GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2022

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

RE: License #: AS390250889
Investigation #: 2022A1024023
Transitions of Kalamazoo

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 49001

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

I. IDENTIFYING INFORMATION

License #:	AS390250889
Investigation #:	2022A1024023
Complaint Receipt Date:	02/22/2022
Investigation Initiation Date:	02/22/2022
Report Due Date:	04/23/2022
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:	Transitions of Kalamazoo
Facility Address:	1353 Oakland Drive Kalamazoo, MI 49008
Facility Telephone #:	(269) 743-2248
Original Issuance Date:	10/23/2002
License Status:	REGULAR
Effective Date:	08/22/2020
Expiration Date:	08/21/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was found in the basement of the facility next to bleach and an opened bottle of Tylenol.	Yes

III. METHODOLOGY

02/22/2022	Special Investigation Intake 2022A1024023
02/22/2022	Special Investigation Initiated – Telephone with administrator Tim Vandyke, home manager Codie Zamora, and direct care staff member Katie Zehner.
02/22/2022	Contact - Document Received-*Patient Sum*mary and *AFC Licensing Division-Incident/Accident Report*.
03/24/2022	Inspection Completed On-site with direct care staff member Tracey Harris and Resident A
03/31/2022	Contact - Telephone call made with direct care staff member Renee Lyndsay
03/31/2022	Contact - Telephone call made with direct care staff member Diallo Mohamadou
03/31/2022	Contact - Telephone call made with administrator Tim Vandyke
04/01/2022	Exit Conference with licensee designee Lori Anderson
04/01/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was found in the basement of the facility next to bleach and an opened bottle of Tylenol.

INVESTIGATION:

On 2/22//2022, I received this complaint through the Bureau of Community and Health Systems online complaint system. This complaint alleged Resident A was found in the basement of the facility next to bleach and an opened bottle of Tylenol on 02/20/2022.

On 2/22/2022, I conducted an interview with administrator Tim VanDyke, home manager Codie Zamora, and direct care staff member Katie Zehner. Mr. VanDyke stated Resident A had been exhibiting aggressive behaviors and was taken to the hospital for evaluation on 02/20/2022. Ms. VanDyke stated while at the hospital Resident A was diagnosed with having COVID-19 and was discharged back to the home around 1am on 02/20/2022. Mr. VanDyke stated later in the morning on 02/20/2022 direct care staff members were not able to locate Resident A in his bedroom during the morning routine checks of the residents conducted by staff members who worked first shift. Ms. VanDyke stated after searching the home, a staff member was eventually able to locate Resident A in the basement of the facility which is an unauthorized area for the residents. Mr. VanDyke stated Resident A was found sitting in a puddle of bleach next to an opened bottle of Tylenol. Mr. VanDyke stated direct care staff members were not able to determine if Resident A digested the bleach or pills therefore Resident A was taken to the emergency room for further examination. Mr. VanDyke stated while at the hospital it was determined that no signs of bleach or Tylenol were found in Resident A's system. Mr. VanDyke stated direct care staff member Renee Lyndsay, who worked the overnight shift, was responsible for ensuring Resident A did not gain access to the basement of the facility by ensuring the basement door was locked and secured.

Ms. Zamora stated she received a telephone call around 7am from direct care staff members stating that they were not able to locate Resident A in the home. Ms. Zamora stated about 3 minutes later she received a call back from direct care staff members stating Resident A was found in the basement of the home sitting in a puddle of bleach near an opened bottle of Tylenol. Ms. Zamora stated she instructed direct care staff members to send Resident A to the hospital to ensure he did not digest any poisonous materials. Ms. Zamora stated the basement door is required to be locked at all times so she was unsure how Resident A would have gotten downstairs with the door being locked. Ms. Zamora stated there have been times she has had to double check the basement door lock to ensure it was locked properly because the double lock on the door malfunctions at times. Ms. Zamora stated she believes the door was accidentally left unlocked by one of the direct care staff members who worked on the overnight shift which allowed Resident A to sneak in the basement of the facility.

Ms. Zehner stated she was made aware that Resident A accessed the office space located in the basement of the home which is where cleaning supplies, facility files, and staff's belongings are stored. Ms. Zehner stated the basement door is required to be locked at all times to prevent residents from gaining access to that area of the home.

On 2/22/2022, I reviewed Resident A's *Patient Summary* dated 2/20/2022. According to this summary Resident A was seen at Ascension Borgess Medical Center Emergency and Trauma Center for accidental ingestion of substance. There

is no mention that there were signs of possible ingestion of any poisons or medications on this report.

