GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2021

Melissa Bentley
WDC Enterprises
11515 N. Saginaw Road
Clio, MI 48420

RE: License #: Investigation #:	AM250008208 2022A0123007 Conquests AFC Clio 1

Dear Ms. Bentley:

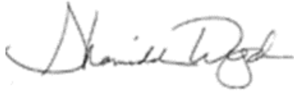
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (906) 226-4171.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250008208
Investigation #:	2022A0123007
Complaint Receipt Date:	11/16/2021
Investigation Initiation Date:	11/17/2021
Report Due Date:	12/16/2021
Licensee Name:	WDC Enterprises
Licensee Address:	14271 Weir Rd Clio, MI 48420
Licensee Telephone #:	(810) 547-1763
Administrator:	Melissa Bentley
Licensee Designee:	Melissa Bentley
Name of Facility:	Conquests AFC Clio 1
Facility Address:	14271 Weir Road Clio, MI 48420
Facility Telephone #:	(810) 686-1865
Original Issuance Date:	02/01/1984
License Status:	REGULAR
Effective Date:	06/06/2020
Expiration Date:	06/05/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 11/13/2021, Resident A eloped from the facility and walked to a neighbor's home. 911 was contacted due to Resident A being unable to be redirected by staff Karrie Graves. The police responded and returned Resident A to the home unharmed.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/16/2021	Special Investigation Intake 2022A0123007
11/16/2021	APS Referral Received information regarding APS referral.
11/17/2021	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
12/02/2021	Inspection Completed On-site I conducted an unannounced on-site visit at the facility.
12/09/2021	Contact - Telephone call made I made a call to Resident A's public guardian's office.
12/09/2021	Contact - Telephone call made I left a voicemail requesting a return call from staff Karrie Graves.
12/09/2021	Contact- Telephone call received I received a voicemail from Staff Graves requesting a return call.
12/09/2021	Contact- Telephone call made I spoke with Staff Graves via phone.
12/13/2021	Contact- Telephone call made I left a voicemail requesting a return call from licensee designee Melissa Bentley.
12/13/2021	Contact- Document received I received requested documentation via fax.
12/15/2021	Exit Conference- I spoke with licensee designee Melissa Bentley via phone.

12/15/2021	Exit Conference- I conducted a follow-up exit conference with Ms. Bentley informing her of the additional findings.

ALLEGATION: On 11/13/2021, Resident A eloped from the facility and walked to a neighbor's home. 911 was contacted due to Resident A being unable to be redirected by staff Karrie Graves. The police responded and returned Resident A to the home unharmed.

INVESTIGATION: On 11/17/2021, I spoke with Complainant 1 via phone. Complainant 1 stated the following:

Complainant 1 is unsure if staff left the facility's grounds because of the other residents in the home. It is unknown if staff went to the neighbor's house. Staff tried to redirect Resident A. Resident A is not capable of being in the community on her own as she has dementia. Resident A has a legal guardian. This is Resident A's first time doing this at this facility, but Resident A has a history of eloping. The facility issued a 30-day notice to Resident A for physical aggression and calling 911. Staff is worried they cannot keep Resident A safe, and Resident A is not a good fit for the home. Resident A stated that she wanted to go to the neighbor's home to get someone to take her home. The facility has door alarms and tries to redirect. When Resident A goes off grounds, staff are to call 911, call a home manager and supervisor, and contact the legal guardian. Staff documented on the incident report that these steps were followed.

On 12/02/2021, I conducted an unannounced on-site visit at the facility. I spoke with home manager Celina Demott. She stated that Resident A went right next door. Staff Karrie Graves was working on the day of the incident and was the only staff person present. One staff person works per shift. Resident A has dementia and MS (multiple sclerosis) and cannot be in the community on her own. Staff Demott stated that Resident A made it to the neighbor's porch. Police had to be called because Resident A refused to leave the neighbor's premises. Staff Demott stated that staff cannot leave the home, and they must call the police if residents refuse to come back. She stated that Resident A has not left the home since then. Resident A has resided in the facility since October 2021. Staff Demott stated that she is not sure if a new placement has been found yet for Resident A.

On 12/02/2021, I interviewed Resident A at the facility. Resident A stated that she is doing great. She stated that it is okay living here, but she wants to go home. She denied eloping. She stated she has never been to the neighbor's house next door and has never been on their porch. She denied seeing any police respond to the home and denied going outside without being accompanied by staff.

A copy of the incident report, dated for 11/13/2021 was obtained. It states the following:

“Resident decided that she was leaving one way or another. She decided to walk up the road to a neighbor’s house. She said that she wanted to find someone to take her home. Called 911 because redirection was unsuccessful.” Under the corrective measures section of the incident report, it states “set alarms on doors. Watch that she doesn’t go outside for any reason; try to keep her calm.” This incident report was completed by staff Karrie Graves.

