GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

August 9, 2024

RE: License #: AS520299825
Investigation #: 2024A0873023
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
250 Ottawa, N.W.
Grand Rapids, MI 49503
(906) 250-9318

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS520299825 |
| | |
| **Investigation #:** | 2024A0873023 |
| | |
| **Complaint Receipt Date:** | 06/17/2024 |
| | |
| **Investigation Initiation Date:** | 06/17/2024 |
| | |
| **Report Due Date:** | 08/16/2024 |
| | |
| **Licensee Name:** | Adult Learning Systems - UP, Inc |
| | |
| **Licensee Address:** | Suite-4<br>228 West Washington<br>Marquette, MI 49855 |
| | |
| **Licensee Telephone #:** | (906) 228-7370 |
| | |
| **Administrator:** | Karen LaFave |
| | |
| **Licensee Designee:** | Karen LaFave |
| | |
| **Name of Facility:** | Life Options |
| | |
| **Facility Address:** | 2632 Moran<br>Marquette, MI 49855 |
| | |
| **Facility Telephone #:** | (906) 273-1414 |
| | |
| **Original Issuance Date:** | 03/23/2009 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 12/05/2023 |
| | |
| **Expiration Date:** | 12/04/2025 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION

| | **Violation Established**? |
|---|---|
| Resident A was able to ingest a dose of Resident B's medication after staff left the medication lying on the floor. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 06/17/2024 | Special Investigation Intake<br>2024A0873023 |
| 06/17/2024 | Special Investigation Initiated - Telephone<br>Interview with Pathways ORR |
| 06/17/2024 | Contact - Face to Face<br>Staff interview |
| 06/18/2024 | APS Referral<br>Referred to APS |
| 06/24/2024 | Inspection Completed On-site |
| 06/24/2024 | Contact - Face to Face<br>Interview with staff |
| 08/05/2024 | Inspection Completed-BCAL Sub. Compliance |
| 08/05/2024 | Exit Conference<br>with Karen LaFave |

**ALLEGATION:**

**Resident A was able to ingest a dose of Resident B's medication after staff left the medication lying on the floor.**

**INVESTIGATION:**

On 6/14/24, I received a telephone call from recipient rights officer Casey Olson. A staff member at Life Options left Resident B's medication on the floor of the home, unattended. Resident A noticed this and ingested a dose of the medication.

On 6/17/24, I interviewed employee Nick Sigan at Adult Learning Systems' offices. Mr. Sigan admitted to leaving the medications on the steps of the home in a common area. The medications were discontinued and Mr. Sigan placed them on the steps, got sidetracked, and forgot about them. It was later determined that Resident A had ingested one of the pills. Resident A was taken to the emergency department and monitored for one hour before being sent home.

On 6/17/24, I interviewed employee Kyle Darcy at Adult Learning Systems' offices. Mr. Darcy was upstairs working when Resident A came and spoke to him. As they walked back downstairs Mr. Darcy noticed the medications on the stairs. Resident A admitted to taking a pill. Staff contacted poison control and took Resident A to the hospital where he was monitored for about an hour and a half and sent home. Mr. Sigan admitted to Mr. Darcy that he was the one that left the medications on the stairs.

On 6/24/24, I interviewed Mr. Sigan at the home. Mr. Sigan, again, admitted that he left the medications sitting on the stairs, explaining that it was a mistake and that he was fully responsible. He explained that he fully understood the consequences of making this mistake.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.** |
| **ANALYSIS:** | Mr. Sigan left Resident B's medications lying on the stairs of the home, unattended. Resident A took a dose of Resident B's medication. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 8/5/24, I explained the findings of this report to licensee designee Karen LaFave. She responded that she would work with the home to develop a corrective action plan.

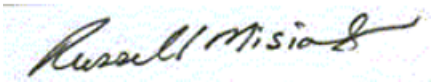
## IV. RECOMMENDATION

Upon receipt of a corrective action plan, I recommend no changes to the status of this license.

8/5/24

Garrett Peters — Date
Licensing Consultant

Approved By:



8/7/24

Russell B. Misiak — Date
Area Manager