarding Resident A receiving the wrong medications
01/10/2023	Contact - Document Received- *Bronson After Visit Summary* for Resident A
01/13/2023	Contact - Face to Face with administrator/licensee designee Lorinda Anderson and program director Felicia Evans
01/17/2023	Contact - Document Received-additional allegations from Intake #192726 regarding Resident B
01/17/2023	Contact with Recipient Rights Officer (RRO) Suzie Suchyta
01/17/2023	Contact - Document Received- Matthew Shinavier's *Training Log, Deficient Performance Notice* and *AFC Licensing Division/Incident-Accident Report* regarding Resident A
01/20/2023	Contact - Document Received-additional allegations from Intake #192795 regarding staff member Shakiyah Singleton not treating the residents with dignity.
01/20/2023	Contact - Document Received- *AFC Licensing Division-Incident/Accident Report* regarding Resident B and *After Visit Summary* for Resident B
02/21/2023	Contact-Telephone call made with Resident A's mental health case manager Toby Ward

01/22/2023	APS Referral-APS already investigating allegations
01/24/2023	Inspection Completed On-site with home manager Amber McPherson
01/26/2023	Contact - Telephone call made with direct care staff members Nikaterri Smith and Matthew Shinavier
01/27/2023	Contact - Telephone call made with Jessica Muellen
01/30/2023	Contact - Telephone call made with direct care staff member Chakiyah Singleton
02/21/2023	Contact-Telephone called made with Resident A and Resident C
02/21/2023	Contact-Telephone contact with Resident A's mental health case manager Toby Ward
02/21/2023	Contact - Document Received Resident B's *Behavior Treatment Plan*
03/02/2023	Exit Conference with licensee designee Lorinda Anderson

ALLEGATION:

Residents have been without water for a week.

INVESTIGATION:

On 1/12023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged residents have been without water for a week.

On 1/10/2023, I conducted an interview with Relative A1 regarding this allegation. Relative A1 stated she is very dissatisfied with the facility. Relative A1 stated she visits the facility regularly and while visiting today she discovered that there was no store purchased bottled water in the home for the residents to drink and only tap water from the faucet. Relative A1 stated the facility has a private water supply therefore she does want her daughter to drink from the faucet as she believes the water does not taste good and is high in iron. Relative A1 stated there is usually a large water jug filled with store purchased water that residents can drink from however the jug has been empty for about a week. Relative A1 stated Resident A has kidney issues and must drink an adequate amount of water per day. Relative A1 stated Resident A is not able to get the water that she needs if there is no store purchased water in the home.

On 1/13/2023, I conducted interviews with administrator Lorinda Anderson and direct care staff member Felicia Evans, whose role is program director, regarding this allegation. Ms. Anderson and Ms. Evans both stated there have been no issues with water in the home and there has always been running water in the home. Ms. Evans stated she has not heard the residents complain about the water in the home however Relative A1 has made complaints that she wants Resident A to drink store purchased water. Ms. Evans stated residents have the liberty to purchase store bought water however this is not something the licensee or direct care staff members are required to do. Ms. Evans further stated there is a water filter on the faucet and direct care staff members usually will purchase a store purchased *Culligan* jug to give residents additional options for drinking water. Ms. Evans and Ms. Anderson both stated the water in the facility is safe to drink and tastes fine and has been tested and approved by an environmental health inspector through the local health department at the facility's last renewal inspection and the private water supply system is inspected every two years as required by Michigan Department of Licensing and Regulatory Affairs (LARA) rules and policies. Ms. Evans stated no resident has a special order to drink a certain amount of water and she believes all residents are drinking an adequate amount of water and are provided with running water daily.

I reviewed the facility's *Environmental Health Inspection Report* dated 9/2/2021 that stated the facility's water supply has been approved and was determined to be in substantial compliance with applicable environmental health rules with regulations.

