GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 29, 2023

Renae Clark
Community Living Support Services, LLC
PO Box 5
Albion, MI 49224

RE: License #: AS130381539
Investigation #: 2023A0578053
Linden Ave.

Dear Renae Clark:

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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130381539
Investigation #:	2023A0578053
Complaint Receipt Date:	08/08/2023
Investigation Initiation Date:	08/09/2023
Report Due Date:	10/07/2023
Licensee Name:	Community Living Support Services, LLC
Licensee Address:	PO Box 5 Albion, MI 49224
Licensee Telephone #:	(517) 554-8788
Administrator:	Renae Clark
Licensee Designee:	Renae Clark
Name of Facility:	Linden Ave.
Facility Address:	504 Linden Ave. Albion, MI 49224
Facility Telephone #:	(517) 554-8788
Original Issuance Date:	04/29/2016
License Status:	REGULAR
Effective Date:	10/18/2022
Expiration Date:	10/17/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care staff were observed sleeping on multiple occasions during the overnight shift at this facility.	Yes
Direct care staff did not use the seatbelt lock as required in Resident A's Behavior Support Plan, resulting in Resident A hitting his head on the center vehicle console when being transported by direct care staff.	Yes

III. METHODOLOGY

08/08/2023	Special Investigation Intake 2023A0578053
08/09/2023	Special Investigation Initiated - On Site
08/09/2023	APS Referral
08/09/2023	Special Investigation Completed On-site- Interview with direct care staff Hope Warren.
08/09/2023	Contact-Document Received- *AFC Licensing Division Incident / Accident Report* dated 06/29/2023.
08/09/2023	Contact-Document Received- *AFC Licensing Division Incident / Accident Report* dated 06/15/2023.
08/09/2023	Contact-Document Received- *Behavioral Support Plan* for Resident A, dated 10/10/2022.
09/27/2023	Contact-Telephone- Interview with Integrated Services of Kalamazoo rights officer Suzie Suchyta.
09/27/2023	Contact-Document Received- *Case Notes* provided by Integrated Services of Kalamazoo rights officer Suzie Suchyta.
09/28/2023	Contact-Document Reviewed- *Original Licensing Study Report,* dated 04/29/2016.
09/28/2023	Exit Conference- Completed with licensee designee Renae Clark.

ALLEGATION:

Direct care staff were observed sleeping on multiple occasions during the overnight shift at this facility.

INVESTIGATION:

On 08/08/2023, I received this complaint through the BCHS On-line Complaint System. Complainant alleged that on 06/15/2023, direct care staff Amber Schroll was sleeping during the overnight shift. Complainant alleged that on 06/29/2023, direct care staff Ariana Bunting was found sleeping during the overnight shift by direct care staff Hope Warren.

On 08/09/2023, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Hope Warren regarding the allegations. Hope Warren reported working at this facility for almost three years and serving as the home manager at this facility. Hope Warren acknowledged that direct care staff Amber Schroll and direct care staff Aiana Bunting were observed sleeping during the overnight shift. Hope Warren reported licensee designee Renae Clark was aware of direct care staff Aiana Bunting being asleep but was not aware of direct care staff Amber Schroll being asleep on the overnight shift until being informed by the office of recipient rights. Hope Warren reported both direct care staff members were provided with written counseling and are no longer employed by the licensee designee. Hope Warren reported this facility currently has six residents and it is required direct care staff members are awake during the overnight shift. Hope Warren reported she directly observed direct care staff Aiana Bunting sleeping while being the only direct care staff working at this facility and had to verbally attempt to wake Aiana Bunting several times before Aiana Bunting responded.

On 08/09/2023, I reviewed the *AFC Licensing Division Incident / Accident Report* dated 06/29/2023 and completed by direct care staff Hope Warren. The *AFC Licensing Division Incident / Accident Report* documented that upon arriving to work to provided assistance with Resident A, Hope Warren observed direct care staff Aiana Bunting laying on the couch asleep. The *AFC Licensing Division Incident / Accident Repor*t documented that Hope Warren told Aiana Bunting that she needed to get up. The *AFC Licensing Division Incident / Accident Report* documented that Aiana Bunting responded, “I’m up” and pointed at another resident that was sleeping on the other couch. The *AFC Licensing Division Incident / Accident Report* documented that Hope Warren reported the incident to the office of recipient rights and the responsible agency.

