GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2022

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

RE: License #: AS390250889
Investigation #: 2023A1024003
Transitions of Kalamazoo

Dear Ms. Anderson:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	2023A1024003
Complaint Receipt Date:	10/20/2022
Investigation Initiation Date:	10/21/2022
Report Due Date:	12/19/2022
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?
Direct care staff members were not able to provide protection and safety to Resident B at all times resulting in multiple elopements from the home.	Yes

III. METHODOLOGY

10/20/2022	Special Investigation Intake 2023A1024003
10/21/2022	Special Investigation Initiated – Telephone with APS Amber Johnson
10/21/2022	Contact - Document Received-Resident B's *Assessment Plan for AFC Residents* and *Behavior Support Plan*
11/07/2022	Inspection Completed On-site with direct care staff member Abubakar Mustafa, home manager Eadoin Grim, and program director Tim VanDyke
11/10/2022	Contact - Document Received-email correspondence with Lori Anderson and Tim VanDyke
11/11/2022	Contact - Document Received with Lori Anderson and Tim VanDyke
11/11/2022	Contact - Document Received-*AFC Licensing Division-Incident/Accident Reports*
11/11/2022	Contact - Document Received-review of SIR #2022A1024052 and CAP received on 10/24/2022
11/22/2022	Contact-Face-to-Face-with Lorinda Anderson and Tim VanDyke
11/22/2022	Exit Conference with licensee designee Lorinda Anderson and Tim VanDyke
11/22/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Direct care staff member were not able to provide protection and safety to Resident B at all times resulting in multiple elopements from the home.

INVESTIGATION:

**To maintain consistency with coding residents across special investigation reports, please note this resident will be coded as Resident B throughout this report.*

On 10/20/2022, I received this complaint through the Bureau of Community and Health Systems' (BCHS) online complaint system. This complaint alleged direct care staff members were not able to provide protection and safety to Resident B resulting in Resident B eloping from the facility on multiple occasions. This complaint further alleged that Resident B eloped from the facility two nights in a row and was eventually arrested by law enforcement for shoplifting while at the grocery store.

On 10/21/2022, I conducted an interview with Adult Protective Services (APS) Specialist Amber Price-Johnson who stated she is also conducting an investigation regarding this allegation. Ms. Johnson stated based on her investigation, Resident B does not listen to direct care staff members when they make attempts to stop Resident B from eloping from the home. Ms. Johnson further stated Resident B regularly elopes from the home.

On 10/21/2022, I reviewed Resident B's *Assessment Plan for AFC Residents* (assessment) dated 1/4/2022. According to this assessment, Resident B is assigned 1:1 staffing who will be close by and available as defined as "close enough to provide immediate assistance if required." This assessment also stated Resident B requires 15-minute interval visual checks while in his room. This assessment also stated Resident B is diagnosed with Prader-Willi Syndrome and would be able to eat himself to death and has encountered dangerous situations when he elopes.

I also reviewed Resident B's *Behavior Support Plan (plan)* dated 7/28/2021. According to this plan, Resident B was admitted to Transitions of Kalamazoo directly from jail on 9/8/2020. This plan stated since moving into Transitions of Kalamazoo, Resident B has demonstrated challenging behaviors such as attempting to elope, biting and striking staff members. This plan stated, Resident B has target behaviors of non-compliance, self-injurious behaviors, food seeking, physical/verbal aggression, property destruction and elopement. This plan also stated due to Resident B's history of behavior that puts him at imminent risk, Resident B will have "1:1 staff who will remain close and available at all times." The plan further stated since Resident B is diagnosed with Prader-Willi Syndrome, eloping from the home creates an imminent risk of harm or death, and this is one of the reasons elopement is probably the single greatest threat to Resident B's safety and must be treated as an emergency.