On 1/24/2023, I conducted an onsite investigation at the facility with home manager Amber McPherson who stated that there have not been any issues with the water in the facility nor has she heard of any complaints from the residents regarding water access or quality in the home. Ms. McPherson stated Relative A1 has reported to her that she would like Resident A to drink store purchased bottled water and Ms. McPherson stated she advised Relative A1 that residents, family, and friends can purchase store bottled water for the residents if that is their preference. Ms. McPherson stated Resident A is also able to purchase her own bottled water. Ms. McPherson stated the home has a water filter on the kitchen sink and there is a *Culligan* jug that is purchased from the store by direct care staff to allow various drinking options for residents in the home however this is not required by staff and the water supply is safe to drink without these options in place. Ms. McPherson stated the residents have not gone without water and all residents are able to drink and use the facility's water at their discretion.

While at the facility, I found not issues with the facility's water supply.

On 1/26/2023, I conducted interviews with direct care staff members Nikaterri Smith and Matthew Shinavier who both stated that there have not been any issues with the water supply in the home and have not heard of any complaints regarding the facility's water.

On 1/27/2023, I conducted an interview with APS Specialist Jessica Mulleen who stated that she has not found any evidence to support the allegation of no water being in the home and she has no concerns.

On 1/30/2023, I conducted an interview with direct care staff member Shakiyah Singleton who stated that there have not been any issues with residents not being able to have water and the residents are able to use and drink water at their discretion.

On 2/21/2023, I conducted an interview with Resident A and Resident C who both stated that they have never been without water in the home and that they are able to drink as much water as they desire.

On 2/21/2023, I conducted an interview with Resident A's mental health case manager Toby Ward who stated he visits Resident A regularly and he has not found any issues with the facility's water. Mr. Ward stated Relative A1 wants Resident A to drink more water however Resident A is her guardian and drinks water to her own discretion. Mr. Ward stated he speaks to Resident A regularly and Resident A has not reported any complaints regarding the facility's water.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.
ANALYSIS:	Based on my investigation which included interviews with Relative A1, Resident A's mental health case manager Toby Ward, administrator/licensee designee Lorinda Anderson, direct care staff members Felicia Evans, Amber McPherson, Nikaterri Smith, Matthew Shinavier, Shakiyah Singleton, APS Specialist Jessica Mullen and review of the facility's environmental health inspection report, there is no evidence the facility was without a running water supply at any time. All direct care staff members and Residents A and C stated that there have not been any issues with the facility's water and residents are provided with adequate running water daily. The facility's private water supply was last inspected by the local health department as part of the licensee's renewal inspection and was found in compliance with applicable health and safety rules. Hot and cold running water is provided in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was given the wrong medication by a staff member.

INVESTIGATION:

On 1/10/2023, I received additional allegations stating Resident A was given the wrong medications.

On 1/10/2023, I conducted an interview with Relative A1 who stated she was notified by a direct care staff that Resident A received another resident's morning medications accidentally by direct care staff member Matthew Shinavier. Relative A1 stated Resident A had to be transported by EMS to the hospital and was admitted for observation for this medication error incident.

On 1/10/2023, I reviewed *Bronson After Visit Summary (*summary) for Resident A dated 1/3/2023. According to this summary, Resident A was seen at the hospital for unintentional overdose of medication. The summary stated Resident A arrived at Bronson ER after accidentally taking the wrong medications given to her by a staff member. This summary stated Resident A was given 40 mg of Atorvastatin, 100mg of Clozapine, 60mg of Propranolol, 67mg of Fenofibrate, and 1mg of Folic Acid. The summary stated Resident A presented with symptoms of fatigue, altered mental status and low heart rate therefore Resident A was admitted for ongoing management and treatment. Resident A was discharged on 1/4/2023.

