GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 23, 2023

Felicia Evans
Community Living Options
626 Reed Street
Kalamazoo, MI 49001

RE: License #: AS390011418
Investigation #: 2023A0581050
Lovell Street Home

Dear Ms. Evans:

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) 284-9730.

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 #:	AS390011418
Investigation #:	2023A0581050
Complaint Receipt Date:	08/08/2023
Investigation Initiation Date:	08/08/2023
Report Due Date:	10/07/2023
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Fiorella Spalvieri
Licensee Designee:	Felicia Evans
Name of Facility:	Lovell Street Home
Facility Address:	710 West Lovell Kalamazoo, MI 49007
Facility Telephone #:	(269) 343-6355
Original Issuance Date:	12/11/1986
License Status:	REGULAR
Effective Date:	02/05/2023
Expiration Date:	02/04/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
Resident A accessed the facility's house keys.	Yes

III. METHODOLOGY

08/08/2023	Special Investigation Intake 2023A0581050
08/08/2023	Referral - Recipient Rights Integrated Services of Kalamazoo (ISK) received the allegations and substantiated.
08/08/2023	Special Investigation Initiated - Telephone Interview with Complainant.
08/08/2023	Contact - Telephone call made Interview with ISK RRO, Suzie Suchyta.
08/08/2023	APS Referral made via email
08/10/2023	Inspection Completed On-site Interview with staff. Obtained documentation.
08/10/2023	Contact - Telephone call made Interview with direct cadre staff, Shyanna Gibbons.
08/10/2023	Contact - Document Received Email from Ms. Schiebel.
08/21/2023	Contact - Telephone call made Interview with Resident A.
08/21/2023	Inspection Completed-BCAL Sub. Compliance
08/22/2023	Exit conference with licensee designee, Felicia Evans, via telephone.

ALLEGATION:

Resident A accessed the facility's house keys.

INVESTIGATION:

On 08/08/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 06/04/2023, direct care staff, Shyanna Gibbons, placed the facility's house keys, which included the medication cabinet keys and keys to the locked sharps drawer, on the kitchen counter. The complaint alleged Ms. Gibbons turned her back to the keys leaving enough time for Resident A to take and hide them from her. The complaint alleged that subsequently, Ms. Gibbons did not provide adequate protection and safety to Resident A by making the facility's house keys accessible.

On 08/08/2023, I interviewed Complainant whose statement to me was consistent with the allegations.

On 08/08/2023, I interviewed Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta, via telephone. Ms. Suchyta stated she was aware of the allegations due to receiving an Incident Report on 06/08/2023, which supported the allegations. She stated she interviewed Ms. Gibbons and Resident A. Ms. Suchyta stated on 06/04/2023, Ms. Gibbons, who was the only staff working in the facility, was cooking the residents a meal when she set the facility's house keys on the kitchen counter and then turned her back. Ms. Suchyta stated Resident A reported to her that while Ms. Gibbons' back was turned, Resident A grabbed the keys and put them in a drawer to hide them from Ms. Gibbons. Ms. Gibbons reported to Ms. Suchyta she looked for the keys for approximately 15-30 minutes before Resident A gave them back to her. Ms. Suchyta stated Resident A was "remorseful and felt bad" for the incident occurring as "he really likes Shyanna as a staff and didn't want her in trouble". Ms. Gibbons reported to Ms. Suchyta that it was protocol to keep the facility's house keys around her neck.

Ms. Suchyta stated none of the residents, including Resident A, used the keys to access anything restricted like the medication cabinet, the sharps drawer, or the staff office where resident files are located.