On 11/7/2022, I conducted an onsite investigation at the facility with direct care staff

member Abubakar Mustafa, home manager Eadoin Grim, and program director Tim VanDyke. Mr. Mustafa stated Resident B routinely elopes from the home and there is nothing they can do to stop him even though a direct care staff member is assigned to be with Resident B at all times and visual checks for Resident B are required every 15 minutes. Mr. Mustafa stated just recently Resident B eloped from the home two days in a row. Mr. Mustafa stated he went after Resident B however lost sight of him when he went into a wooded area. Mr. Mustafa stated all staff members must immediately call law enforcement when direct care staff are no longer able to lay eyes on Resident B while they are following him. Mr. Mustafa stated direct care staff members are not able to physically intervene to stop Resident B from eloping from the home as Resident B becomes physically aggressive therefore the only management technique staff can use is body positioning and follow Resident B once he leaves the facility. Mr. Mustafa stated direct care staff members are not able to keep Resident B safe in the home.

Ms. Grim stated Resident B recently eloped from the home on two consecutives nights and was arrested on the second night for shoplifting while at Meijer, a local grocery store. Ms. Grim stated direct care staff members are not able to stop Resident B from eloping from the home. Ms. Grim stated when Resident B elopes from the facility direct care staff must follow Resident B and call law enforcement once they lose sight of him. Ms. Grim stated while Resident B is in the home there is 1:1 staffing assigned to Resident B and a staff member must check on Resident B every 15 minutes when he is in his bedroom. Ms. Grim stated Resident B continues to regularly elope from the home despite the 1:1 staff supervision that is in place.

Mr. VanDyke stated Resident B's mental health treatment team has been discussing alternative placement options for Resident B for quite some time as direct care staff members were not able to keep Resident B from eloping from the home. Mr. VanDyke stated direct care staff members can no longer safely use body positioning and standing in front of the door as Resident B becomes violent by kicking and biting at direct care staff members as he elopes from the facility. Mr. VanDyke stated direct care staff members continue to follow Resident B once he leaves but often lose sight of Resident B causing direct care staff to call law enforcement for assistance in locating Resident B.

On 11/10/2022 and 11/11/2022, I received email correspondence from licensee designee/administrator Lori Anderson and program director Tim VanDyke. Ms. Anderson stated Resident B has 1:1 staffing however there continued to be issues with him since admission. Ms. Anderson stated Resident B was a difficult resident to serve however stated she had not provided a discharge notice to Resident B because his mental health provider would have to be in agreement with the discharge. Ms. Anderson stated even if she was to provide a discharge notice to Resident B, Ms. Anderson believed there were no other placement options for Resident B. Ms. Anderson stated direct care staff members supervise, watch, and follow Resident B and use blocking techniques by doors to stop Resident B from exiting when attempts to elope. Ms. Anderson stated no other physical intervention techniques are used due to a direct care staff member once being bitten 11 times by Resident B as the direct care staff member attempted to stop Resident B from exiting a door and eloping. Ms. Anderson

documented in the email that she has had numerous discussions with Resident B's mental health treatment team regarding Resident B's behavior issues and staff behavior management techniques but so far nothing has successfully stopped the elopement behavior.

Mr. VanDyke provided an email sent to Resident B's mental health treatment team dated 6/30/22 informing them Resident B had eloped from the facility and placed in jail due to assaulting an officer. Mr. VanDyke further stated in the email that Resident B had assaulted police officers three other times over summer 2022 and requested Resident B's mental health provider work with the jail liaison and to keep Resident B over the July 4th holiday weekend as Mr. VanDyke anticipated Resident B to have more incidents.

On 11/11/2022, I reviewed 18 *AFC Licensing Division Accident/Incident Reports* dated 5/1/22, 5/9/22, 5/24/22, 5/31/22, 6/5/22, 6/16/22, 6/23/22, 6/26/22, 6/29/22, 7/3/22, 7/8/22, 7/13/22, 8/11/22, 9/22/22, 9/28/22, 10/15/22, 10/16/22 and 10/22/22 which documented incidents of Resident B eloping from the facility. These include incidents where Resident B left the facility, was initially followed by direct care staff members, but then was no longer within view of direct care staff members and law enforcement was called to further assist with locating Resident B. It should be noted Resident B was arrested for biting and assaulting police officers who attempted to intervene on at least two incidents.