On 1/13/2023, I conducted interviews with administrator Lorinda Anderson and direct care staff member Felicia Evans whose role is program director regarding this allegation. Ms. Anderson and Ms. Evans both stated that on the morning of 1/3/2023 staff member Mr. Shinavier accidentally gave Resident A another resident's medication. Ms. Evans and Ms. Anderson both stated that Mr. Shinavier is a very good staff member who is trained to give resident medications. Ms. Anderson stated due to this medication error performed by Mr. Shinavier, a written disciplinary notice was issued to Mr. Shinavier, and Mr. Shinavier had to complete a refresher training on giving medications to residents. Ms. Evans and Ms. Anderson also both stated Mr. Shinavier followed the appropriate procedures as soon as he realized he passed the wrong medications to Resident A and immediately called poison control and 911.

On 1/17/2023, I reviewed direct care staff member Matthew Shinavier's *Training Logs* which stated that Mr. Shinavier successfully completed adult foster care employee trainings which included medication training on 8/21/2015. I also reviewed Mr. Shinavier's training log for medications dated 1/10/2023 that stated Mr. Shinavier completed a medication quiz and was required to pass/prepare medications observed by his supervisor during two shifts as a refresher medication training.

I reviewed Ms. Shinavier's *Deficient Performance Notice* (notice) dated 1/3/2023 which stated that on 1/3/2023 Mr. Shinavier passed Resident A the wrong morning

medications and gave 40mg Atorvastatin, 100mg Clozapine, 67mg Fenofibrate, 1mg Folic Acid, 100 mg Docusate Sodium, 60mg Propranolol, and 1000mg Vitamin B-12. This notice stated Mr. Shinavier is expected to retake medication training and has received a written disciplinary notice regarding this policy violation.

I also reviewed the facility's *AFC Licensing Division/Incident-Accident Report* dated 1/3/2023. This report stated staff Mr. Shinavier passed the wrong medication to Resident A and when direct care staff noticed, direct care staff monitored Resident A, called Resident A's primary doctor, called poison control and 911. Resident A was transported to the hospital.

On 1/24/2023, I conducted an onsite investigation at the facility with direct care staff member Amber McPherson whose role is home manager. Ms. McPherson stated that she was made aware Mr. Shinavier gave Resident A's another resident's morning medication accidentally and sent Resident A to the hospital for further evaluation. Ms. McPherson stated she believes Resident A was admitted to the hospital due to her heart rate continuing to drop while at the hospital. Ms. McPherson stated Mr. Shinavier is a good staff member and she has not observed any issues with Mr. Shinavier in the past.

On 1/26/2023, I conducted interviews with direct care staff members Nikaterri Smith and Matthew Shinavier regarding this allegation. Ms. Smith stated while she was assisting a resident with showering, she was informed by Mr. Shinavier that he accidentally gave Resident A another resident's morning medication. Ms. Smith stated Mr. Shinavier called poison control and 911 who transported Resident A to the hospital. Ms. Smith stated Resident A was eventually admitted for further observed for 24 hours. Ms. Smith stated she works with Mr. Shinavier regularly and she has never known for Mr. Shinavier to give residents the wrong medications in the past.

I also conducted an interview with Mr. Shinavier. Mr. Shinavier stated on the morning of 1/3/2023, he asked Resident A and another resident to come to the office to get their medications. Mr. Shinavier stated he prepared both resident's medications simultaneously and put their medications in cups placing the cups next to each other. Mr. Shinavier stated when Resident A came to the office door, he accidentally gave Resident A the wrong cup of medications. Mr. Shinavier stated after Resident A took her medications, Mr. Shinavier immediately realized that the wrong cup of medications was given to Resident A as Mr. Shinavier is familiar with all the resident's medications. Mr. Shinavier stated he immediately called 911 and poison control for further instructions and EMS eventually transported Resident A to the hospital for further evaluation. Mr. Shinavier stated while waiting for EMS, he monitored Resident A closely for any adverse effects and noticed Resident A appeared tired. Mr. Shinavier stated Resident A was admitted to the hospital for observation for 24 hours.