On 08/09/2023, I reviewed the *AFC Licensing Division Incident / Accident Report* dated 06/15/2023 and completed by direct care staff Aiana Bunting. The *AFC Licensing Division Incident / Accident Report* documented that direct care staff Amber Schroll was observed by direct care staff Aiana Bunting sleeping from about 3AM until 5AM. The *AFC Licensing Division Incident / Accident Report* documented

that licensee designee Renae Clark was informed of this incident on 06/20/2023 and instructed direct care staff to report the incident to the office of recipient rights and other responsible agencies.

On 09/27/2023, I reviewed the details of the allegations with Integrated Services of Kalamazoo rights officer Suzie Suchyta. Suzie Suchyta reported she had established a rights violation as direct care staff Aiana Bunting had reported that she had laid down at 5:30AM to stretch her back, but Resident A was to be woken up at 5AM in order to prepare for school. Suzie Suchyta reported direct care staff Hope Warren reported arriving at 5:45AM to provide direct care staff Aiana Bunting with assistance with Resident A, but instead found Aiana Bunting sleeping. Suzie Suchyta reasoned direct care staff Aiana Bunting would have been asleep longer than 15 minutes and put Resident A at serious risk, especially with this facility having open access to a river in the back yard and Resident A's history of elopement.

On 09/27/2023, I reviewed the *Case Notes* provided by Integrated Services of Kalamazoo rights officer Suzie Suchyta. The *Case Notes* documented that Aiana Bunting informed Suzie Suchyta that she had laid down around 5:30am on the couch in the living room to stretch her back. The *Case Notes* documented that Aiana Bunting informed Suzie Suchyta she closed her eyes because she was trying to relax her body due to a back injury. The *Case Notes* documented that Aiana Bunting informed Suzie Suchyta that she heard direct care staff Hope Warren enter the facility and thought Hope Warren was in the kitchen. The *Case Notes* documented that Aiana Bunting informed Suzie Suchyta she was not asleep and denied Hope Warren had to wake her. The *Case Notes* documented that Aiana Bunting informed Suzie Suchyta she was single staffed during her shift until Hope Warren arrived at the home.

The *Case Notes* documented that Hope Warren informed Suzie Suchyta that she arrived at this facility at 5:38AM and observed Aiana Bunting asleep on the couch with her hair over her face and unresponsive to Hope Warren entering the room. The *Case Notes* documented Hope Warren informed Suzie Suchyta she had to stand over Aiana Bunting and call her name several times before Aiana Bunting responded. The *Case Notes* documented that Hope Warren informed Suzie Suchyta that once Aiana Bunting was awake, Hope Warren immediately woke Resident A to make him breakfast and get Resident A ready for school.

On 09/28/2023, I reviewed the *Original Licensing Study Report* for this facility, completed by AFC licensing consultant Leslie Herrguth on 04/29/2016. The *Original Licensing Study Report* documented that direct care staff will be awake during sleeping hours at this facility.

On 09/28/2023, I completed an exit conference with licensee designee Renae Clark. Renae Clark acknowledged the findings of this investigation and did not disagree with these findings but added there was personal conflict between direct care staff Aiana Bunting and direct care staff Amber Schroll and the reported occurrence of

Amber Schroll sleeping was only reported by Aiana Bunting and not substantiated by other agencies.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Hope Warren and Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta, as well as a review of pertinent facility documentation relevant to this investigation, direct care staff at this facility have been asleep during sleeping hours and have been incapable of responding to emergency situations.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff did not use the seatbelt lock as required in Resident A's Behavior Support Plan, resulting in Resident A hitting his head on the center vehicle console when being transported by direct care staff.

