GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 3, 2024

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

RE: License #: AS390396025
Investigation #: 2024A1024033
Bronson Circle

Dear Ms. 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 June 19, 2024, 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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396025
Investigation #:	2024A1024033
Complaint Receipt Date:	05/14/2024
Investigation Initiation Date:	05/16/2024
Report Due Date:	07/13/2024
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Felicia Evans
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?
Staff are rude and did not treat Resident A with dignity by not assisting Resident A after she was found lying on the floor unclothed.	Yes

III. METHODOLOGY

05/14/2024	Special Investigation Intake 2024A1024033
05/16/2024	Special Investigation Initiated – Telephone with direct care staff members Amber Potter and Rebecca Kirk
05/16/2024	APS Referral-APS denied to investigate allegations
05/16/2024	Contact - Document Received-Resident A's *Assessment Plan for AFC Residents* and *AFC Licensing Division-Incident/Accident Report*
06/04/2024	Contact - Document Received additional allegations from intake 201101 alleging staff is rude.
06/04/2024	Contact - Telephone call made with direct care staff member Scott Bessy
06/05/2024	Inspection Completed On-site with direct care staff member Micah Lee, Danica Millard, Diamond Shaver, and Resident A
06/05/2024	Contact - Document Received-Scott Bessy's *Deficient Performance Notice*
06/17/2024	Exit Conference with licensee designee Felicia Evans
06/17/2024	Inspection Completed-BCAL Sub. Compliance
6/17/2024	Corrective Action Plan Requested and Due on 06/27/2024
06/19/2024	Corrective Action Plan Received
06/19/2024	Corrective Action Plan Approved

ALLEGATION: Staff are rude and did not treat Resident A with dignity by not assisting Resident A after she was found lying on the floor unclothed.

INVESTIGATION:

On 5/14/2024, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged that staff did not treat Resident A with dignity by not assisting Resident A after she was found lying on the floor unclothed. On 6/4/2024, additional allegations were received alleging that staff are rude.

On 5/16/2024, I conducted an interview with direct care staff members Amber Potter and Rebecca Kirk. Amber Potter stated on 5/13/2024 she arrived to work at 7:30pm and was notified by direct care staff member Diamond Shaver that direct care staff member Scott Bessy had just left, and he was in a rush to leave. Amber Potter stated shortly after, while doing bedroom checks Diamond Shaver heard a noise and found Resident A lying on the floor in need of assistance with getting up from the floor. Amber Potter stated she then went to Resident A's bedroom and also found Resident A lying on the floor unclothed with dry blood on her arm. Amber Potter stated Resident A stated she fell while trying to get up to go to the bathroom and when she asked Scott Bessy for help, he refused to help her. Resident A also stated she scratched her arm when she fell which caused her arm to bleed. Amber Potter stated she believes Resident A fell while attempting to change out of her clothes as she observed Resident A's clothes soiled with urine positioned on the floor next to her. Amber Potter stated Resident A requires assistance with dressing and bathing therefore she was unsure why Scott Bessy did not assist her. Amber Potter stated she does not know how long Resident A was on the floor prior to being found however the blood on her arm was dried. Consequently, Amber Potter stated she believes Resident A was on the floor for a long amount of time. Amber Potter stated she and Diamond Shaver assisted Resident A and immediately notified management regarding Scott Bessy leaving the facility without attending to Resident A.

Rebecca Kirk stated she is the home manager and was called by staff member Diamond Shaver to notify her that Resident A was found lying on her bedroom floor with blood on her arm. Rebeccas Kirst stated Diamond Shaver reported to her that Scott Bessy refused to help Resident A get up and advised her to wait for the next staff members to arrive to receive assistance. Rebecca Kirk stated she contacted Scott Bessy who stated that Resident A fell right before the next shift direct care staff members arrived for their shift and he informed them that Resident A needed assistance as he was leaving the facility. Rebecca Kirk stated Diamond Shaver and Amber Potter both stated Scott Bessy never reported anything to them prior to Scott Bessy leaving the facility or at any given time. Rebecca Kirk stated Resident A also reported to her that she needed help getting off the floor when she fell during the evening, and Scott Bessy stated to her that he didn't feel comfortable helping her because she did not have any clothes on and to wait for the next shift staff members to

arrive. Rebecca Kirk stated the hospice nurse was immediately called and came out to evaluate Resident A's arm injury. Rebecca Kirk stated Resident A has received hospice services since March 2024.

On 5/16/2024, I reviewed Resident A's *Assessment Plan for AFC Residents* dated 4/24/2024 which stated that Resident A requires assistance with toileting, bathing, grooming, dressing and participates with Hospice.

I also reviewed the facility's *AFC Licensing Division-Incident/Accident Report (IR)* dated 5/13/2024. According to this report, Diamond Shaver walked in Resident A's bedroom and saw Resident A lying on the floor and stated, "I fell and I'm bleeding". The IR stated Diamond Shaver immediately turned Resident A's oxygen on and examined her body to look for injuries. The IR stated Hospice was then called along with the supervisor. The IR stated Resident A was cleaned up and assisted into bed. Adult Protectives Services was contacted.