On 2/21/2023, I conducted an interview with Resident A who stated that Mr. Shinavier gave her the wrong medications which required her to be hospitalized for a day. Resident A stated this medication error has never happened before in the past and she

normally receives her correct medications. Resident A further stated after she took the medications she was immediately sent to the hospital.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation which included interviews with Relative A1, Resident A's mental health case manager Toby Ward, administrator/licensee designee Lorinda Anderson, direct care staff members Felicia Evans, Amber McPherson, Nikaterri Smith, Matthew Shinavier, APS Specialist Jessica Muellen, review of Mr. Shinavier's training logs, disciplinary notice, the facility's incident report and Resident A's hospital notes, there is evidence Resident A was given the wrong medication. All staff members stated that Mr. Shinavier accidentally gave Resident A another resident's morning medications. According to hospital after visit summary, Resident A arrived at Bronson ER after accidentally taking the wrong medications given to her by a direct care staff member and presented with symptoms of fatigue, altered mental status and low heart rate therefore Resident A was admitted for ongoing management and treatment and discharged on 1/4/2023. The facility's incident report also stated Mr. Shinavier passed the wrong medication to Resident A. Mr. Shinavier stated he accidentally gave Resident A the wrong medications because he prepared two resident's medications at the same time and accidentally grabbed the wrong medications that were placed in a cup. Mr. Shinavier was disciplined for this medication error and was required to complete a medication refresher training. Reasonable precautions were not taken to ensure Resident A received her correct prescription medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B ingested 37 tablets of aspirin found in the facility's vehicle that was unlocked and residents are not treated with dignity.

INVESTIGATION:

On 1/17/2023, I received additional allegations that stated Resident B ingested 37 tablets of aspirin found in the facility's vehicle that was unlocked. On 1/20/2023, I also

received additional allegations that stated residents are not treated with dignity because direct care staff member Shakiyah Singleton told a resident to “move your fat ass out the way.”

On 1/17/2023, I conducted an interview with RRO Suzie Suchyta regarding this allegation who stated she received notification from direct care staff members that there was an emergency kit in the facility van that contained a bottle of aspirin and Resident B was able to get access to this kit and ingested 37 tablets of aspirin on 9/23/2022 which required Resident B to be hospitalized. Ms. Suchyta stated Resident B was able to gain access to the aspirin medication due to the facility vehicle being unlocked in the garage of the facility. Ms. Suchyta stated Resident B has a history of demonstrating self-harm behaviors and overdosing on medications. Ms. Suchyta further stated Resident B was also hospitalized on 11/11/2022 for ingesting aspirin medications again, however Resident B did not report where she retrieved the aspirin medication. Resident B did not report to anyone that she received the aspirin medications from the facility when she ingested the medication on 11/11/2022. Ms. Suchyta stated she believes staff members were neglectful and should have done a better job of safeguarding medications away from Resident B on 9/23/2022 due to Resident B’s history of seeking medications to abuse for self-harm purposes. Ms. Suchyta further stated she has no evidence at this time to support the allegation any direct care member spoke inappropriately to any residents or treated them with lack of dignity.

On 1/20/2023, I reviewed *AFC Licensing Division-Incident/Accident Report* (report) dated 9/23/2022 written by Shakiyah Singleton. According to this report, Resident B reported to staff that she had taken a bottle of aspirin and Tylenol from the facility van’s First Aid kit and had already called 911. Resident B was taken to the hospital.

I also reviewed *AFC Licensing Division-Incident/Accident Report* dated 11/12/2022 written by Shakiyah Singleton. According to this incident report, Resident B stated she wanted to get high and then went downstairs to her bedroom. The report stated Resident B returned upstairs and stated that she just called the police because she took a bottle of aspirin. Resident A was transported to Bronson Hospital.