INVESTIGATION:

On 08/08/2023, Complainant alleged that on 6/29/23, direct care staff Hope Warren did not use the seatbelt lock as required in Resident A's Behavior Support Plan and Resident A "launched forward" in the van and hit his head on the center console.

On 08/09/2023, I completed an unannounced investigation on-site and interviewed direct care staff Hope Warren regarding the allegations. Hope Warren reported working at this facility for almost three years. Hope Warren acknowledged the allegations and reported the bus stop that Resident A uses to get to school is "around the corner" from this facility. Hope Warren reported that she was transporting Resident A to this bus stop in the facility van when she realized Resident A needed to have his adult undergarment changed. Hope Warren reported she returned to the facility in the van with Resident A when Resident A had taken off his seat belt and lunged forward between the front seats, causing her to stop. Hope Warren reported she stopped the van which resulted in Resident A being "launched

forward” and hitting the side of his face on the middle of the driving console in the van. Hope Warren denied this incident resulted in any injury or bruising to Resident A. Hope Warren reported Resident A is non-verbal and will gesture but immediately got to his feet. Hope Warren reported Resident A was monitored for any developing injuries and had none. Hope Warren reported that she may have been driving 10MPH, and the road leading to this facility is 15MPH.

Hope Warren acknowledged that Resident A should have been equipped with a seat belt lock as identified in his behavior treatment plan. Hope Warren reported that she did not think the seat belt lock was necessary as he was only transporting Resident A “from around the corner” but acknowledged that Resident A should have been equipped with a seat belt lock, which would have prevented Resident A from removing his seat belt, resulting in Resident A hitting his head on the center console of the vehicle.

On 08/09/2023, I reviewed the *AFC Licensing Division Incident / Accident Report* related to the allegations and dated 06/29/2023. The *AFC Licensing Division Incident / Accident Report* documented that while transporting Resident A back to the facility, Resident A took off his seat belt and “lunged forward,” causing direct care staff Hope Warren to stop the vehicle, resulting in Resident A hitting his face on the center console of the vehicle. The *AFC Licensing Division Incident / Accident Report* documented that direct care staff Hope Warren pulled over this vehicle and buckled Resident A back in his seat and inspected Resident A for any marks or injuries and found none.

On 08/09/2023, I reviewed the *Behavioral Support Plan* for Resident A, dated 10/10/2022. The *Behavioral Support Plan* for Resident A documented that Resident A has a mutation of the second chromosome and is diagnosed with moderate intellectual and developmental disability. The *Behavioral Support Plan* for Resident A defined Resident A’s target behaviors as wiping spit, dropping (to the ground), physical aggression, elopement, and “unsafe transport.”

The *Behavioral Support Plan* for Resident A defined unsafe transport as Resident A standing, unbuckling his seatbelt and/or any behavior that poses a risk to Resident A or others during transport. The *Behavioral Support Plan* for Resident A documented that Resident A can be unsafe during transport and will unbuckle his seat while the vehicle is moving. The *Behavioral Support Plan* for Resident A documented that Resident A has a freedom of movement restriction due to Resident A’s behavior of elopement, lack of safety awareness and the possibility of Resident A entering other people’s homes. The *Behavioral Support Plan* for Resident A documented that when Resident A is being transported with only one direct care staff, Resident A will wear a seatbelt lock on his seat belt for safety purposes. The *Behavioral Support Plan* for Resident A added that Resident A had a recent history of getting up while in the van and unbuckling his seat belt.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based upon my investigation, which consisted of an interview with direct care staff Hope Warren, as well as a review of pertinent facility documentation relevant to this investigation, the seat belt lock identified in Resident A's Behavioral Support Plan was not implemented by direct care staff Hope Warren, resulting in Resident A releasing his seat belt and hitting his head on the center console of a facility van while being transported.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

09/28/2023

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Eli DeLeon Date
Licensing Consultant

Approved By:

09/29/2023

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Dawn N. Timm Date
Area Manager