GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 25, 2021

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

RE: License #: AS390396025
Investigation #: 2021A0578035
Bronson Circle

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) 284-9727.

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 #:	AS390396025
Investigation #:	2021A0578035
Complaint Receipt Date:	05/04/2021
Investigation Initiation Date:	05/04/2021
Report Due Date:	07/03/2021
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Lorinda Anderson
Licensee Designee:	Lorinda Anderson
Name of Facility:	Bronson Circle
Facility Address:	1206 Bronson Circle Kalamazoo, MI 49008
Facility Telephone #:	(269) 343-6355
Original Issuance Date:	01/14/2019
License Status:	REGULAR
Effective Date:	07/14/2019
Expiration Date:	07/13/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
This facility is transporting Resident A downtown in the mornings and telling Resident A to meet them in the evening but Resident A does not return. Resident A is then reported missing by the facility. This intentional lack of supervision for Resident A has led to concern for Resident A's safety.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/04/2021	Special Investigation Intake 2021A0578035
05/04/2021	Special Investigation Initiated – Telephone -Interview with staff member Felicia Evans.
05/04/2021	Contact – Telephone -Records Request, Kalamazoo Department of Public Safety.
05/05/2021	Contact – Telephone -Interview with InterAct case manager Jeff Holtman.
05/05/2021	Contact – Document Reviewed. - *Special Investigation Report* #2021A0578025, dated 04/26/2021, *Assessment Plan for AFC Residents* for Resident A dated 01/05/2020, *InterAct of Michigan, Inc. Assessment* for Resident A, dated 07/21/2020.
05/06/2021	Contact – Document Reviewed. *-AFC Licensing Division Incident/Accident Report* dated 04/24/2021 and *AFC Licensing Division Incident/Accident Report* dated 05/04/2021, submitted by staff member Felicia Evans.
05/06/2021	Contact – Document Reviewed. -KDPS *Incident/Investigation Reports Case Number* 2021-00003379 dated 03/11/2021, *Case Number* 2021-00003704, dated 03/17/2021, *Case Number* 2021-005003870, dated 03/20/2021, *Case Number* 2021-00005561, dated 04/09/2021, *Case Number* 2021-00005700, dated 04/11/2021, *Case Number* 2021-00005968, dated 04/17/2021, *Case Number* 2021-00006391, dated 04/24/2021, *Case Number* 2021-00006768,

	dated 05/01/2021, *Case Number* 2021-00006969, dated 05/04/2021.
05/07/2021	Contact – Telephone -Case conference with AFC licensing consultant Cathy Cushman.
05/07/2021	Contact – Telephone -Case conference with AFC licensing consultant Ondrea Johnson.
06/03/2021	Special Investigation Completed On-site -Interview with Resident A.
06/03/2021	Contact – Document Reviewed -*Activity Tracking Form* for Resident A.
06/24/2021	Exit Conference with Ms. Lorinda Anderson.
06/24/2021	APS Referral Completed.

ALLEGATION:

This facility is transporting Resident A downtown in the mornings and telling Resident A to meet them in the evening but Resident A does not return. Resident A is then reported missing by the facility. This intentional lack of supervision for Resident A has led to concern for Resident A's safety.

INVESTIGATION:

On 05/04/2021, I received this complaint through the BCHS on-line complaint system. Complainant alleged the facility is dropping off Resident A in the downtown area in the mornings and telling Resident A to meet them in the evening but Resident A does not return. Complainant alleged facility direct care staff members then reports Resident A as missing. Complainant alleged this has led to concerns for Resident A's safety.

On 05/04/2021, I requested records from Kalamazoo Department of Public Safety (KDPS) regarding the allegations. KDPS Executive lieutenant Mike Treu reported that in addition to leaving the facility and not returning, Resident A is being transported by direct care staff to where she wants to go, including the liquor store. Lt. Treu acknowledged that finding new placement for Resident A was in process by the facility but expressed concern over avoiding potential tragedy.