A copy of Resident A’s *Assessment Plan for AFC Residents* was obtained. For Moves Independently in Community it is check no. It states “*Needs staff supervision in community. Family need guardian approval.”* Resident A’s assessment plan also indicates that she “may become verbally & physically aggressive when frustrated, needs no assistance with walking, and uses a walker and walking cane for assistive devices. The assessment plan is dated for 01/08/2021. Resident A’s health care appraisal states that her diagnoses are multiple sclerosis, NG bladder, dementia, edema, and frequent UTI, and it also indicates use of a walker.

On 12/09/2021, I made a call to Resident A’s public guardian’s office. I spoke with her case manager at the office, Individual 1. Individual 1 stated that the facility is doing the best that they can do. Resident A was placed at a different home owned by the company and was moved to this current facility. She stated that the move triggered Resident A’s dementia issues. Resident A received a 30-day notice, and they are currently looking for a memory care placement. Individual 1 stated that they think this move to her current facility upset Resident A, her dementia is bad, and Resident A cannot settle in. Individual 1 stated that Resident A has displayed verbal aggression and has a history of elopement issues. She stated that the facility has alarms on their doors and stated they are keeping a close eye on Resident A. Individual 1 stated that Resident A is not safe in the community on her own, and there should be more than one staff in the home for Resident A. Individual 1 stated that Resident A should be moving in about a week or so.

On 12/09/2021, I interviewed staff Karrie Graves via phone. Staff Graves stated that on the day of the incident, Resident A was cursing/swearing, and said she was going to sit on the home’s stoop. Resident A then took off down the driveway, and down the road. Staff Graves stated that she tried to redirect Resident A, and then went back inside and called 911. She stated that Resident A walked about three houses down on the opposite side of the road but did not get to the neighbor’s porch. She stated that the police responded and brought Resident A back to the facility. Resident A had refused to get out of the police vehicle, but police were able to calm Resident A down. Resident A came back into the facility, ate, and took her medication. Staff Graves stated that Resident A has been outside and unruly before, but never took off down the driveway. She stated that there have been no elopement issues that she knows of since this incident, and that she does not work at this facility anymore. She stated that the facility is staffed one person per shift.

On 12/13/2021, I obtained a copy of Resident A’s 30-day notice. The 30-day notice is dated for 11/01/2021 and is addressed to Resident A’s public guardian. The 30-

day notice is due to "*consumer is physically and verbally aggressive and threatening towards staff and other consumers.*"

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:	An incident report dated for 11/13/2021 details that Resident A eloped from the facility. Complainant 1, Staff Demott, and Staff Graves reported that Resident A eloped from the home and the police had to be called to intervene. Individual 1 stated that Resident A has a history of eloping. It was reported by Staff Demott and Staff Graves that the facility had one staff on shift at the time of this incident, and the staff person could not leave the home to intervene in Resident A's eloping. Resident A's assessment plan indicates that she is not capable of being in the community on her own. There is a preponderance of evidence to substantiate a rule violation due to staff not attending to Resident A's protection and safety at all times, as she was in the community without staff supervision due to eloping.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

Investigation: On 11/03/2021, Complainant 1 reported being unsure if staff left the facility's grounds because of the other residents in the home. It is unknown if staff went to the neighbor's house. Staff tried to redirect Resident A. Resident A is not capable of being in the community on her own as she has dementia. This is Resident A's first time doing this at this facility, but Resident A has a history of eloping.

On 12/02/2021, I conducted an unannounced on-site visit at the facility. I spoke with home manager Celina Demott. She stated that Resident A went right next door. Staff Karrie Graves was working on the day of the incident and was the only staff person present. One staff person works per shift. Resident A has dementia and MS (multiple sclerosis) and cannot be in the community on her own.

On 12/09/2021, I made a call to Resident A's public guardian's office. I spoke with her case manager at the office, Individual 1. Individual 1 stated that Resident A is not safe in the community on her own, and there should be more than one staff in the home for Resident A.

A copy of Resident A's *Assessment Plan for AFC Residents* was obtained. For *Moves Independently in Community* it is check no. It states "*Needs staff supervision in community. Family need guardian approval."* Resident A's health care appraisal indicates that she has dementia.

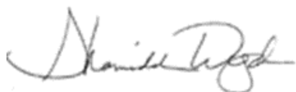
On 12/09/2021, I interviewed staff Karrie Graves via phone. She stated that the facility is staffed one person per shift.

APPLICABLE RULE	
R 400.14206	**Staffing Requirements.**
	(2) A licensee shall have sufficient direct care 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:	During this investigation, it was reported by Staff Demott and Staff Graves that the home is staffed with one staff per shift. Resident A's assessment plan indicates that she cannot move independently in the community. Resident A also has a history of elopement. When Resident A eloped on 11/13/2021, there was only one staff on shift who was not able to leave the home to intervene as Resident A walked away from the facility. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/15/2021, I spoke with licensee designee Melissa Bentley via phone. I informed her of the findings and conclusion. On 12/15/2021, I conducted a follow-up exit conference with Ms. Bentley informing her of the additional findings.

IV. RECOMMENDATION

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



12/15/2021

Shamidah Wyden
Licensing Consultant

Date

Approved By:

12/15/2021

Mary E Holton
Area Manager

Date