GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 16 , 2024

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

RE: License #: AS390092832
Investigation #: 2024A1034011
CLO/Cliffwood Home

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 (517) 284-9730.

Sincerely,

Kevin L. Sellers

Kevin Sellers, Licensing Consultant
Department of Licensing and Regulatory Affairs
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-3704
SellersK1@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390092832
Investigation #:	2024A1034011
Complaint Receipt Date:	11/16/2023
Investigation Initiation Date:	11/17/2023
Report Due Date:	01/15/2024
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:	CLO/Cliffwood Home
Facility Address:	127 Cliffwood Avenue Portage, MI 49002
Facility Telephone #:	(269) 323-7257
Original Issuance Date:	06/30/2000
License Status:	REGULAR
Effective Date:	12/26/2023
Expiration Date:	12/25/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct Care worker Alicia Dickerson was verbally abusive and made threats towards Resident A.	Yes

III. METHODOLOGY

11/16/2023	Special Investigation Intake 2024A1034011
11/17/2023	APS Referral made relating to the allegations in the complaint.
11/17/2023	Special Investigation Initiated – Telephone contact with Complainant, interviewing Complainant.
12/01/2023	Inspection Completed On-site interviewed direct care worker (DCW) Nikki Smith and Matthew Shinaver, direct care worker/program manager, Amber McFerson and Resident A.
12/12/2023	Contact - Telephone call made leaving message for direct care worker, Emily Ferguson, to return contact.
12/12/2023	Contact - Telephone call received interviewing direct care worker, Emily Ferguson.
12/15/2023	Contact - Telephone call made leaving message for direct care worker, Alicia Dickerson.
12/20/2023	Contact - Telephone call made leaving second message for Alicia Dickerson.
01/03/2024	Contact - Telephone call made leaving message about investigation outcomes for licensee designee, Lorinda Anderson.
01/05/2024	Contact – Document Sent- email sent about investigation outcomes to Lorinda Anderson.
01/05/2024	Exit Conference with Lorinda Anderson.
01/05/2024	Inspection Completed-BCAL Sub. Compliance.

ALLEGATION: Direct Care worker Alicia Dickerson was verbally abusive and made threats towards Resident A.

INVESTIGATION:

On 11/16/2023, I received a complaint through the Bureau of Community Health Systems (BCHS) online complaint system alleging that on 11/12/2023 direct care worker (DCW) Alecia Dickinson yelled, cursed, and called Resident A an "ugly bitch", threatened to slap Resident A's glasses off her face, and refused to allow Resident A to attend an outing with peers. The complaint stated DCW Emily Ferguson recorded DCW Alecia Dickinson yelling at Resident A.

On 11/17/2023, I interviewed Complainant via telephone who verified the allegation identified in the complaint were accurate.

On 12/01/2023, I conducted an unannounced onsite investigation and interviewed direct care worker (DCW) Nicki-Terri Smith who reported receiving a telephone call from DCW Emily Ferguson on 11/12/2023 about an incident at the facility between DCW Alicia Dickerson and Resident A. DCW Smith reported DCW Ferguson told her DCW Dickerson engaged into a verbal argument with Resident A by calling Resident A an "ugly bitch" and was yelling, cursing and made threats toward Resident A that she would slap Resident A's glass off her face. DCW Smith stated DCW Ferguson then told her DCW Dickerson told Resident A she was not going to participate in an outing with the other residents. DCW Smith reported DCW Ferguson informed her she recorded the entire verbal argument on video. DCW Smith reported telling DCW Furguson to send her the recorded videos and she contacted DCW/program Manager, Amber McFerson.

On 12/01/2023, I interviewed Resident A who reported on the morning of 11/12/2023 making a cup of coffee in the kitchen area when DCW Alicia Dickerson instructed her that she did not need another cup of coffee. Resident A reported having two cups of coffee but wanted another. Resident A reported telling DCW Dickerson she wanted another cup of coffee but DCW Dickerson yelled and screamed at her telling her to get out of the kitchen. Resident A reported being upset after DCW Dickerson yelled at her and admitted to yelling back. Resident A reported before leaving the kitchen area, DCW Dickerson told her if she did not leave now she would slap her face knocking off her glasses. Resident A denied hearing DCW Dickerson call her an "ugly bitch" nor could she remember DCW Dickerson telling her she could not be able to participate in the outing for the day. Resident A denied DCW Dickerson ever physically hit her at any time. Resident A denied ever having any prior issues with DCW Dickerson.