On 05/05/2021, I interviewed InterAct, Inc. case manager Jeff Holtman regarding the allegations. Mr. Holtman acknowledged being the case manager for Resident A and

acknowledged receiving a 30-day discharge notice from this facility. Mr. Holtman reported that Resident A was referred to another facility and was awaiting admission pending approval of a court order restricting Resident A's movement. Mr. Holtman reported the organization accepting Resident A was not willing to do so without a court order.

Mr. Holtman acknowledged Resident A continues to elope from the facility and believed Resident A had been reported as missing from this facility on at least 21 different occasion since January 2021. Mr. Holtman further stated he was informed by a detective for KDPS that Resident A was transported by staff to a local liquor store so he was not clear if this was considered eloping since transportation by direct care staff members was provided. Mr. Holtman clarified that Resident A only requires transportation to medication reviews and injections. Mr. Holtman reported Resident A has a known history of alcohol abuse. Mr. Holtman stated he was not aware of how often direct care staff were transporting Resident A to the liquor store.

On 05/04/2021, I interviewed staff member Felicia Evans regarding the allegations by telephone. Ms. Evans acknowledged that Resident A continues to exercise her community access without returning by her established curfew and is then reported as missing or eloped from the facility. Ms. Evans reported the facility had identified an alternate placement for Resident A, but this placement could not occur until Resident A was under court order as Resident A does not have a guardian. Ms. Evans reported the licensee does not operate its own secured facility.

Ms. Evans acknowledged that staff at this facility provides Resident A with transportation during her community access but reported this had happened very few times. Ms. Evans also stated direct care staff provide Resident A with reminders that she can be picked up and returned to the facility whenever necessary.

On 05/06/2021, staff member Felicia Evans provided *AFC Licensing Division Incident/Accident Reports* involving Resident A and completed after 03/04/2021. Ms. Evans provided an *AFC Licensing Division Incident/Accident Report* dated 04/24/2021 and completed by staff member Yvonne Nunes. The *AFC Licensing Division Incident/Accident Report* documented that Resident A did not return to the facility by curfew and had missed her nightly medications. Ms. Nunes documented that KDPS was notified as well as the supervisor for the facility. Ms. Evans provided an *AFC Licensing Division Incident/Accident Report* dated 05/04/2021 and completed by staff member Yvonne Nunes. The *AFC Licensing Division Incident/Accident Report* documented that Resident A did not return to the facility by curfew and had missed her nightly medications. Ms. Nunes documented that KDPS was notified as well as the supervisor for the facility.

On 05/07/2021, I requested documentation of *AFC Licensing Division Incident/Accident Reports* involving Resident A and submitted to previously assigned AFC licensing consultant Cathy Cushman after 03/20/2021. Ms. Cushman provided an *AFC Licensing Division Incident/Accident Report* dated 03/20/2021 and

completed by staff member Lazaria Landen. This *AFC Licensing Division Incident/Accident Report* documented that Resident A left the facility at 9PM and refused medications and did not return to the facility for the remainder of the overnight shift. Ms. Landen documented notifying law enforcement at 2AM.

On 05/07/2021, I requested documentation of *AFC Licensing Division Incident/Accident Reports* involving Resident A and submitted to assigned AFC licensing consultant Ondrea Johnson after 03/20/2021. Ms. Johnson confirmed only receiving the *AFC Licensing Division Incident/Accident Report* dated 05/04/2021.

On 05/06/2021, KDPS provided the following *Incident/Investigation Reports*:

- 03/11/2021 - *Case Number* 2021-00003379, Staff members of this facility reported [Resident A] was last seen at 3PM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

- 03/17/2021 - *Case Number* 2021-00003704, Staff members of this facility reported [Resident A] was last seen at 3PM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

- 03/20/2021 - *Case Number* 2021-005003870, Staff members of this facility reported [Resident A] was last seen at 3PM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

- 04/09/2021 - *Case Number* 2021-00005561, Staff members of this facility reported [Resident A] was last seen at 10:30AM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