Ms. Suchyta forwarded me the *AFC Licensing Division – Incident / Accident Report* (IR), dated 06/06/2023, which was completed by Ms. Gibbons. According to the IR, on 06/04/2023 at approximately 7:30 pm, after Ms. Gibbons prepared dinner she documented the "whole entire house keys goes missing". She documented she searched the kitchen, office, bathroom, living room and dining room, but was unable to locate the keys. She documented "about 30 mintues[*sic*] pass [Resident A] hands me the house keys." She documented she asked Resident A where the house keys had been; however, Resident A reported he didn't know. Ms. Gibbons documented, "So [Resident A] could have got into anything without me knowing. While I was

searching for the house keys[*sic*]". Ms. Gibbons stated she took the keys from Resident A, wrote an IR, and contacted another staff.

The facility's identified "Program Director" at the time the IR was written, Tim VanDyk, documented in the IR Ms. Gibbons was given "written corrective feedback regarding safeguarding keys at all time". Mr. VanDyk documented he also spoke to Resident A about "safety issues with keys". Mr. VanDyk documented Resident A "did not access any restricted area as [Ms. Gibbons] was visually monitoring".

On 08/10/2023, I conducted an unannounced inspection at the facility to interview Resident A; however, Resident A was not present during my inspection due to working at his job. I interviewed direct care staff, Kristin Bauer, who stated she had not been working when the incident with Ms. Gibbons and Resident A took place; however, she stated it was the facility's policy for staff to always keep facility keys on his or her person. She stated the facility's keys contain the keys to resident bedrooms, the facility's office where resident records are stored, the medication cabinet, and the drawer where the knives are kept.

I reviewed Resident A's ISK mental health assessment (assessment plan), dated 09/09/2022, which documented Resident A has a history of self-harm using sharp objects, and requires staff to administer his medications.

On 08/10/2023, I interviewed direct care staff, Shyanna Gibbons, via telephone. Ms. Gibbons' statement to me was consistent with the allegations. She stated the keys were only on the kitchen counter for approximately two to three minutes before she realized they were gone. She stated when she had set them on the counter, none of the residents were present or around her. She stated she asked the residents who were home at the time if they had seen the keys; however, none of them knew where the keys were. She stated, "out of nowhere", Resident A found the keys and gave them to her. She stated Resident A later admitted to putting the keys in a drawer to hide them from her, for which he later apologized. Ms. Gibbons stated the incident was a one-time incident as nothing like that had occurred before. She stated she was in the facility the entire time the keys were missing; therefore, none of the residents accessed any restricted areas. Ms. Gibbons stated she's aware of always keeping the house keys around her neck.

On 08/21/2023, I interviewed Resident A via telephone. Resident A's statement to me was consistent with the allegations and Ms. Gibbons' statement to me. Resident A stated he was being "spiteful", had an attitude, and was mad with himself, which he took out on Ms. Gibbons by hiding her keys. Resident A stated he "had no clue what the keys were for" or what they could access. He stated he did not take the keys and try to open anything. Resident A could not recall how long the keys were hidden but stated "it wasn't long". He stated Ms. Gibbons discovered the keys because he pointed to the drawer in which he put them in. Resident A stated this was a one time occurrence and also stated Ms. Gibbons does a "good job at what she does."

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, direct care staff, Shyanna Gibbons and Kristin Bauer, and ISK RRO, Suzie Suchtya, and a review of the facility's IR and Resident A's assessment plan, Ms. Gibbons did not provide Resident A with protection and safety, as required, on 06/04/2023 when Resident A obtained the facility's house keys, which access the facility's medication cabinet and locked sharp items, after Ms. Gibbons set the keys down on the kitchen counter and turned her back. This is especially concerning given Resident A's history of self-harm with sharp objects.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/22/2023, I conducted an exit conference with licensee designee, Felicia Evans, via telephone. Ms. Evans acknowledged the findings and stated a staff meeting had already been held at the facility to remind staff about always keeping the facility keys on their person. She had no questions and indicated she would submit an acceptable plan of correction upon receipt of the report.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

08/21/2023

Cathy Cushman Date
Licensing Consultant

Approved By:

08/23/2023

Dawn N. Timm Date
Area Manager