GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 25, 2021

Magline Whitley
914 Lapeer Ave.
Saginaw, MI 48607

RE: License #:	AM730347313
Investigation #:	2021A0123015
	Whitley AFC I

Dear Ms. Whitley:

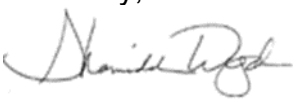
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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 (810) 787-7031.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM730347313
Investigation #:	2021A0123015
Complaint Receipt Date:	02/17/2021
Investigation Initiation Date:	02/17/2021
Report Due Date:	04/18/2021
Licensee Name:	Magline Whitley
Licensee Address:	914 Lapeer Ave. Saginaw, MI 48607
Licensee Telephone #:	(989) 327-1464
Administrator:	Magline Whitley
Licensee:	Magline Whitley
Name of Facility:	Whitley AFC I
Facility Address:	215 S. 3rd. Saginaw, MI 48607
Facility Telephone #:	(989) 752-0056
Original Issuance Date:	03/24/2015
License Status:	REGULAR
Effective Date:	09/24/2019
Expiration Date:	09/23/2021
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 1/22/2021, Resident A was taken out to run errands by the facility transportation van. He became agitated and was dropped off on the side of the road at an unknown location. Staff filed a missing person report. Resident A was picked up by EMS at 8:30pm and taken to the hospital with hypothermia.	Yes

III. METHODOLOGY

02/17/2021	Special Investigation Intake 2021A0123015
02/17/2021	APS Referral Information received regarding APS referral.
02/17/2021	Special Investigation Initiated - Telephone I spoke with Jessire Ramos of adult protective services.
02/22/2021	Contact - Telephone call made I conducted a FaceTime call. I interviewed residents and staff.
02/25/2021	Contact - Document Received I received requested documentation via fax.
03/12/2021	Contact- Telephone call made I made a call to Resident A's case manager. I left a message requesting a return call.
03/12/2021	Contact- Document Sent A letter was faxed to the Saginaw Township Police department requesting a copy of the police report.
03/23/2021	Contact- Telephone call made I made a follow-up call to the Saginaw Township Police Department regarding the police report.
03/23/2021	Contact- Document Sent I sent a letter via email to the Saginaw County Sheriff's Department requesting a copy of the police report.
03/23/2021	Contact- Telephone call made

	I attempted to contact Resident A's case manager. I left a second message requesting a return call.
03/24/2021	Contact- Document Received I received a copy of the police report via email.
03/24/2021	Contact- Telephone call made I left a message, requesting a return call from Ms. Whitley.
03/24/2021	Exit Conference I spoke with Magline Whitley via phone.

ALLEGATION: On 1/22/2021, Resident A was taken out to run errands by the facility transportation van. He became agitated and was dropped off on the side of the road at an unknown location. Staff filed a missing person report. Resident A was picked up by EMS at 8:30pm and taken to the hospital with hypothermia.

INVESTIGATION:
This investigation was completed virtually due to the COVID-19 pandemic.

On 02/17/2021, I spoke with adult protective services worker Jessire Ramos via phone. She stated that she was told by staff Lester Whitley that he did not want to let Resident A out of the vehicle, but Resident A became aggressive. She stated that Staff Whitley became fearful, so he let Resident A out of the vehicle, and left to go and drop off the other residents. She stated that Staff Whitely went looking for Resident A and made a missing person's report. She stated that Resident A reported to her that he wanted to get out of the vehicle and go back to the credit union. She stated that Resident A was being aggressive by making threats and getting loud. She stated that Resident A walks around the community and can do so on his own. Ms. Ramos stated that Resident A was treated at the hospital for hypothermia and was sent home the same day. She stated that to her knowledge, Resident A is not susceptible to hypothermia. She stated that Resident A reported that he got lost, and also reported that he was wearing a winter coat.

On 02/22/2021, I interviewed Resident A via FaceTime. Resident is his own person and does not have a guardian. Resident A stated that he wanted to get out (of the vehicle) on January 21, 2021. He stated that Staff Whitley let him out because he was getting out of it anyway. Resident A stated that he felt like walking. He stated that he walked for about two to three minutes and got lost. Resident A stated that it got dark and he could not see. He stated that the police pulled up on him. He stated that it was not snowing, but it had gotten really cold outside. He stated that he told the police that he could not see but a few feet ahead of him, and his shoes. He stated that an ambulance took him to Covenant Hospital. He stated that hospital staff gave him a "warm up thing" and checked him over. He stated that the hospital let him go after he warmed up, and then Staff Whitley came and picked him up.

Resident A further stated that he can go out into the community on his own. He stated that he usually goes a couple of blocks from home and comes back. Resident A stated that he was wearing a coat and hat on the day of the alleged incident. Resident A stated, “I’ll never do that no more.” He stated that he thought he knew where he was at, but he did not.

On 02/25/2021, I obtained copies of documentation regarding Resident A. I reviewed a copy of Resident A’s *AFC Licensing- Health Care Appraisal* dated for 03/25/2019. The health care appraisal notes that Resident A is fully ambulatory. There were no notes in the “Susceptibility to Hyper/Hypothermia and Related Limitations” section of the form.

Resident A’s *Assessment Plan for AFC Residents,* dated for 02/13/2021, indicates that Resident A “moves independently in community,” and does not need staff assistance with personal care activities, except taking medication. In regard to “Controls Aggressive Behavior” it is noted that “at times get upset.” For “Physical Exercise” and “Recreation” it notes that Resident A “like to walk.”

