GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 10, 2023

Pamela Wilkins and Danielle Beville
1308 Jefferson Ave
Kalamazoo, MI 49006

RE: License #: AS390407928
Investigation #: 2023A0581054
Closer To Home

Dear Pamela Wilkins and Danielle Beville:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390407928
Investigation #:	2023A0581054
Complaint Receipt Date:	09/06/2023
Investigation Initiation Date:	09/08/2023
Report Due Date:	11/05/2023
Licensee Name:	Pamela Wilkins and Danielle Beville
Licensee Address:	306 4409 Clayborne Dr Kalamazoo, MI 49009
Licensee Telephone #:	269-491-9832
Administrator:	Pamela Wilkins and Danielle Beville
Licensee Designee:	N/A
Name of Facility:	Closer To Home
Facility Address:	1308 Jefferson Ave Kalamazoo, MI 49006
Facility Telephone #:	(269) 350-5219
Original Issuance Date:	02/17/2022
License Status:	REGULAR
Effective Date:	08/17/2022
Expiration Date:	08/16/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
Direct care staff threaten residents.	No
Direct care staff grabbed Resident A.	No
Direct care staff give residents the wrong medication.	No
Additional Findings	Yes

III. METHODOLOGY

09/06/2023	Special Investigation Intake 2023A0581054
09/06/2023	APS Referral APS received the allegations but denied investigating.
09/08/2023	Special Investigation Initiated - On Site Interviewed residents and staff, obtained documentation.
09/12/2023	Contact - Telephone call made Interview with case manager, Mikayla Davis, Riverwood.
09/12/2023	Contact - Telephone call made Interview with Relative A1
09/12/2023	Contact - Telephone call made Interview with Resident A.
09/12/2023	Inspection Completed-BCAL Sub. Compliance
10/09/2023	Exit conference with the licensee, Pamela Wilkins, via telephone.

ALLEGATION:

- **Direct care staff threaten residents.**

- **Direct care staff grabbed Resident A.**

INVESTIGATION:

On 09/06/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged the direct care staff at the facility “often threatened the residents” and a couple of days ago, a direct care staff member grabbed Resident A from the back, but it was unknown if Resident A sustained any marks or bruises. The complaint also alleged on or around 09/05/2023, a staff member threatened to kill Resident A in his sleep.

On 09/08/2023, I conducted an unannounced inspection at the facility. I interviewed direct care staff, Brandon Burnette, licensees Pamela Wilkins and Danielle Beville, and Residents B, C, and D.

Mr. Burnette denied the allegations stating there was no one in the facility who threatened Resident A, including himself. He stated there were no staff who threated to kill Resident A, and no one ever touched Resident A inappropriately.

Both Ms. Wilkins and Ms. Beville stated Resident A had a diagnosis of schizophrenia. They denied ever threatening Resident A or being aware of any direct care staff threatening him. They stated no one threatened to kill Resident A or grabbed his back.

Resident A was no longer residing in the facility; therefore, I was unable to interview him.

Resident B, C, and D all stated there had never been any incidences where direct care staff were threatening residents, including Resident A, or putting their hands on them. They all denied ever witnessing any incidences where Resident A had been spoken to or touched inappropriately or disrespectfully by any direct care staff, including the licensees.

I attempted to interview Resident E; however, he refused to answer any of my questions relating to how staff treat residents.

On 09/12/2023, I interviewed Resident A’s relative, Relative A1. Relative A1 stated that while he didn’t visit with Resident A when Resident A resided at the facility over the last two months, he had visited with Resident A when he attended appointments at Riverwood Community Health. Relative A1 stated he had no concerns with staff threatening or being physical with Resident A.

On 09/12/2023, I interviewed Resident A's Riverwood Community Mental Health case manager, Mikayla Davis, via telephone. Ms. Davis also stated she had no concerns with any staff threatening or physically assaulting Resident A.

On 09/12/2023, I interviewed Resident A via telephone. Resident A could not recall living at the facility nor could he recall either of the licensees. Subsequently, Resident A was unable to answer my questions relating to how staff treated him when he resided at the facility. He stated he recently had a medication change, which he attributed to his memory loss.

On 09/13/2023, I interviewed direct care staff, Lolita Rose, via telephone. Ms. Rose's statement was consistent with Mr. Burnette's, Ms. Wilkins', and Ms. Beville's statements to me.