I reviewed Resident B’s *Bronson After Visit Summary* (summary) dated 9/23/2022. According to this summary, Resident B was seen at the hospital for suicide attempt and diagnosed with suicidal overdose.

I also reviewed Resident B’s *Bronson After Visit Summary* (summary) dated 11/12/2022. According to this summary, Resident B was seen admitted to the hospital on 11/12/2022 for aspirin overdose and discharged 11/14/2022.

On 1/24/2023, I conducted an onsite investigation at the facility with direct care staff member Amber McPherson whose role is home manager. Ms. McPherson stated she was not working during the two incidents Resident B was transported to the hospital for taking aspirin however was made aware by direct care staff and Resident B that Resident B obtained aspirin medication found in the emergency first aid kit located in

the facility's van that was unlocked in the garage on 9/23/2022. Ms. McPherson stated the facility van is usually locked in the garage therefore she is unsure why the facility van was not locked as usual on the day of 9/23/2022. Ms. McPherson stated since the incident on 9/23/2022, no more medications are kept in the first aid kit and there are no medications stored in the facility outside of the medication cabinet located in staff's office. Ms. McPherson stated she is unsure how Resident B obtained aspirin medications for the incident that occurred on 11/12/2022 however Resident B can visit with her father without staff supervision regularly therefore Ms. McPherson believes Resident B was able to retrieve aspirin medications while out in the community. Ms. McPherson further stated she is aware that Resident B has a history of seeking medications to self-harm. Ms. McPherson stated she has not heard of any reports that any staff member including Ms. Singleton has treated any resident with lack of respect and dignity. Ms. McPherson stated she has never heard Ms. Singleton be inappropriate towards the residents and no residents has expressed any concern.

On 1/26/2023, I conducted interviews with direct care staff members Nikaterri Smith and Matthew Shinavier. Ms. Smith stated she was not present however heard from other staff members that Resident B was able to retrieve aspirin medications on 9/23/2022 from the first aid kit in the facility's van as the van was found to be unlocked in the garage. Ms. Smith stated she also was told that Resident B ingested aspirin medications on 11/12/2023 however Resident B stated to her that she did not get the medications from the facility and will not disclose how she was able to retrieve the aspirin medication on 11/12/2022. Ms. Smith stated to her knowledge the van is always locked and there have been no medications stored in the first aid kit since the 9/23/2022. Ms. Smith stated she is aware that Resident B has a history of suicide attempts and seeking medications to self-harm. Ms. Smith further stated she has never seen or heard Ms. Singleton be disrespectful or treat residents in an undignified way and has not heard of any reports from any resident stating Ms. Singleton or any direct care staff member has been inappropriate with them.

Mr. Shinavier stated the staff will usually store aspirin and Tylenol medications in the facility's first aid kit that is kept in the facility's van locked and located in the garage however since Resident B continues to seek aspirin and Tylenol medication to self-harm, there are no longer any form of medications stored in the facility's first aid kit located in the facility's vehicle since 9/23/2022. Mr. Shinavier stated Resident B reported to staff she retrieved aspirin medications from the facility van on 9/23/2022 however did not disclose where she retrieved aspirin medication that she took on 11/12/2023. Mr. Shinavier stated he has never seen or heard Ms. Singleton be disrespectful or treat residents in an undignified way and has not heard of any reports from any resident stating that Ms. Singleton or any staff member has been inappropriate with them.