On 12/01/2023, I interviewed Residents B and C who denied knowing anything about DCW Dickerson yelling, screaming, or making threats towards Resident A on 11/12/2023. Residents B and C denied any issues with any of the direct care staff members including DCW Dickerson.

On 12/01/2023, I interviewed DCW/program manager Amber McFerson who reported having knowledge of the verbal incident between DCW Alicia Dickerson and Resident A on 11/12/2023. Ms. McFerson reported receiving a telephone call from DCW Niki-Terri Smith after she received a call from DCW Emily Ferguson who witnessed the verbal altercation and verbal threats made by DCW Dickerson towards Resident A. and DCW Ferguson video records the entire incident. Ms. McFerson reported going to the facility immediately to address the situation and remained at the facility while completing an internal investigation by interviewing DCWs Ferguson, Dickerson, Resident A, B and C, reviewing recorded videos taken by DCW Ferguson and contacting licensee designee Lorinda Anderson. Ms. McFerson reported after completing her investigation and discussing with licensee designee Lorinda Anderson, DCW Alicia Dickerson's employment was terminated on 11/12/2023.

On 12/05/2023, I reviewed four separate videos taken by DCW Emily Ferguson of the incident. I observed no visuals of Resident A and DCW Alicia Dickerson only audio footage of the incident. While observing the videos, I could clearly hear a person identified as DCW Dickerson screaming, yelling, making threats towards Resident A and calling Resident A an "ugly bitch." I could not hear DCW Dickerson tell Resident A she would not be able to participate in an outing with the other residents.

On 12/05/2023, I reviewed CLO/Cliffwood Home Incident Report (IR), dated 11/12/2023, and determined what was written in the IR was consistent with what was reported by DCWs Furguson and Smith, program manager McFerson and Resident A. The IR indicated in the morning of 11/127/2023 DCW Alicia Dickerson yelled, screamed and made threats towards Resident A. The action taken section documented direct care staff contacted program manager Amber McFerson. It documented Ms. McFerson came to the home, interviewed DCWs Furguson, Dickerson, Residents A, B and C, reviewed video footage taken of the incident and contacted licensee designee. Under the section 'Action taken to prevent the incident from reoccurring' it documented "management terminated DCW Dickerson's employment on 11/12/2023."

On 12/12/2023, I interviewed Kalamazoo County Recipient Rights Officer, Suzie Suchyta, via telephone. Ms. Suchyta reported investigating the allegation that on 11/12/2023 DCW Alicia Dickerson yelled, screamed and made threats towards Resident A. Ms. Suchyta reported interviewing DCWs Emily Furguson, Niki Smith, Resident A, program manager Amber McFerson, obtaining an incident report and reviewing the video recording of the incident. Ms. Suchyta reported attempting to interview DCW Alicia Dickerson but after several minutes into the interview DCW

Dickerson refused to continue the interview. Ms. Suchyta reported completing her investigation finding neglect against DCW Alicia Dickerson for the threats she made towards Resident A. Ms. Suchyta reported being aware DCW Dickerson's employment was terminated on 11/12/2023 and denied any further concerns for Resident A or any other resident's safety and supervision living at the facility.

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.** **(iv) Threats.**
ANALYSIS:	Based on my interviews with DCW/program manager McFerson, DCWs Smith and Furguson, Residents A, B and C, recipient rights officer Suzie Suchyta along with reviewing CLO/Cliffwood Home Incident Report dated on 11/12/2023 and four separate video clips of the incident, there was supporting evidence DCW Alicia Dickerson made cruel and threatening statements towards Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remain unchanged.

Kevin L. Sellers 1/12/2024

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Kevin Sellers Date
Licensing Consultant

Approved By:

Dawn Timm 01/16/2024

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Dawn N. Timm Date
Area Manager