GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2023

Karen LaFave
Adult Learning Systems - UP, Inc
Suite-4
228 West Washington
Marquette, MI 49855

RE: License #: AS520299825
Investigation #: 2023A0873010
Life Options

Dear Ms. LaFave:

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) 643-7960.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 250-9318

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS520299825
Investigation #:	2023A0873010
Complaint Receipt Date:	04/20/2023
Investigation Initiation Date:	04/21/2023
Report Due Date:	06/19/2023
Licensee Name:	Adult Learning Systems - UP, Inc
Licensee Address:	Suite-4 228 West Washington Marquette, MI 49855
Licensee Telephone #:	(906) 228-7370
Administrator:	Cole Lindberg
Licensee Designee:	Karen LaFave
Name of Facility:	Life Options
Facility Address:	2632 Moran Marquette, MI 49855
Facility Telephone #:	(906) 273-1414
Original Issuance Date:	03/23/2009
License Status:	REGULAR
Effective Date:	12/05/2021
Expiration Date:	12/04/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Home manager Kyle Darcy was observed being verbally abusive toward Resident A and dragged him across the floor by his wrists and ankles.	No
Additional Findings	Yes

III. METHODOLOGY

04/20/2023	Special Investigation Intake 2023A0873010
04/20/2023	APS Referral Received referral from APS
04/21/2023	Special Investigation Initiated - Face to Face Met at ALS with Kelsey Williams, Casey Oconnor, and Kyle Darcy
04/21/2023	Inspection Completed On-site Interview with Resident A
04/21/2023	Contact - Face to Face Met at Life Options with Karen LaFave, APS/David Livingston, Casey O'Connor, and detective Jason Hart
04/25/2023	Contact - Face to Face Interview with James Roat, Peter Martinac, Chris Cunningham, Nick Sigan
04/26/2023	Contact - Face to Face Interview with Rose Mouradian, Elijah Claucherty
05/15/2023	Contact - Telephone call received Interview with APS worker
06/09/2023	Exit Conference Discussed findings with Karen LaFave
06/09/2023	Inspection Completed-BCAL Sub. Compliance
06/09/2023	Contact – Telephone call made Interview with Resident A's guardian

ALLEGATION: Home manager Kyle Darcy was observed being verbally abusive toward Resident A and dragged him across the floor by his wrists and ankles.

INVESTIGATION: On 4/20/2023, I received a referral from adult protective services that included an allegation against Kyle Darcy, staff person, stating that Mr. Darcy was verbally abusive toward Resident A and had dragged him across the floor by his wrists and ankles. Also, on this day I spoke with Kelsey Williams, area director at Adult Learning Systems. Ms. Williams informed me that she was aware of the allegations. I was told that I was welcome to join her and Pathways Community Mental Health recipient rights officer Casey O'Connor at Adult Learning Systems' main office the next day as they were bringing Kyle Darcy into the office to interview him about the allegations.

On 4/21/2023 I met with the above-named individuals to interview Mr. Darcy. Mr. Darcy has been working at Life Options for 7-8 years. He reported he has no idea what the allegation against him is but thinks it might be related to staff swearing too much around residents. Mr. Darcy made it clear that staff are not swearing at residents, but, rather, swearing while talking to one another where residents may be present. Mr. Darcy was asked about his interactions with Resident A specifically and reported that Resident A can be difficult to deal with due to his severe behavioral issues and size/strength. Resident A has broken two televisions in the home and staff have since installed plexiglass in front of the tv to prevent further breakage. Mr. Darcy explained that when Resident A begins exhibiting aggressive behaviors, the incident usually ends in physical management and calling the resident's guardian for permission to pass a PRN medication to reduce aggression. Mr. Darcy denied ever getting into Resident A's face and yelling at him. He denied ever grabbing the resident's wrists or ankles and dragging him across the floor. Mr. Darcy explained that although it is not a daily occurrence, Resident A regularly throws things and hits other residents and staff. He explained that although it is frustrating having Resident A in the home, Mr. Darcy "swears on his life" that he is not guilty of the allegations against him. When asked why he thinks these allegations were made, Mr. Darcy reported that he believes staff members are "throwing each other under the bus." Immediately after this interview, Ms. Williams informed Mr. Darcy that his employment was being suspended pending the results of the investigations.

