GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 1, 2023

Felicia Evans
Community Living Options
626 Reed Street
Kalamazoo, MI 49001

RE: License #: AS390396025
Investigation #: 2023A1024054
Bronson Circle

Dear Felicia Evans:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On September 13, 2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396025
Investigation #:	2023A1024054
Complaint Receipt Date:	09/06/2023
Investigation Initiation Date:	09/07/2023
Report Due Date:	11/05/2023
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Fiorella Spalvieri
Licensee Designee:	Felicia Evans
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:	07/14/2023
Expiration Date:	07/13/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Angela Silipunas mistreated Resident A.	Yes

III. METHODOLOGY

09/06/2023	Special Investigation Intake 2023A1024054
09/06/2023	APS Referral-already involved
09/06/2023	Contact - Document Received-*AFC Licensing Division Incident/Accident Report*
09/07/2023	Special Investigation Initiated – Telephone with Adult Protective Service (APS) Specialist Thomas Larthridge
09/07/2023	Contact - Telephone call made with direct care staff member Angela Silipunas
09/07/2023	Inspection Completed On-site with direct care staff member Nora Shaffer
09/07/2023	Contact - Telephone call made with licensee designee Felicia Evans
09/12/2023	Exit Conference with licensee designee Felicia Evans
09/12/2023	Inspection Completed-BCAL Sub. Compliance
09/13/2023	Corrective Action Plan Requested and Due on 9/26/2023
09/13/2023	Corrective Action Plan Received
10/26/2023	Corrective Action Plan Approved

ALLEGATION: Direct care staff member Angela Silipunas mistreated Resident A.

INVESTIGATION:

On 9/6/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged direct care staff

member Angela Silipunas mistreated Resident A by forcefully shoving Resident A and Resident A shoved her back. No injuries to Resident A were reported.

On 9/6/2023, I reviewed the facility's *AFC Licensing Division Incident/Accident Report* dated 9/4/2023. According to this report, Resident A told direct care staff members that things were bad in the morning while working with direct care staff member Angela Silipunas because she told Resident A that he had to find somewhere to live and shoved Resident A multiple times, so he shoved her back. Resident A also mentioned frustration about his house shoes coming up missing and Angela Silipunas stated she did not know what happened to Resident A's shoes. The report stated Angela Silipunas mentioned to direct care staff that Resident A hit her however she did not report this on an incident report because Angela Silipunas stated, "they won't do anything about it."

On 9/7/2023, I conducted an interview with APS Specialist Thomas Larthridge who stated that he was also investigating this allegation and has found a preponderance of evidence to support the allegation. Thomas Larthridge stated he interviewed a staff member who informed him Angela Silipunas was suspended pending his investigation. Thomas Larthridge stated he has attempted to contact Angela Silipunas on multiple occasions however has not been successful in contacting her. Thomas Larthridge further stated he interviewed Resident A who reported to him that Angela Silipunas forcefully pushed him when they argued about his missing shoes.

On 9/7/2023, I conducted an interview with direct care staff member Angela Silipunas who denied this allegation. Angela Silipunas stated Resident A got upset because another resident, who has Dementia and doesn't realize what she is doing, grabbed his food off his plate and became impatient while she fixed him another plate. Resident A started yelling at Angela Silipunas and when she tried to put his plate on the table, Resident A stood in front of her until he saw his plate when he stepped aside to allow Angela Silipunas to put his plate on the table. Angela Silipunas stated she did not tell Resident A he can move out however stated to him "I need you move out the way so I can put your plate down." Angela Silipunas stated once Resident A saw his plate of food, he was calm and there were no further issues. Angela Silipunas further stated there was no physical contact made by her or by Resident A and she believes Resident A was just cranky however easily redirected.

On 9/7/2023, I conducted an onsite investigation at the facility with direct care staff member Nora Shaffer who stated upon arriving on her shift in the afternoon, Angela Silipunas advised her that Resident A had a rough morning by being rude and frustrated the entire morning. Nora Shaffer stated Angela Silipunas told her Resident A became agitated when another resident grabbed his food off his plate and did not want to patiently wait for her to make him another plate of food therefore, he hit Angela Silipunas. Nora Shaffer stated Angela Silipunas refused to complete an incident report involving Resident A as she stated she did not feel management would do anything about Resident A hitting her. Nora Shaffer stated she then talked with Resident A regarding the incident who stated that he only hit Angela Silipunas because she hit him first and threw his plate of food towards him on the table. Nora Shaffer stated she

believes Resident A is telling the truth about the incident because she has noticed that Angela Silipunas and Resident A often argue, and Angela Silipunas has a “harsh tone with him.” Nora Shaffer stated she has also observed Angela Silipunas get irritated with Resident A and yell at him therefore she believes Resident A and Angela Silipunas do not get along very well. Nora Shaffer stated in the past, Resident A has reported to her that he will sometimes wait until she arrives to work because he does not want to bother Angela Silipunas or get her upset by asking her for assistance. Nora Shaffer stated she recently saw Resident A and Angela Silipunas get into an argument about his missing house shoes that were later found in the garbage. Nora Shaffer stated she does not know why Resident A’s house shoes were in the trash however he was planning on getting new ones from a relative that have yet to arrive to the facility. It should be noted I was not able to interview Resident A at the time of this home visit due to him not feeling well.

On 9/7/2023, I conducted an interview with licensee designee Felicia Evans who stated that she has been trying to contact Angela Silipunas regarding the incident involving her pushing and yelling at Resident A and to ask about his missing house shoes however Angela Silipunas has not been returning any of her phone calls therefore she is going to move forward with terminating Angela Silipunas’s employment.

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 direct care staff members Angela Silipunas's, Nora Shaffer, licensee designee Felicia Evans, APS Specialist Thomas Larthridge and review of the facility's incident report there is evidence to support the allegation staff member Angela Silipunas mistreated Resident A. According to Nora Shaffer she has witnessed Angela Silipunas and Resident A get into repeated arguments and have seen Angela yell and use a "harsh tone" towards Resident A. Felicia Evans has not been able to get in touch with Angela Silipunas to further discuss complaints made regarding her mistreating Resident A therefore Angela Silipunas has been terminated from employment. Based on this information, Resident A was verbally mistreated by staff member Angela Silipunas.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/12/2023, I conducted an exit conference with licensee designee Felicia Evans. I informed Felicia Evans of my findings and allowed her an opportunity to ask question and make comments.

On 9/13/2023, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

I received an acceptable corrective action plan therefore I recommend the current license status remain unchanged.

Ondrea Johnson

10/26/2023

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn Timm

11/01/2023

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Dawn N. Timm
Area Manager

Date