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, Brandon Burnette and Lolita Rose, the licensees, Pamela Wilkins and Danielle Beville, Residents A, B, C, and D, Relative A1, and Riverwood Community Mental Health case manager, Mikayla Davis, there was no supporting evidence any direct care staff at the facility grabbed Resident A from the back causing any marks or bruises or any kind of injury.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.**

	(ii) Verbal abuse. **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	Based on my investigation, which included interviews with direct care staff, Brandon Burnette and Lolita Rose, the licensees, Pamela Wilkins and Danielle Beville, Resident A, B, C, and D, Relative A1, and Riverwood Community Mental Health case manager, Mikayla Davis, there was no supporting evidence any facility staff threatened the facility's residents, including Resident A. Additionally, there is no supporting evidence any staff threatened to kill Resident A on or around 09/05/2023, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff give residents the wrong medication.

INVESTIGATION:

The complaint alleged residents are given wrong medication, but no additional information was provided.

Direct care staff Mr. Burnette and Ms. Rose and licensees Ms. Wilkins and Ms. Beville all denied any issues with resident medications. They all indicated resident medications are given, as prescribed.

Residents B, C, and D all stated they receive their medications, as prescribed, and reported no issues.

During the inspection, I reviewed Resident A's, B's, C's, D's, and E's August 2023 Medication Administration Records (MARs), which did not indicate any issues or concerns medications were not being administered, as prescribed.

Relative A1 stated he had no issues or concerns with staff not providing or administering the correct medications to Resident A while he was residing in the facility.

Ms. Davis stated Resident A had significant medication changes when residing at the facility, which she stated Resident A often got "confused" about. She stated as a result, Resident A often thought he was being administered the incorrect medications. Ms. Davis stated facility staff and the licensees would take Resident A

for medication reviews at Riverwood CMH where medical staff would confirm Resident A was on the right medication and was receiving medications, as prescribed.

Resident A was unable to provide any information to me regarding the administration of medication while he was residing at the facility because he was unable to recall living there.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation, which included interviews with direct care staff, Brandon Burnette and Lolita Rose, licensees Pamela Wilkins and Danielle Beville, Residents A, B, C, and D, Relative A1, and Riverwood Community Mental Health case manager, Mikayla Davis, and review of Resident A's, B's, C's, D's, and E's Medication Administration Records, there was no supporting evidence any facility staff were not administering medications to residents, as prescribed and required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Direct care staff, Brandon Burnette, stated Resident A left the facility on 09/07/2023 sometime between 5 pm and 7 pm and never returned. He stated Resident A somehow made it to Relative A1's house in the Benton Harbor area, which is approximately 53 miles West of Kalamazoo.

Licensees Ms. Wilkins and Ms. Beville also confirmed Resident A was no longer residing in the facility. They both stated Resident A was admitted to the facility 07/07/2023, was his own guardian, and involved with Riverwood Community Mental Health (CMH). Ms. Wilkins stated the previous day (09/07/2023), she had been in contact with Ms. Davis who advised her to take Resident A to Kalamazoo's Behavioral Urgent Care due to Resident A's concerning behaviors. Ms. Wilkins stated Resident A didn't want her to take him to the Behavioral Urgent Care, so he left the facility on foot. She stated direct care staff, Lolita Rose, followed him in her car, picked him up and then dropped him off at the Behavioral Urgent Care. Ms. Wilkins stated Ms. Rose did not go in with Resident A and neither she nor Ms.

Beville contacted the Behavioral Urgent Care to check on Resident A while he was there. They also stated they did not contact police or Resident A's case manager regarding Resident A not returning from the Behavioral Urgent Care or ending up in Benton Harbor. Ms. Wilkins stated she did not hear from Resident A or any updates concerning Resident A until she received a telephone call from Relative A1 that morning (09/08/2023) at approximately 8:50 am. She stated Relative A1 informed her Resident A showed up to his house the previous night but had to sleep in Relative A1's vehicle because he didn't want him in the house due to his concerning behaviors.

Both Ms. Wilkins and Ms. Beville indicated Resident A would often go to local convenience stores, within walking distance, by himself, with other residents, or with staff. They both indicated if Resident A walked by himself or with another resident then he would come back to the facility with no issues.

I requested to review Resident A's resident file. According to Resident A's *Health Care Appraisal*, dated 06/29/2023, Resident A has a diagnosis of paranoia schizophrenia. I reviewed Resident A's *Assessment Plan for AFC Residents*, dated 07/07/2023, which documented Resident A is able to move independently within the community.

