GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 1, 2022

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

RE: License #: AS390250889
Investigation #: 2022A1024038
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, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390250889
Investigation #:	2022A1024038
Complaint Receipt Date:	06/09/2022
Investigation Initiation Date:	06/09/2022
Report Due Date:	08/08/2022
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:	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?
Clinical staff member Tim Henson witnessed direct care staff member Michael Dwyer throw Resident A to the ground.	Yes

III. METHODOLOGY

06/09/2022	Special Investigation Intake 2022A1024038
06/09/2022	Special Investigation Initiated – Telephone with Recipient Rights Officer Michele Schiebel
06/22/2022	Contact - Telephone call made with clinical worker Tim Hensen
06/22/2022	Contact - Telephone call made with program manager Tim VanDyke
06/22/2022	Contact - Document Received-Resident A's *Assessment Plan for AFC Residents* and *Behavior Treatment Plan*
06/22/2022	Contact - Telephone call made with direct care staff member Michael Dwyer
07/19/2022	Inspection Completed On-site with home manager Codi Zamora, direct care staff member Shantanique Harden and Resident A
07/25/2022	Contact - Telephone call made with Recipient Rights Officer Michele Schiebel
07/26/2022	Exit Conference with licensee designee Lori Anderson
07/26/2022	Inspection Completed-BCAL Sub. Compliance
08/01/2022	Contact - Document Received- *AFC Licensing Division-Incident/Accident Report*
08/01/2022	APS Referral

ALLEGATION:

Clinical staff member Tim Hensen witnessed direct care staff member Michael Dwyer throw Resident A to the ground.

INVESTIGATION:

On 6/9/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged staff member witnessed staff member throw Resident A to the ground.

On 6/9/2022 and 7/25/2022, I conducted an interview with Recipient Rights Officer Michele Schiebel who stated that she is also investigating this allegation and found substantial evidence to support the allegation.

On 6/22/2022, I conducted an interview with clinical worker Tim Hensen regarding this allegation. Mr. Hensen stated on 6/8/2022 Resident A began to have an emotional crisis in the living room area as evidence by her throwing her shoes at staff, pushing chairs around and hitting her head on the wall. Mr. Hensen stated staff member Michael Dwyer then put his hands on Resident A's shoulders and pushed her to sit on the floor. Mr. Hensen stated Mr. Dwyer then threw Resident A's shoes over the counter in the kitchen and poured a cup of juice out that Resident A was drinking and placed on the table. Mr. Hensen stated as Mr. Dwyer walked by Resident A, while she was sitting calming on the floor, Mr. Dwyer shoved her by her shoulders. Mr. Hensen stated Resident A then got up and began to hit and kick the basement door. Mr. Hensen stated he then went upstairs and tended to the other residents to make sure they were safe who were in a separate room. Mr. Henson also stated he noticed Resident A leg was bleeding and informed Mr. Dwyer of this before tending to the residents. Mr. Hensen stated he works downstairs in the basement of the facility and observed this incident on the facility's camera in his office. Mr. Hensen further stated he was prompted to look at the camera because he continued to hear loud noises as if furniture was being moved around. Mr. Hensen stated he became immediately alarmed because Mr. Dwyer is trained in a behavior management technique called MANDT and according to this training Mr. Dwyer was supposed to put his hand or pillow between the wall and Resident A's head to prevent her from banging her head on the wall instead of pushing her to the floor. Mr. Dwyer stated he does not believe Mr. Dwyer properly intervened to de-escalate the situation and intentionally mistreated Resident A by pushing her to the ground and shoving her while she was sitting on the floor.

I also conducted an interview with program manager Tim VanDyke. Mr. VanDyke stated he was made aware by Mr. Hensen that Mr. Dwyer did not use proper physical interventionist techniques and pushed Resident A while she was experiencing an emotional crisis. Mr. VanDyke stated direct care staff members are trained to "back off' and allow the resident to de-escalate on their own with time and space. Mr. VanDyke stated he has talked with both Mr. Hensen and Mr. Dwyer

regarding this incident and believe Mr. Hensen should have assisted Mr. Dwyer by going upstairs sooner. Mr. VanDyke also stated he is arranging for Mr. Dwyer to be retrained and have a 1:1 in-service training in behavior management as Mr. Dwyer did not intervene appropriately.