On 1/30/2023, I conducted an interview with direct care staff member Shakiyah Singleton. Ms. Singleton stated on 9/23/2022, Resident A informed her that she had taken aspirin medications out of the first aid kit in the facility's van that was unlocked in the garage and ingested 37 tablets of aspirin. Ms. Singleton stated she was not aware

that there were any medications in the first aid kit, and she is unsure why the facility's van was unlocked as the van is usually locked. Ms. Singleton on 11/12/2022, Resident B approached her laughing and stated to her that she had just ingested "a ton of aspirin" however Resident B would not disclose where she was able to obtain any aspirin medications. Ms. Singleton stated, Resident A regularly goes out in the community without staff supervision to visit with her father therefore Ms. Singleton believes Resident B obtained aspirin that she took on 11/12/2022 while out in the community. Ms. Singleton further stated to her knowledge Resident B does not have access to any medications in the facility as all medications are locked and stored in a medication cabinet located in staff's office. Ms. Singleton further stated she has never told any resident to "move their fat ass" nor has she ever treated any resident in an undignified way. Ms. Singleton stated she gets along with all the residents in the facility and there has not been any issues. Ms. Singleton further stated she believes Relative A1 is targeting her due to her own biases and has made false accusations towards her.

On 2/21/2023, I reviewed Resident B's *Behavior Treatment Plan* dated 2/15/2022. According to this plan, Resident B has a history of attempting elopement and self-harm behaviors which includes overdosing on medications. Resident B also has a tendency to attempt to purchase over the counter medications while on outings. This plan stated Resident B requires staff to supervise and monitor Resident B while out in the community and Resident B can visit with approved persons without staff supervision for 4 hours twice per month.

On 2/21/2023, I conducted an interview with Resident A and Resident C who both stated that they get along with staff and they like the staff members in the facility. Resident A and Resident C also stated they have not heard any staff member be mean to any resident.

On 2/21/2023, I conducted an interview with Resident A's mental health case manger Toby Ward who stated that he has not seen any staff member be rude or speak with a lack of dignity to any resident in the facility. Mr. Ward also stated Resident A has reported to him that she loves all the staff members and has not had any issues with staff in the facility.

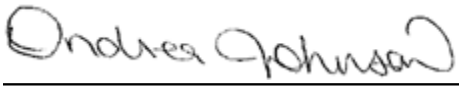
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on my investigation which included interviews with Resident A's mental health case manager Toby Ward, RRO officer Suzie Suchyta, direct care staff members Amber McPherson, Nikaterri Smith, Shakiyah Singleton and Matthew Shinavier, review of Resident B's hospital documents, facility's incident reports, and Resident B's treatment plan there is evidence Resident B ingested aspirin medications that were found in the facility's vehicle that was unlocked. It should be noted there are no findings to support the allegation residents are not treated with dignity and no staff member nor resident reported having knowledge of any staff member being rude or not treating residents with dignity and respect. Ms. McPherson, Ms. Smith, Ms. Singleton and Mr. Shinavier all stated that Resident B reported that she was able to retrieve aspirin medications from the facility's van that was found unlocked in the facility's garage. These staff members further stated aspirin medications were stored in a first aid kit in the facility's van up until the incident on 9/23/2022 when Resident B ingested aspirin tablets and was taken to the hospital for medication overdose. According to the facility's incident reports, Resident B ingested aspirin medications on 9/23/2022 and on 11/12/2022 and Resident B reported that she was able to retrieve the aspirin medications from the unlocked facility van on 9/23/2022. All staff members stated that no medications were continued to be stored anywhere in the facility other than the staff's locked office after 9/23/2022. According to Resident B's treatment plan, Resident B has a history of self-harm behaviors which includes overdosing on medications and attempting to purchase over the counter medications when on outings. Ms. Suchyta also stated based on her investigation she found staff to be neglectful for failing to secure all medications in the home by having the facility's vehicle unlocked giving Resident B access to aspirin medications knowing she has a history of self-harm with medication. Staff failed to provide safety and protection at all times for Resident B by not safeguarding all medications in the facility which resulted in Resident B self-harming by overdosing on medications, a behavior all staff members were aware of and was documented in Resident B's treatment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/2/2023, 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.

III. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the current license status remain unchanged.



Ondrea Johnson — 03/02/2023

Ondrea Johnson
Licensing Consultant
Date

Approved By:

03/06/2023

Dawn N. Timm
Area Manager
Date