- 04/11/2021 - *Case Number* 2021-00005700, Staff members of this facility reported [Resident A] was last seen at 3PM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

- 04/17/2021 - *Case Number* 2021-00005968, Staff members of this facility reported [Resident A] was last seen at 3PM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

- 04/24/2021 - *Case Number* 2021-00006391, Staff members of this facility reported [Resident A] was last seen at 3PM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

• 05/01/2021 - *Case Number* 2021-00006768, Staff members of this facility reported [Resident A] was last seen at 3PM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

• 05/04/2021 - *Case Number* 2021-00006969, Staff members of this facility reported [Resident A] was last seen at 3PM and had not returned by her curfew time. KDPS documented that [Resident A] was entered into LEIN as a missing/endangered person.

On 06/03/2021, I completed an unannounced investigation on-site at this facility and interviewed Resident A regarding the allegations. Resident A acknowledged having independent community access between the hours of 8AM and 11PM. Resident A acknowledged receiving transportation by direct care staff to her community access and reported this occurs at least every other day. Resident A reported she is typically transported by staff to the Howard St. Party Store. Resident A reported that she requests transportation to the Howard St. Party Store to purchase cigarettes and "stuff." Resident A denied having any current injuries and reported feeling safe at this facility and denied having any additional concerns.

While at the facility, I reviewed the *Activity Tracking Form* for Resident A, which included the following descriptions by staff:

04/02/2021 – Went to Family Centre.
04/03/2021 – Howard Party Store.
04/05/2021 – Howard Party Store.
04/06/2021 – Watched TV.
04/07/2021 – Meijer.
04/07/2021 – Howard Market.
04/08/2021 – Went Downtown.
04/10/2021 – Watched Television.
04/11/2021 – Watched Television.
04/12/2021 – Pizza Hut.
04/13/2021 – Pizza Hut.
04/13/2021 – Howard Party Store.
04/16/2021 – Howard Party Store.
04/20/2021 – Watched TV.
04/21/2021 – Deacon's Conference.
04/22/2021 – Went out for breakfast.
04/23/2021 – Speedway/Library.
04/24/2021 – Howard Market.
04/27/2021 – Slept.
04/28/2021 – Howard Party Store.
04/29/2021 – Howard Party Store.
05/03/2021 – Tobacco Shop.

05/03/2021 – Party Store.
05/08/2021 – Walked to Howard Market Store.
05/10/2021 – Went to Howard Market.
05/11/2021 – Van ride, went for a walk.
05/13/2021 – Watched TV.
05/15/2021 – Howard Market.
05/16/2021 – Howard Market.
05/22/2021 – Sunny Mart.
05/23/2021 – Party Store.
05/26/2021 – Howard Party Store.
05/27/2021 – InterAct.
05/28/2021 – Went to Court.
05/29/2021 – Dropped off at Liquor store.

On 05/05/2021, I reviewed *Special Investigation Report* #2021A0578025, dated 04/26/2021. The allegations of *Special Investigation Report* #2021A0578025 included that law enforcement had been called to the facility on over ten occasion in the past few months regarding Resident A not returning by her curfew of 2AM. I reviewed the *Assessment Plan for AFC Residents* for Resident A dated 01/05/2020 and obtained during Special Investigation Report #2021A0578025. The *Assessment Plan For AFC Residents* for Resident A documented that Resident A moved independently in the community with no other identified supervision requirements. The *Assessment Plan For AFC Residents* for Resident A documented that during periods of elopement, Resident A had been observed intoxicated and had taken medications not prescribed to her.

On 05/05/2021, I reviewed the *InterAct of Michigan, Inc. Assessment* for Resident A, dated 07/21/2020 and obtained during Special Investigation Report #2021A0578025. The *InterAct of Michigan, Inc. Assessment* for Resident A identified Resident A is diagnosed with Schizophrenia, Alcohol Use Disorder (Moderate), Cannabis Use Disorder (Mild), and Cocaine Use Disorder (Severe).

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.