I also reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 2/20/2022 written by Diallo Mohamadou. This report stated the overnight direct care staff Renee Lindsay discovered Resident A to be missing from his bedroom and minutes later one of the morning direct care staff members found Resident A in the basement destroying all that he could. Resident A was found in bleach and there was an open bottle of Tylenol on the ground near Resident A. This report stated Resident A was taken to Borgess Medical Center for possible ingestion of substances. The report further stated Resident A was cleared and released from Borgess Medical Center and responsible direct care staff member Renee Lindsay was suspended pending investigation.

On 3/24/2022, I conducted an onsite investigation at the facility and interviewed direct care staff Tracy Harris. Ms. Harris stated when she arrived to work her morning shift at 6am the staff member from the overnight shift stated to her that Resident A was having a hard time sleeping during the night however had not heard him in his room therefore wanted someone to check on him. Ms. Harris stated when she went to Resident A's bedroom, she did not see him. Ms. Harris stated she and Ms. Lyndsay searched the home and while downstairs getting food items from the basement refrigerator, Ms. Harris noticed the basement to be in disarray. Ms. Harris stated she found Resident A on the ground rolling in wrapping paper, drenched with bleach all over him with a bottle of Tylenol pills spilled out next to him. Ms. Harris stated there is a staff office in the basement and the facility's laundry room is in the basement.

I observed Resident A in the home to be clean with no concerns.

On 3/31/2022, I conducted an interview with direct care staff member Renee Lyndsay. Ms. Lindsay stated she believed she checked on Resident A to ensure he was in his bedroom during her overnight shift on 2/20/2022 however she did not recall the number of times she checked on him. Ms. Lindsay stated during her overnight shift Resident A was able to enter into the basement where the staff office is located. Ms. Lindsay stated she never went downstairs for anything while working therefore she did not believe she left the basement door unlocked. Ms. Lindsay stated she believes the home manager Ms. Zamora left the basement door unlocked as Ms. Lindsay observed Ms. Zamora enter and exit the basement while she was working on the evening of 2/19/2022. Ms. Lindsay stated Resident A was found in the basement with debris everywhere in the basement however Ms. Lindsay stated she never heard or had any reason to believe that Resident A was in the basement of the home.

On 3/31/2022, I conducted an interview with direct care staff member Diallo Mohamadou regarding this allegation. Mr. Mohamadou stated when he arrived to work on 2/20/2022 at 7:05am he discovered that Resident A was not in his bedroom.

Mr. Mohamadou stated he and other direct care staff members searched inside and outside of the home and was able to locate him. Mr. Mohamadou stated his coworker was eventually able to locate Resident A in the basement of the home where he was found covered with bleach. Mr. Mohamadou stated Resident A had "destroyed" the basement area as evidenced by facility paperwork and direct care staff personal belongings observed scattered throughout the room. Mr. Mohamadou stated there was a bottle of Tylenol that belonged to a staff member opened nearby Resident A along with bleach spilled all over Resident A therefore Resident A was immediately transported to the hospital to ensure neither the Tylenol nor bleach substances were ingested. Mr. Mohamadou stated when Resident A was found in the basement, he was observed to be calm and playing with paper. Mr. Mohamadou stated he believed the basement door was not locked properly after a direct care staff closed the door. Mr. Mohamadou stated since this incident, the basement door locks have been fixed and there have not been any issues.

On 3/31/2022, I conducted an interview with administrator Tim VanDyke. Mr. VanDyke stated the basement door of the home should have been closed and locked properly to prevent any residents from entering the basement area. Mr. VanDyke stated the lock to the basement door has been repaired and now locks properly.

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 administrator Tim VanDyke, home manager Codi Zamora, direct care staff members Katie Zehner, Diallo Mohamadou, Renee Lyndsay, Resident A was found in the basement of the facility next to bleach and an opened bottle of Tylenol after having access to a non-resident area of the facility. Mr. VanDyke, Ms. Zamora, Ms. Zehner, Mr. Mohamadou, and Ms. Lindsay all stated that the door to the basement is required to be locked at all times to prevent residents gaining access to this area and was not locked properly by a staff member which allowed Resident A to enter in the basement where he was found covered with bleach next to an opened bottle of Tylenol. The basement area of the home includes staff's office where additional cleaning supplies are stored along with facility records and staff's belongings. Mr. VanDyke stated the lock to the basement door has since been repaired and there have not been any additional issues with shutting and locking the basement door. Consequently, Resident A's protection and safety needs were not attended to at all times after the basement door locking mechanism failed allowing Resident A to access caustic chemicals and medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/01/2022, I conducted an exit conference with licensee designee Lori Anderson. I informed Ms. Anderson of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

Upon an acceptable corrective active plan, I recommend the current license status remain unchanged.

4/15/2022

Ondrea Johnson
Licensing Consultant

Date

Approved By:

04/19/2022

Dawn N. Timm
Area Manager

Date