Also, on 4/21/2023, I met at Life Options with licensee designee Karen LaFave, adult protective services worker David Livingston, recipient rights officer Casey O'Connor, and detective Jason Hart. While there we attempted to interview Resident A. However, he was not responsive and did not want to talk to anyone. The other residents there seemed in good spirits and well-taken care of by staff. Resident A's assessment plan indicates that he has a behavior plan to assist in controlling aggressive behaviors. The behavior plan indicates that Resident A is prone to property destruction, disruptive verbal behavior, and physical aggression. Further,

the behavior plan explains that standard PCM procedures have not been adequate to keep Resident A and others safe and explains several modifications of PCM procedures to ensure Resident A's and others safety.

On 4/25/2023 I conducted an interview with staff member James Roat. Mr. Roat has worked at Life Options for two years. When Mr. Roat was told of the allegation against Mr. Darcy, and he replied that staff member Rose Mouradian told him that she was going to report Mr. Darcy. Mr. Roat reported that Ms. Mouradian has a new job that she is leaving for soon and has been telling everyone that she was going to make complaints against Mr. Darcy. When asked specifically about the allegations against Mr. Darcy toward Resident A, Mr. Roat reported that he was there that day and, from what he remembers, Resident A was exhibiting heightened behaviors about the television. Mr. Darcy was downstairs in the living room with Resident A and said to him "I am fucking done with your bullshit, and I can't wait until you are out of this home." Mr. Darcy dragged Resident A by the arms onto the mat in an adjoining room (on the floor, used for calming residents exhibiting aggressive/potentially injurious behavior) after Resident A fell to the ground. Mr. Roat reported that Peter Martinac, Chris Cunningham, and Elijah Claucherty were all witnesses to this event. Mr. Roat explained that no one wrote an incident report about this because everyone assumed someone else was going to do it. Mr. Roat also admitted that swearing in the home occurs at "an inappropriate level" and that "everyone swears, from management to staff."

Also, on 4/25/23 I conducted an interview with staff member Peter Martinac. Mr. Martinac had heard that staff are being investigated for swearing but had heard from Ms. Mouradian that they were being investigated for a "bunch of things." Mr. Martinac has been at Life Options for about four years and reports that all staff are guilty of swearing but that they do not swear at residents, although the residents most likely hear staff swear. When Mr. Martinac was told of the allegations against Mr. Darcy, he reported that he believes the incident happened in the fall of 2022. He reported that Resident A broke the television and Mr. Darcy ran up to him and swore. Resident A then took a swing at Mr. Darcy and Mr. Darcy dragged him by his wrists to the backroom mat. When asked why he did not report his incident to anyone he said that he assumed Ms. Mouradian was going to report it and that "maybe Elijah" wrote an incident report (according to Casey O'Connor, recipient rights officer, there is no evidence an incident report was completed about this particular incident involving these staff members taking place this time of the year).

Also, on 4/25/2023, I interviewed staff member Chris Cunningham. According to others, and Mr. Cunningham himself, he was there during the incident. Mr. Cunningham reports that Mr. Darcy did not drag Resident A by the wrists. He reported that Mr. Darcy had Resident A under the arms but was not grasping his wrists. Mr. Cunningham reported that Ms. Mouradian said that she was going to report Mr. Darcy because she is quitting soon and does not like Mr. Darcy. Mr. Cunningham reported that he does not remember the incident at all like how Mr. Martinac reports it and has never seen Mr. Darcy handle a resident aggressively. Mr.

Cunningham reported that he did not report the incident to recipient rights because he did not feel like there was a violation involved. He also reported that these allegations may stem from the fact that Mr. Darcy has been cracking down on staff not doing work and has heard Ms. Mouradian telling everyone about the investigation and how “this place is going down.”

Also, on 4/25/2023, I interviewed Nick Sigan, the other home manager, along with Mr. Darcy, at Life Options. Mr. Sigan reports he has worked at Life Options for several years and worked for Adult Learning Systems for about 11 years. Mr. Sigan reports he has heard staff swearing among one another, but never at residents. Mr. Sigan admitted that he had heard that Mr. Darcy was suspended but does not believe Mr. Darcy would ever do anything like what is claimed in the allegation. Mr. Sigan reported that no staff had come to him to report their concerns about Mr. Darcy being overly aggressive with any residents or dragging residents by the ankles or wrists.