On 11/22/2022, I conducted interviews with licensee designee/administrator Ms. Anderson and Mr. VanDyke who both stated the home is not able to protect and keep Resident B safe however as of the date of the interview there were no other placement options for Resident B. Both stated this was the reason Resident B was not given a discharge notice and since there has not been any progress made finding an alternative placement, Resident B's mental health placing agency has not agreed with discharging Resident B from the home. Ms. Anderson and Mr. VanDyke both confirmed Resident B has assaulted law enforcement on multiple occasions since Resident B's admission to the home. These assaults occurred after Resident B eloped from the facility and law enforcement was called to assist with locating Resident B. Ms. Anderson stated Resident B has 1:1 staff supervision and Resident B has assaulted staff on multiple occasions when staff has made attempts to stop Resident B from eloping from the home in the past and there is there is no other behavior management techniques that can be done to keep Resident B from eloping from the home. Ms. Anderson and Mr. VanDyke stated that Resident B was placed in jail due to shoplifting and assaulting an officer during his most recent incident of eloping from the home which is his second time being placed in jail when he has eloped from the facility.

Special Investigation #2022A1024052 date 10/26/2022 cited rule 400.14305 (3) after direct care staff members did not provide a resident with the supervision this resident required resulting in the resident eloping from the facility. The resident involved in this previous report is a different resident. The corrective action plan dated 10/24/2022 stated the facility disciplined the direct care staff member who did not properly supervise the resident and that the facility would continue to work with the mental health authority

to find appropriate placement for the resident. A discharge notice was also given as part of the corrective action plan.

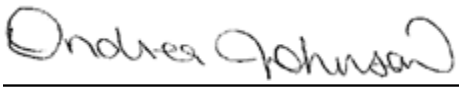
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation which included interviews with direct care staff member Abubakar Mustafa, home manager Eadoin Grim, program director Tim VanDyke, administrator and licensee designee Lorinda Anderson, along with my review of facility incident reports, and Resident B's *Behavior Support Plan* and written assessment plan, direct care staff members did not provide Resident B with protection, safety, and supervision per his Behavior Support Plan and written assessment plan required on at 18 separate occasions. Resident B has eloped 18 times in the last six months from the home despite being on 1:1 supervision along with 15-minute checks when in his bedroom yet there have been no effective measures taken to stop Resident B from eloping from the home. According to Resident B's *Behavior Support Plan* eloping from the home puts Resident B at imminent risk of harm or death due to Resident B's medical diagnosis of Prader-Willi Syndrome. Resident B's written assessment plan also stated due to Resident B's medical diagnosis Resident B would be able to eat himself to death and has encountered dangerous situations like this when he elopes. During the two of the 18 times Resident B has eloped from the home over the last six months, he has assaulted police officers leading to Resident B being arrested and lodged in jail. Licensee designee and administrator Lori Anderson stated facility direct care staff members have not been able to protect and keep Resident B safe despite having 1:1 staff supervision assigned to Resident B, yet no discharge notice has been provided to Resident B or his designated representative. Consequently, Resident B's protection and safety needs are not being attended to at all times by direct care staff members and licensee designee Lori Anderson.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/22/2022, I conducted an exit conference with licensee designee Lori Anderson and program director Tim VanDyke. I informed Ms. Anderson and Mr. VanDyke of my

findings and allowed them an opportunity to ask questions or make comments. Ms. Anderson verbally accepted the provisional recommendation at that time.

IV. RECOMMENDATION

Due to the quality of care violations cited in this report along with repeat violations, a six-month provisional license is recommended.



12/08/2022

Ondrea Johnson
Licensing Consultant

Date

Approved By:

12/15/2022

Dawn N. Timm
Area Manager

Date