GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2021

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

RE: License #: AS390011445
Investigation #: 2021A0581040
Oak Creek 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 (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 #:	AS390011445
Investigation #:	2021A0581040
Complaint Receipt Date:	06/11/2021
Investigation Initiation Date:	06/11/2021
Report Due Date:	08/10/2021
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:	Oak Creek Home
Facility Address:	2416 Oakcreek Drive Kalamazoo, MI 49004
Facility Telephone #:	(269) 383-0747
Original Issuance Date:	09/14/1990
License Status:	REGULAR
Effective Date:	10/22/2019
Expiration Date:	10/21/2021
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A 2nd shift staff left residents unattended and unsupervised for approximately 20 minutes.	Yes

III. METHODOLOGY

06/11/2021	Special Investigation Intake 2021A0581040
06/11/2021	Special Investigation Initiated - Letter Requested facility documentation and resident AFC documentation.
06/11/2021	Contact - Document Received Received Incident Reports relating to the incident.
06/11/2021	Referral - Recipient Rights Emailed Kalamazoo Recipient Rights Officer, Lisa Smith.
06/11/2021	Contact - Document Received Received resident's documentation via email.
06/14/2021	Contact - Document Received Received timesheet from program director, Souleymane Illa, via email.
06/14/2021	Contact - Document Received Email from licensee designee, Lori Anderson.
06/16/2021	Inspection Completed On-site Interviewed residents and staff.
06/17/2021	Inspection Completed-BCAL Sub. Compliance
06/21/2021	Exit conference with licensee designee, Lori Anderson, via telephone.

ALLEGATION:

A 2nd shift staff left residents unattended and unsupervised for approximately 20 minutes.

INVESTIGATION:

This complaint was received on 06/11/2021 after the licensee designee, Lori Anderson, notified the facility's assigned Adult Foster Care Consultant, Ondrea Johnson, of the incident by sending her the *AFC Licensing Division Incident/Accident Report (*IR). The IR's was forwarded to me and I opened a special investigation due to the IR's indicting the facility was left unstaffed for approximately 20 minutes.

On 06/11/2021, I reviewed the IR's provided by Ms. Anderson. According to these IR's, on 06/10/2021 2nd shift direct care staff, Naya Reynolds, did not wait long enough for the facility's overnight staff to arrive to the facility. The IR indicated Ms. Reynolds left the facility and/or clocked out at 11:22 pm and the incoming 3rd shift staff clocked in at approximately 11:41 pm, indicating the five residents in the facility were without any supervision for approximately 20 minutes. The IR also indicated Ms. Reynolds employment was terminated on 06/11/2021.

On 06/11/2021, I received and reviewed Resident A's, Resident B's, Resident C's, Resident D's, and Resident E's *Assessment Plans for AFC Residents* and their respective community mental health (CMH) assessment plans, if applicable. None of the resident's assessment plans indicated any of the residents required increased supervision from direct care staff at any point during the day. In addition, none of the assessment plans indicated any of the residents were nonverbal or unable to communicate their needs.

On 06/14/2021, I received an email from Ms. Anderson confirming her human resources personnel had sent a letter to Ms. Reynolds on 06/11/2021 terminating her employment with the licensee.

On 06/15/2021, I conducted an announced on-site at the facility to interview direct care staff and residents. Integrated Services of Kalamazoo's (ISK) Recipient Rights Officer, Michele Schiebel, was present via MiTeams. The facility's program director, Felicia Evans, was also present. Ms. Schiebel and I interviewed direct care staff, Ben Mukundi. Mr. Mukundi stated he has worked for the licensee for approximately three months. He stated on 06/10/2021 he had been scheduled to work 3rd shift at the facility, starting at 11 pm, but finished working at 11 pm at another facility for the licensee located 15 minutes away from Oakcreek and was subsequently running late. He stated he got a call from the licensee's on-call supervisor, Sulayman Aninure, around 11 pm stating Ms. Reynolds was unable to stay at the facility and would be leaving prior to Mr. Mukundi's arrival.

Mr. Mukundi stated he arrived at Oakcreek around 11:41 pm to no direct care staff being present in the facility with residents. He stated there were no issues upon his arrival and all the residents were asleep. He stated he checked on the residents every two hours, per the licensee's regular supervision checks. He stated none of the residents have elopement issues, significant behavioral issues at night, recent history of seizures, smoke, or even get up frequently throughout the night. He stated since he has worked at the facility, there had not been any times when the residents were left unattended or unsupervised indicating Ms. Reynold's leaving the residents alone was an isolated event.

I also interviewed program supervisor, Mr. Aninure. Mr. Aninure's statement to me was consistent with Mr. Mukundi's statement to me. Mr. Aninure stated Ms. Reynolds was unable to stay a substantial amount of time past her shift because she did not have a vehicle and was being picked up. Mr. Aninure stated Ms. Reynolds stayed at the facility until 11:22 pm and then left. He stated the residents were left unattended and unsupervised from the time she left until Mr. Mukundi arrived at 11:41 pm.

Ms. Evans, Mr. Aninure, and Mr. Mukundi all stated the residents in the facility are capable of speaking and can use the facility's phone in case of an emergency. Ms. Evans stated Ms. Reynolds did not have past issues with leaving residents unattended.

I interviewed Resident A, Resident C, Resident D, and Resident E during my on-site at the facility. Resident B was not interviewed because he was not at the facility due to being employed and working at the time of my on-site investigation. During my interviews with the residents, I confirmed they were all verbal and capable of using the facility's telephone. All the residents stated they go to bed around 8 pm or 9 pm and stay asleep throughout the night. The residents all stated they are supervised by direct care staff and could not recall a time they were not supervised by direct care staff at the facility indicating they had been left alone prior to the 06/10/2021 incident. None of the residents could recall any details of the 06/10/2021 incident due to all being asleep.

On 06/21/2021, I interviewed former direct care staff, Naya Reynolds, via telephone. She confirmed the allegations. She stated due to not having a vehicle and getting picked up she was unable to stay at the facility after her shift ended at 11 pm. She stated she informed the on-call supervisor, Mr. Aninure, she was unable to stay. Ms. Reynolds stated she left sometime between 11:20 pm and 11:25 pm. She stated prior to being terminated, she worked 2nd shift five days a week. She stated all the residents go to sleep around 9 pm and were asleep when she left. She stated they typically stay asleep throughout the night, as well. She said none of the residents had recent histories of seizures or had any recent medical or behavior issues in the night. She also stated the residents are "pretty independent."

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based on my investigation, there was evidence indicating direct care staff, Naya Reynolds, left the residents of the facility with insufficient staff on 06/10/2021 when she left work at 11:22 pm before 3rd shift staff, Ben Mukundi, relieved her of her duties. Mr. Mukundi did not come into work until 11:41 pm, therefore, the facility was insufficiently staffed, with no direct care staff members present, for approximately 20 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/21/2021, I conducted my exit conference with licensee designee/administrator, Lori Anderson, via telephone. She stated in addition to the staff being terminated, all staff were reminded on 06/11/2021 about not leaving the facility so residents are unsupervised. She stated the licensee is also in the process of hiring a driver to assist with staff who do not have vehicles.

IV. RECOMMENDATION

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

06/21/2021

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Cathy Cushman Date
Licensing Consultant

Approved By:

06/28/2021

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Dawn N. Timm Date
Area Manager