An incident report dated for 01/22/2021 states that Staff Whitley took Resident A to the bank to cash his check. The bank would not cash the check because Resident A did not have an account at the bank. When Resident A came back to the van, he became upset and wanted to get out on Bay Rd. (Saginaw Township, MI). Staff asked him to wait until he pulled over. Staff called the police and Resident A’s brother because Resident A had not made it back to the facility. A missing person’s report was made.

On 02/22/2021, I interviewed staff Lester Whitley via FaceTime. Staff Whitley stated that he took the residents to the bank. Resident A did not have an account, so Staff Whitley stated that he told Resident A that the licensee Magline Whitley could cash the check for him. He stated that Resident A told him he “owned the bank.” Staff Whitley stated that Resident A went inside the bank, and they would not cash the check. He stated that Resident A wanted to get out of the vehicle while they were in traffic. Staff Whitley stated that he pulled into Best Buy’s parking lot, and Resident A got out. Staff Whitley stated that he waited, but Resident A said he would be okay. Staff Whitley stated that he went to a bank, and then came back to Bay Rd., then went back to the facility. He stated that he waited for Resident A to call or come home. He stated that around 8:00 pm, at medication time, he called the police. He stated that the police picked up Resident A right away about 20-30 minutes after his call to the police. Staff Whitley stated that the hospital called him to pick up Resident A. Staff Whitley stated that Resident A has been okay since, and Ms. Whitley ended up cashing Resident A’s check for him. He stated that Resident A has been out around Bay Rd. on his own before and has taken the bus for transportation in the past. Staff Whitley stated that Resident A was not diagnosed with anything at the hospital, and Resident A did not provide staff with any discharge paperwork. He stated that the hospital said they would keep Resident A for a few hours to warm him

up. Staff Whitley stated that per the police, Resident A said he was smoking cigarettes not knowing he had gotten cold.

On 02/22/2021, I interviewed Resident B via FaceTime. Resident B stated that Resident A had received his stimulus check but did not have a bank account and wanted Staff Whitley to take him to the bank. Resident B stated that Resident A came out of the bank saying that Staff Whitley took him to the wrong bank, and that he wanted to go to another bank. Resident B stated that Resident A was yelling. Resident B stated that she witnessed Resident A starting to open the car door while in traffic on Bay Rd. She stated that Staff Whitley pulled over, and Resident A got out, slammed the door, and started walking. Resident B stated that Resident A was agitated. Resident B stated that Resident A does go to the store on his own.

On 02/22/2021, I interviewed Resident C via FaceTime. Resident C stated that Resident A said that the bank that they went to was Resident A's bank, but it was not. Resident C stated that Resident A was mad and wanted to get out of the car. Resident C stated that Resident A took off mad walking down the street.

Two attempts were made on 03/12/2021 and 03/23/2021 to contact Resident A's case manager. Voicemails were left, and the calls were not returned.

On 03/24/2021, I received a copy of the Saginaw County Sheriff's Office case report dated for 01/22/2021. The report states that Officer Cole McGregor responded with an SVSU (Saginaw Valley State University) officer to a call at 8:30 pm to Resident A standing in the turn lane in front of SVSU (Saginaw Valley State University). The report notes that the "caller was concerned due to the weather (16 Degrees F outside) and wanted his well being checked." Under the "Officer Observations" section of the report it says that Resident A appeared to be confused, cold, and had difficulty answering questions. Resident A was placed in the police vehicle to stay warm until MMR (ambulance) responded. Resident A told the officer that he was going blind and had difficulty seeing, and that he had been outside since 3:00 pm because the van left him there. The officer spoke with staff Lester Whitley via phone. Staff Whitley reported the following per the officer's notes:

"Whitley said he was driving multiple residents including [Resident A] to the bank around 2:30 pm today so that [Resident A] could cash his check. Whitley said [Resident A] became frustrated when the bank wouldn't cash his check and he demanded to get out of the car. Whitley said [Resident A] would not get back in his car, so he left him in the Bed Bath and Beyond parking lot on Bay Rd. Whitley said he called Dispatch later when he realized [Resident A] had not returned home."

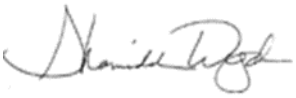
The report ends with stating that Resident A was transported to Covenant for further evaluation.

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:	Resident A was interviewed and reported that after he got out of the van, and started walking, he got lost. He reported in his interview, and during the interview with police that he could only see a few feet ahead of himself. Resident A reported that he received medical treatment in regards to getting warmed up, before he was discharged from the hospital. He reported that he did not know where he was at. An incident report dated for 01/22/2021 states that a missing person's report was made for Resident A after he did not return to the facility. Staff Lester Whitley, Resident A, Resident B, and Resident C all reported that Resident A exited the van on Bay Rd. A copy of the Saginaw County Sheriff's Office case report dated for 01/22/2021 states that when the responding officer encountered Resident A, Resident A was cold, confused, and had difficulty answering questions. The report also indicates that the officer responded around 8:30 pm and the temperature that night was 16 degrees Fahrenheit. Resident A was transported to Covenant Hospital per MMR (ambulance). There is a preponderance of evidence to substantiate a rule violation in regard to protection and safety. The facility was not aware of Resident A's general whereabouts. He was found near SVSU per the police report, and not near the area where he got out of the vehicle. The police had to intervene, and Resident A had to seek medical attention due to the outside freezing temperature.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/24/2021, I conducted an exit conference with licensee designee Magline Whitley via phone. I informed of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC medium group home (capacity 12).

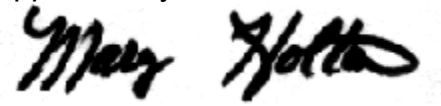


03/25/2021

_____

Shamidah Wyden Date
Licensing Consultant

Approved By:



03/25/2021

_____

Mary E Holton Date
Area Manager