On 6/4/2024, I conducted an interview with direct care staff member Scott Bessy who stated on 5/13/2024 at around 7pm he found Resident A lying on her bedroom floor who asked him to help her get up. Scott Bessy stated he advised Resident A that she would have to put her clothes back on before he would be able to assist her. Scott Bessy stated when one of the staff members arrived, he informed them that Resident A needed assistance and he left the facility as he had to rush out to take care of personal business. Scott Bessy stated he left at around 7:30pm without checking back with Resident A however he was under the impression that the next two staff members would be able to assist her. Scott Bessy stated Resident A did not inform him that she was injured, and he did not observe any blood on her arm that would indicate that she was injured. Scott Bessy further stated he assumed Resident A was more independent and would be able to get up on her own and dress herself without staff assistance. Scott Bessy stated he is new to working with Resident A therefore he did not realize that she needed more assistance with her personal care needs and since he was in a rush to leave, he failed to ask Resident A any other questions regarding why she was on the floor. Scott Bessy stated he has not seen any staff members be rude to any resident.

On 6/5/2024, I conducted an onsite investigation at the facility with direct care staff members Micah Lee, Danica Millard, and Diamond Shaver. Micah Lee stated she has never seen any direct care staff member be rude to any residents however it was reported to her that direct care staff member Scott Bessy refused to assist Resident A with getting up off the floor after she was found lying on her bedroom floor. Micah Lee stated she discussed this incident with Scott Bessy who informed her that he did not feel comfortable assisting Resident A when he found on her on the floor because she did not have on any clothes. Micah Lee stated Resident A requires assistance with all of her personal care needs such as bathing, grooming, and toileting.

Danica Millard stated she heard about the incident that occurred involving Resident A and Soctt Bessy however was not working when the incident occurred therefore has no

direct knowledge of the incident. Danica Millard stated she has no knowledge of any direct care staff member being rude to any resident.

Diamond Shaver stated on 5/13/2024 she arrived at the facility for work and saw Scott Bessy on the telephone with another supervisor discussing a medication issue for an unrelated matter. Diamond Shaver stated Scott Bessy then handed her the telephone to speak with the supervisor who advised her to look for a medication in the medication room. Diamond Shaver stated when she got off the phone, she noticed that Scott Bessy had left the facility at which time she and Amber Potter began to conduct their routine bedroom checks. Diamond Shaver stated while conducting routine bedroom checks she heard Resident A call out for help and when she went to her bedroom, she observed Resident A lying on the floor bleeding from her arm. Diamond Shaver stated Resident A then asked for help and stated that Scott Bessy stated to her that he couldn't help her until he put on a shirt however never came back to help her. Diamond Shaver stated Resident A is not able to perform her own personal care needs such as dressing and bathing therefore there is no way Resident A would be able to dress herself without staff assistance. Diamond Shaver stated she observed Resident A's clothes soiled with urine and feces and immediately put Resident A's oxygen on her until her hospice worker arrived for further evaluation. Diamond Shaver stated she has no knowledge of any other staff member being rude or not assisting residents.

While at the facility I also conducted an interview with Resident A who stated that on 5/13/2024 she got up out of bed because she wanted to change her clothes and when she got up, she fell hitting her elbow on the floor which is why her elbow was bleeding. Resident A stated she asked Scott Bessy to help her when he came to her bedroom however Scott Bessy advised that he could not help her because she did not have on her clothes and was eventually assisted by Diamond Shaver and Amber Potter after about 30 minutes of being on the floor. Resident A stated she is usually treated nicely by staff members and has never had any issues with staff members in the past.

On 6/5/2024, I reviewed Scott Bessy's *Deficient Performance Notice* dated 5/16/2024. According to this notice, "on 5/13/2024 while coming off an overnight shift, a consumer asked Scott Bessy for assistance with changing out of her soiled clothing. When unable to get help, the consumer began to change herself. The consumer fell and was on her bedroom floor asking for help and did not receive any help until first shift staff arrived." This notice stated this is a violation of CLO's *Employee Ethical Conduct Policy* as every staff interaction with consumers must reflect consumer needs. This notice also stated Scott Bessy is expected to follow all essential duties and responsibilities and comply with all performance standards. This employee has received a written disciplinary notice regarding this policy violation and failure to make improvement or recurrence of inappropriate behavior or conduct will result in further disciplinary action up to and including termination.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation which included interviews with Micah Lee, Danica Millard, Diamond Shaver, Amber Potter, Soctt Bessy, Rebecca Kirk, Resident A, and review of the facility's incident report, Resident A's assessment plan and Scott Bessy's *Deficiency Performance Notice* there is evidence to support direct care staff member Scott Bessy did not treat Resident A with dignity by not assisting Resident A after she was found lying on the floor unclothed. Diamond Shaver and Amber Potter both stated that while conducting routine bedroom checks upon their initial shift arrival they found Resident A lying on her bedroom floor bleeding from her arm. Both direct care staff members stated Resident A reported to them that Scott Bessy stated to her that he couldn't assist her because she did not have on any clothes. Scott Bessy stated he found Resident A lying on her bedroom floor and when she requested for help, he advised her to put her clothes back on before he would be able to assist her however did not check back in to assist Resident A as he had to abruptly leave the facility. Resident A also stated Scott Bessy refused to assist her off the floor when she fell and instructed her to wait for other staff members to help. Resident A was not treated with dignity and her personal care needs were not attended to by Scott Bessy.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/17/2024, I conducted an exit conference with licensee designee Felicia Evans. I informed Felicia Evans of my findings and allowed her an opportunity to ask questions or make comments.

On 6/19/2024, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved therefore I recommend the current license remain unchanged.

6/27/2024

Ondrea Johnson
Licensing Consultant

Date

Approved By:

07/03/2024

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Dawn N. Timm
Area Manager

Date