On 4/26/2023 I interviewed Rose Mouradian. Ms. Mouradian reported that she witnessed PCM break down between Mr. Darcy and Resident A and that Mr. Darcy then dragged Resident A to the mat in the other room. However, she also reported that she was in a spot of the home in which it would be difficult to see into the living room fully and impossible to see into the room with the mat. She reports that Mr. Martinac was not there during the incident but was coming to help and that she believes Mr. Cunningham and Mr. Roat were also there. When asked, Ms. Mouradian reported that this incident occurred in September or October of 2022 and that she was the one that wrote the incident report. Ms. Mouradian reports that while she was writing the incident report Mr. Darcy was standing over her watching what she wrote. Although Mr. Darcy did not tell her to change anything, she felt that she could not mention that Mr. Darcy had dragged Resident A. (I discussed this incident report with Ms. Williams who told me that no incident report from this time period exists. Further, the way Adult Learning Systems reporting system is set up, even if an incident report was started but not finished, there would still be a record of it). Ms. Mourdian admits that she did not report this incident to APS, recipient rights, or licensing until right before this investigation was opened, approximately 7 months after the incident occurred, because she “didn’t know what to do.”

Also, on 4/26/2023, I interviewed staff member Elijah Cloucherty. Mr. Cloucherty reported that Resident A hit Mr. Darcy and that PCM broke down during a double Sunday stroll. Mr. Cloucherty reported that Mr. Martinac was there and that he fell, Mr. Darcy continued moving forward with Resident A until he “dead-weighted.” At that point Mr. Darcy finished dragging Resident A to the back room. Also in the interview was recipient rights officer Ms. O’Connor who had previously questioned Mr. Cloucherty before I was involved. In that original interview Mr. Cloucherty reported that he was not a witness to this incident. When asked why he is now claiming he was a witness, he reported that originally he thought they were discussing a different incident. Mr. Cloucherty reported that he believes Ms.

Mouradian is right about her allegations against Mr. Darcy, but not other allegations that she has made.

On 6/09/2023 I interviewed Resident A's guardian over the phone. Guardian told me that Resident A is a big, strong guy and that he could see how someone could find themselves in a difficult position with him. However, I was told that guardian regularly takes Resident A out of the home to visit and has never noticed any bruising. Further, every time guardian has picked Resident A up from the home, he is always happy and has never shown any concern or anxiety about being dropped back off at the home at the end of the visit. Guardian told me that staff at the home are all doing a great job and that he is not concerned about the care Resident A is receiving.

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:	After conducting an investigation and speaking to several staff members about this incident, their stories often diverge from one another, if they are not being outright denied. Although at least one staff member claims to have written an incident report there is no record of her doing so. Further, those that do remember an incident place different staff in different roles as the incident was occurring. Of all staff involved, no one reported the incident to adult protective services, recipient rights, licensing, adult learning systems, or to other management. Although some sort of incident may have occurred, I do not believe there is sufficient evident to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 4/21/2023 I interviewed home manager Kyle Darcy. As part of this interview, Mr. Darcy stated that he believed this investigation may be related to staff swearing too much around residents. Mr. Darcy made it clear that staff are

not swearing at residents, but, rather, swearing while talking to one another where residents may be present.

On 4/25/2023 I interviewed Mr. Roat who admitted that swearing in the home occurs at “an inappropriate level” and that “everyone swears, from management to staff.”

Also, on 4/25/2023, I interviewed Mr. Martinac who reported that he had heard that staff are being investigation for swearing. As part of the interview, Mr. Martinac admitted that that all staff are guilty of swearing but they do not swear at residents, although the residents most likely hear staff swear.

Also, on 4/25/2023, I interviewed home manager Mr. Sigan who reports he has heard staff swearing among one another, but never at residents.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Between 04/21/2023 and 04/26/2023 I interviewed seven staff members at Life Options. Four of these individuals, two of whom are home managers, report that they believe staff swear too much while working around residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/09/2023 I conducted an exit conference with Karen LaFave, licensee designee. I explained that although there was not sufficient evidence to substantiate the allegation against mistreatment of residents, nearly all staff interviewed admitted that they use derogatory language among themselves and around residents, although never at residents. For this reason, a corrective action plan will be required, and I discussed with Ms. LaFave what that corrective action plan could include.

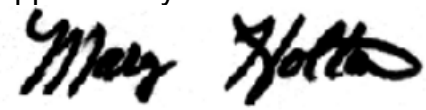
IV. RECOMMENDATION

Contingent upon an adequate corrective action plan, I do not recommend any changes to the status of this license.

06/09/2023

Garrett Peters — Date
Licensing Consultant

Approved By:



06/09/2023

Mary E. Holton — Date
Area Manager