ANALYSIS:	During this investigation, I reviewed the *Assessment Plan for AFC Residents* for Resident A dated 01/05/2020 which documented that during periods of elopement, Resident A had been observed intoxicated and had taken medications not prescribed to her. The *InterAct of Michigan, Inc. Assessment* for Resident A, dated 07/21/2020 identified Resident A is diagnosed with Schizophrenia, Alcohol Use Disorder (Moderate), Cannabis Use Disorder (Mild), and Cocaine Use Disorder (Severe). In an interview, Resident A acknowledged having independent community access and disclosed that direct care staff have provided her with transportation to a local party store. During an unannounced investigation on-site, I reviewed the *Activity Tracking Form* for Resident A, which included several documented activities identified as "party store" and an activity on 05/29/2021 described as "dropped off at liquor store." As such, the care and service of providing Resident A, who has an established history of substance and alcohol abuse, with transportation to local party stores is not designed to improve or maintain Resident A's physical and intellectual functioning and independence.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 05/06/2021, staff member Felicia Evans submitted *AFC Licensing Division Incident/Accident Report* dated 04/24/2021 and *AFC Licensing Division Incident/Accident Report* dated 05/04/2021 as the only documentation of Resident A not returning to the facility by her nightly curfew after 03/20/2021, the date of the last documented *AFC Licensing Division Incident/Accident Report* obtained during Special Investigation #2021A0578025.

On 05/07/2021, I requested documentation of *AFC Licensing Division Incident/Accident Reports* involving Resident A and submitted to previously assigned AFC licensing consultant Cathy Cushman and currently assigned AFC licensing consultant Ondrea Johnson. Ms. Cushman provided an *AFC Licensing Division Incident/Accident Report* dated 03/20/2021. Ms. Johnson confirmed receiving *AFC Licensing Division Incident/Accident Report* dated 05/04/2021.

On 05/06/2021, KDPS provided *Incident/Investigation Report Case Number* 2021-00005561, dated 04/09/2021, *Incident/Investigation Report Case Number* 2021-00005700, dated 04/11/2021, *Incident/Investigation Report Case Number* 2021-00005968, dated 04/17/2021, *Incident/Investigation Report Case Number* 2021-00006391, dated 04/24/2021, and *Incident/Investigation Report Case Number* 2021-00006768, dated 05/01/2021 related to the allegations. *Incident/Investigation Report Case Number* 2021-00005561, *Incident/Investigation Report Case Number* 2021-

00005700, *Incident/Investigation Report Case Number* 2021-00005968, *Incident/Investigation Report Case Number* 2021-00006391, and *Incident/Investigation Report Case Number* 2021-00006768 documented KDPS responding to the facility based on staff reports that Resident A had not returned to the facility by her established curfew. *Incident/Investigation Report Case Number* 2021-00005561, *Incident/Investigation Report Case Number* 2021-00005700, *Incident/Investigation Report Case Number* 2021-00005968, *Incident/Investigation Report Case Number* 2021-00006391, and *Incident/Investigation Report Case Number* 2021-00006768 had no associated *AFC Licensing Division Incident Accident Report* submitted to the department by the facility.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
ANALYSIS:	During this investigation, I reviewed *Incident/Investigation Report Case Number* 2021-00005561, *Incident/Investigation Report Case Number* 2021-00005700, *Incident/Investigation Report Case Number* 2021-00005968, *Incident/Investigation Report Case Number* 2021-00006391, and *Incident/Investigation Report Case Number* 2021-00006768 provided by the Kalamazoo Department of Public Safety and documenting the Kalamazoo Department of Public Safety responding to the facility based on staff reports that Resident A had not returned to the facility by her established curfew. There are no associated *AFC Licensing Division Incident/Accident Reports* that correspond to with these *Incident/Investigation Reports* provided by KDPS that have been submitted to the department.
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.

06/24/2021

Eli DeLeon Date
Licensing Consultant

Approved By:

06/25/2021

Dawn N. Timm Date
Area Manager