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
228 West Washington
Marquette, MI 49855

January 7, 2025

RE: License #: AS520083567
Investigation #: 2025A0873004
Transitions

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
350 Ottawa, N. W.
Grand Rapids, MI 49503
(906) 250-9318
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520083567
Investigation #:	2025A0873004
Complaint Receipt Date:	11/18/2024
Investigation Initiation Date:	11/19/2024
Report Due Date:	01/17/2025
Licensee Name:	Adult Learning Systems - UP, Inc
Licensee Address:	Suite-4 228 West Washington Marquette, MI 49855
Licensee Telephone #:	(906) 228-7370
Administrator:	Karen LaFave
Licensee Designee:	Karen LaFave
Name of Facility:	Transitions
Facility Address:	607 Spring Street Marquette, MI 49855-9396
Facility Telephone #:	(906) 228-6359
Original Issuance Date:	11/03/1998
License Status:	REGULAR
Effective Date:	09/06/2023
Expiration Date:	09/05/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
Staff did not provide residents transportation to their medical appointments.	No
Staff neglected to give residents their medications.	No
The amount of food in the home was inadequate for the residents.	No
Staff slept during their shift.	Yes
Additional Findings	No

III. METHODOLOGY

11/18/2024	Special Investigation Intake 2025A0873004
11/19/2024	Special Investigation Initiated - Telephone Interview with Casey Olson ORR CMH
11/26/2024	Inspection Completed On-site
11/26/2024	Contact - Face to Face Interview with home manager
12/05/2024	Contact - Document Sent Email to complainant
12/23/2024	Contact - Document Sent Email to complainant
01/07/2025	Contact - Telephone call made Interview with Guardian A
01/07/2025	Contact - Telephone call made Interview with Guardian B
01/07/2025	Contact - Telephone call made Interview with CMH caseworker
01/07/2025	Inspection Completed-BCAL Sub. Compliance
01/07/2025	Exit Conference with Karen LaFave

ALLEGATION:

Staff did not provide residents transportation to their medical appointments.

INVESTIGATION:

On 11/18/24, I received a complaint alleging staff at Transitions did not take residents to their medical appointments.

On 11/19/24, I interviewed Pathways community mental health (CMH) officer of recipient rights (ORR) Casey Olson. No residents or guardians have ever reported to her that staff were not transporting residents to their medical appointments.

On 11/26/24, I interviewed home manager Krystal Wells at the facility. Staff at the facility regularly transported residents to their medical appointments as needed.

On 11/26/24, I interviewed Adult Learning Systems (ALS) area director Elisa Cowling at the facility. ALS regularly provided transportation to and from medical appointments as needed with no issue.

On 1/7/24, I interviewed Guardian A over the telephone. Resident A never had a problem with transportation to medical appointments.

On 1/7/24, I interviewed Guardian B over the telephone. Resident B would tell Guardian B if there was ever a problem of any kind at the facility.

On 1/7/24, I interviewed Pathways community mental health (CMH) case worker Amy Koenig over the telephone. Ms. Koenig was responsible for several residents at the facility and none of them have ever reported to her any issue with missed medical appointments.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following:

	(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.
ANALYSIS:	After interviewing ORR Olson, several ALS staff, and several guardians, I find no evidence residents are not receiving transportation to their medical appointments.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff neglected to give residents their medications.

INVESTIGATION:

On 11/26/24, I interviewed home manager Krystal Wells at the facility. Residents received their medications when they were supposed to. If they did not, staff filed an incident report and sent it to CMH, following proper protocol. Resident B recently had his medication window changed due to a change in scheduling regarding his employment, but all procedures were properly followed.

On 1/7/24, I interviewed Guardian A. She has never heard of an instance in which Resident A did not receive his medications or received them late.

On 1/7/24, I interviewed Guardian B. If Resident B did not receive his medications on time as required, Resident B would immediately let Guardian B know of the problem. Guardian B has never heard of a problem with medications at the facility.

On 1/7/24, I interviewed CMH case worker Amy Koenig over the telephone. Ms. Koenig was responsible for several residents at the facility and has never had an issue with residents not receiving their medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	After interviewing several guardians, as well as staff of the facility and CMH case worker Ms. Koenig, I find no evidence staff are neglecting to give residents their medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The amount of food in the home was inadequate for the residents.

INVESTIGATION:

On 11/26/24, I interviewed home manager Krystal Wells at the facility. While there I observed food prepared, shelves and the refrigerator stocked with an adequate food supply.

On 1/7/25, I interviewed Guardian A on the telephone who told me that she has never heard of there being any problems at the facility regarding lack of food.

On 1/7/24, I interviewed Guardian B over the telephone who told me that if there were any issues in the home Resident B would have let her know.

On 1/7/24, I interviewed CMH case worker Amy Koenig over the telephone. Ms. Koenig works with several of the residents housed at the facility and reported that she had never had any complaints from them regarding lack of food.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(5) A home shall be properly equipped as required by the health authority, to prepare and serve adequate meals.
ANALYSIS:	After conducting an inspection at the facility, as well as interviewing CMH case worker Koenig and several guardians, I could find no evidence the facility has an inadequate food supply.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff slept during their shift.

INVESTIGATION:

On 11/19/24, I interviewed Pathways CMH officer of recipient rights Casey Olson. Staff members Max Holiday and Amber Dawson admitted to sleeping during their shift.

On 11/26/24, I interviewed home manager Krystal Wells at the facility. Ms. Wells confirmed that Mr. Holiday and Ms. Dawson admitted to sleeping during their shift.

On 11/26/24, I interviewed ALS area director Elisa Cowling at the facility. Ms. Cowling confirmed that Mr. Holiday and Ms. Dawson admitted to sleeping during their shift. ALS has taken steps with staff to prevent this from happening again.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Staff Holiday and Dawson admitted to sleeping during their shift. This was confirmed by the home manager Wells and ALS area director Cowling.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/7/25, I explained the findings of this report to licensee designee Karen LaFave. Staff members Holiday and Dawson continue to work for ALS but received verbal consultation and a written warning for sleeping during their shift.

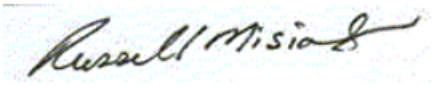
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of this license.

1/7/25

Garrett Peters Date
Licensing Consultant

Approved By:



1/9/24

Russell B. Misiak Date
Area Manager