On 6/22/2022, I reviewed Resident A's *Assessment Plan for AFC Residents* dated 2/18/2022 and *Behavior Treatment Plan* dated 7/28/2021. According to Resident A's treatment plan Resident A has a history of physical aggression and self-injurious behaviors. The plan stated it is important "direct care staff members remain calm and patient when [Resident A] negatively reacts to certain situations. Staff should allow space when [Resident A] is upset by distancing yourself from her while unobtrusively monitoring her."

On 6/22/2022, I conducted an interview with direct care staff member Michael Dwyer regarding this allegation. Mr. Dwyer stated on 6/8/2022 Resident A was behaving violently by screaming, kicking, and banging her head against the wall. Mr. Dwyer stated he responded by attempting to physically intervene by putting his arms around her shoulder at which time Resident A dropped to the floor. Mr. Dwyer stated while Resident A was sitting calmly on the floor, he walked past her, and he put his hands up to try to block any attempted hits from Resident A as in the past Resident A has been aggressive towards others. Mr. Dwyer stated when he put his hand up, he made contact with Resident A's shoulder and hit her. Mr. Dwyer stated he did not intentionally try to push Resident A. Mr. Dwyer stated afterwards, Mr. Hensen came up and informed him he intervened inappropriately, and that Resident A had blood on her leg. Mr. Dwyer stated Resident A was bleeding because she was picking sores on her legs and the blood was not result of an injury caused by him.

On 7/19/2022, I conducted an onsite investigation at the facility with home manger Codi Zamora, direct care staff member Shantanique Harden and Resident A. Ms. Zamora stated while she was out of the home picking up groceries, she was notified Mr. Dwyer was not using MANDT approved behavior management techniques. Ms. Zamora stated Mr. Hensen informed her he observed Mr. Dwyer push Resident A to the floor and while she was on the floor, Mr. Dwyer pushed Resident A again. Ms. Zamora stated although Resident A has history of physical aggression it is very rare direct care staff members need use physical management techniques with Resident A in order for her to de-escalate. Ms. Zamora stated she believes Mr. Dwyer is a good staff however became frustrated with Resident A and mishandled the situation.

Ms. Harden stated she has worked with Resident A and has seen her have some challenging behaviors. Ms. Harden stated she has not witnessed Resident A become aggressive and believe Resident A is "easy to work with."

I attempted to interview Resident A who became very anxious and started jumping around therefore I was unable to conduct an interview.

On 8/1/2022, I reviewed the facility's *AFC Licensing Division-Accident/Incident Report* dated 6/8/2022 written by Tim Hensen. According to this report, while in the basement Mr. Hensen heard a loud noise and observed, via a video camera, Resident A push chairs and throw her shoe at Mr. Dwyer. The report stated Resident then hit her head against the wall and Mr. Dwyer then pushed Resident A by her shoulders down to the floor in a forceful way. While Resident A was on the floor, Mr. Dwyer pushed her with his hands in a forceful shove as he walked by her. The report stated Resident A then continued to shove furniture around at which time Mr. Dwyer attempted to physically intervene again twice by grabbing her from behind "like a bear hug." Resident A then got away from his grip and pushed a chair over. The report stated Mr. Hensen then came upstairs and saw that Resident A's leg was bleeding therefore went to the med room and informed Mr. Dwyer Resident A's leg was bleeding at which time Mr. Dwyer seemed shock to see him there. The report stated Mr. Hensen then went to be with the other residents in another location of the home.

On 8/1/2022, I made an APS referral.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based on my investigation which included interviews with clinical worker Tim Hensen, program manager Tim VanDyke, home manager Codi Zamora, direct care staff members Michael Dwyer, Shantanique Harden, Recipient Rights Officer Michele Sheibel, review of Resident A's assessment plan, behavioral treatment plan and facility's incident report there is enough evidence to support direct care staff member Michael Dwyer used an inappropriate physical intervention technique with Resident A while she was exhibiting a behavior. While watching the facility camera, clinical staff member Mr. Henson observed Mr. Dwyer push Resident A twice and then attempt to manage her behavior using a bear hug like technique. Mr. Dwyer denied intentionally mistreating Resident A in any way but stated he had grabbed her shoulders, hit her shoulder accidentally while passing by and interacted with Resident A while she was calmly on the floor. These responses are not in-line with Resident A's *Behavior Treatment Plan.* Consequently, Resident A was mistreated by staff member Mr. Dwyer in this situation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/26/2022, 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 action plan, I recommend the current license status remained unchanged.

Ondrea Johnson 8/1/2022

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 08/01/2022

Dawn N. Timm Date
Area Manager