I also reviewed Resident A's Riverwood Center Behavior Treatment Plan (BTP), dated 08/10/2023 with an effective date of 07/31/2023. According to my review of Resident A's BTP, elopement was defined as the following:

> "…leaving the property of Closer to Home AFC home and going to the community without staff's permission or supervision. Regular monitoring needs to be done on a 24/7 basis. Leave of absence (LOA), is not considered elopement because family is accountable for [Resident A], and they take him into the community to do activities."

The BTP documented Resident A had the ability to walk around the facility's property and a nearby street, but "Staff will keep checking to see if [Resident A] is in line of sight." The BTP documented if Resident A walked away from the facility without staff supervision, then staff were expected to start following him on foot and in the facility van. The BTP documented staff should verbally redirect Resident A back to the facility, but if he refused initial prompting then staff should get additional staff to help guide him back to the facility. The BTP further documented if Resident A continued to refuse to return then facility staff should follow elopement procedures for residents. The BTP also documented "when in the community on an activity, he needs to be in staff's line of sight, if [Resident A] alures the staff, verbally redirect him to return; if he refused to return, follow the protocol of the staff". It also documented "If [Resident A] wants to walk in the community, he will have staff be with at all times."

Relative A1 stated Resident A never went into the Behavioral Urgent Care after he was dropped off by direct care staff. He stated Resident A was taken to the Behavioral Urgent Care to be evaluated with the hope he would get taken to the Emergency Room (ER). Relative A1 stated after Resident A was dropped off at the Behavioral Urgent Care, Resident A walked to a nearby gas station, called Relative A2, who then picked him up and dropped him off at the Benton Harbor homeless shelter. Relative A1 stated that rather than stay at the homeless shelter, Resident A walked to Relative A1's house in Stevensville. Relative A1 stated he refused to let Resident A in his house, so Resident A slept in Relative A1's car overnight. Relative A1 stated he took Resident A to a local motel the following day, which is where he is currently.

Ms. Davis stated she had advised the facility's direct care staff to take Resident A to the Behavioral Urgent Care to find mental health resources on or around 09/07/2023. Ms. Davis stated she was not aware of staff just dropping Resident A off at the Behavioral Urgent Care. She stated that upon review of Resident A's BTP, staff should have stayed with Resident A and provided supervision.

Direct care staff, Ms. Rose stated on 09/07/2023 she was getting to work when Resident A was getting ready to leave the facility to walk to the Behavioral Urgent Care. She stated she asked Resident A if he wanted a ride and he complied. Ms. Rose stated when they arrived to the Behavioral Urgent Care she watched Resident A walk into the building and then she left. She stated Resident A told her his case manager was going to pick him up.

Ms. Rose stated Resident A would often go to local stores within walking distance by himself, but she stated he would always return. Ms. Rose stated Resident A could walk to the stores by himself or he'd go with other residents. She stated Resident A needed staff supervision when in the facility. Ms. Rose stated her shift ended at approximately 11:30 pm that night and she did not contact the Behavioral Urgent Care to check on Resident A during that time frame.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.

ANALYSIS:	Based on my investigation, Resident A had a Riverwood Community Mental Health Behavior Treatment Plan, dated 08/10/2023 with an effective date of 07/31/2023, which documented Resident A was unable to be in the community without staff supervision and while in the community on an activity, Resident A needed to be in staff's line of sight. Despite the licensee having Resident A's BTP, on 09/07/2023 at approximately 5 pm, direct care staff, Lolita Rose, transported Resident A to a local Behavioral Urgent Care, dropped him off and then left. Soon after being dropped off, Resident A contacted Relative A2 who then picked him up and transported him to Benton Harbor, which is approximately 53 miles away. It was not until the following morning on 09/08/2023 at approximately 8:50 am that licensees Pamela Wilkins and Danielle Beville discovered Resident A was in the Benton Harbor area as they were contacted by Relative A1 and informed Resident A arrived to his house the previous evening. Consequently, the licensees did not implement Resident A's level of supervision as documented in his BTP, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/09/2023, I conducted my exit conference via telephone with licensee, Pam Wilkins. She acknowledged my findings and stated she had gone through all the resident's assessments and CMH plans to ensure she and staff were providing the appropriate level of supervision within the community for each resident.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

10/09/2023

Cathy Cushman — Date
Licensing Consultant

Approved By:

10/10/2023

Dawn N. Timm — Date
Area Manager