GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 26, 2022

Brooke Selleck-Fredrickson
The Mitten Adult Foster Care L.L.C.
1546 N. Royston Road
Charlotte, MI 48813

RE: License #: AM230402660
Investigation #: 2022A1033005
The Mitten Adult Foster Care LLC

Dear Ms. Selleck-Fredrickson:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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 (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM230402660
Investigation #:	2022A1033005
Complaint Receipt Date:	04/27/2022
Investigation Initiation Date:	04/28/2022
Report Due Date:	06/26/2022
Licensee Name:	The Mitten Adult Foster Care L.L.C.
Licensee Address:	4957 Burt Avenue Grand Ledge, MI 48813
Licensee Telephone #:	517-898-1983
Administrator:	Brooke Selleck-Fredrickson
Licensee Designee:	Brooke Selleck-Fredrickson
Name of Facility:	The Mitten Adult Foster Care LLC
Facility Address:	4957 Burt Avenue Grand Ledge, MI 48837
Facility Telephone #:	(517) 898-1983
Original Issuance Date:	04/16/2020
License **Status:**	REGULAR
Effective Date:	10/16/2020
Expiration Date:	10/15/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has eloped from the facility on multiple occasions.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/27/2022	Special Investigation Intake 2022A1033005
04/28/2022	Special Investigation Initiated - On Site Interview conducted with Licensee Designee, Brooke Selleck-Fredrickson, direct care staff, Emily Rhodabeck and Joshelyn Blankenberg, Residents A, B, C. Review of resident record initiated.
05/06/2022	Contact - Telephone call made- Attempt to interview, Tri County Office on Aging staff, Chris Hornburg. Voicemail message left.
05/09/2022	Contact - Telephone call made- Attempt to interview TCOA staff, Chris Hornburg. Voicemail message left.
05/09/2022	Contact - Telephone call received- Interview with TCOA staff, Christine Hornburg.
05/10/2022	Contact - Telephone call made- Attempt to interview, Guardian A1, via telephone. Voicemail message left.
05/11/2022	Contact – Telephone call received- Interview with Guardian A1 via telephone.
05/11/2022	Exit Conference with Licensee Designee, Brooke Selleck-Fredrickson, via telephone call.
05/11/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A has eloped from the facility on multiple occasions.

INVESTIGATION:

On 3/29/22 I received an *AFC Licensing Division – Incident Accident Report (*IR) that was dated for 3/29/22 and completed by direct care staff (DCS), Joshelyn Blankenberg. The report referred to an incident of elopement concerning Resident A that occurred on 3/28/22. The report stated, "A resident saw [Resident A] leave the property and contacted me. I ran upstairs, waited to see if he went to DG. Ten minutes later I contacted police and guardian. Sheriff brought [Resident A] home around 1045pm. Sheriff told me he spoke to him about following the rules of the home. Alarms were all checked and walk through done. Waited for all residents to get to their rooms."

On 4/6/22 I reviewed an IR that was dated for 3/30/21 and completed by DCS Blankenberg. The report referenced an incident of elopement with Resident A. The reported stated, "[Resident A] brought home by GLPD (no one aware he even left). Was found by high school. Alarms checked, multiple rounds throughout the night. Asked residents if anything suspicious is seen to call me on my cell phone."

On 4/21/22 I received an IR dated 4/17/22 that was completed by DCS Emily Rhodabeck. This report referred to an incident of elopement concerning Resident A that occurred on 4/16/22. The report stated, "Eaton County called to see if we had a "walk away." Someone called to report a suspicious male walking in their neighborhood, fit the description of [Resident A]. Upon inspection [Resident A] was not here. Eaton County dispatched GLPD to pick him up and bring him home. [Resident A] was counseled by GLPD officers, told that if he keeps leaving he may end up in a lockdown facility. [Resident A] promised not to leave tonight but made no promises for the future."

On 4/27/22 I received an IR dated 4/25/22 and completed by DCS Rhodabeck. This report referred to an incident of elopement concerning Resident A. The report stated, "GLPD brought [Resident A] home at approx 1am, said they found him by GLHS. [Resident A] told police officers we have alarms on most doors so he snuck out the back door."

On 4/28/22 I completed an on-site investigation at The Mitten Adult Foster Care LLC facility. I interviewed DCS Rhodabeck. DCS Rhodabeck reported she lives in the "staff apartment" in the lower level of this facility. She reported midnight staff have been able to sleep while residents are sleeping. It was reported midnight staff sleep on the lower level. She further stated there are cameras in the common areas of the home (hallways, living room, entry way, kitchen) and staff have view of the cameras from the lower level. She reported Resident A requires assistance with medication management, shower prompts and supervision. DCS Rhodabeck stated, "he loves

to leave," when discussing Resident A's behaviors. She reported Resident A waits for staff to be busy with other residents and then he leaves or elopes from the facility. DCS Rhodabeck reported the facility has made multiple attempts to monitor Resident A's elopement risk by using security cameras and having alarms installed on all the doors. She stated the alarm on the sliding glass door was newly installed after his last elopement on 4/25/22. DCS Rhodabeck reported she had been working the evening of 4/25/22 and was in the downstairs apartment when the Grand Ledge Police Department (GLPD) arrived at the facility at 1am with Resident A. DCS Rhodabeck reported she had not known he had eloped from the facility. DCS Rhodabeck reported Resident A had advised he left through the "back patio door" as there was not an alarm on this exit. DCS Rhodabeck reported she had visually seen Resident A on the security cameras around 12am as he was standing in the back hallway. She reported he must have left the facility after this, being gone for less than one hour. DCS Rhodabeck reported Resident A was not on regular safety checks prior to this occurrence on 4/25/22. DCS Rhodabeck further reported Resident A began exit seeking behaviors around January of 2022. She stated direct care staff members have caught him trying to leave the facility and they have had to call GLPD to assist in getting him to return to the facility as Resident A can become verbally abusive with staff when they try to redirect him.

During the on-site investigation, on 4/28/22, I interviewed, Licensee Designee (LD), Brooke Selleck-Fredrickson. LD Selleck-Fredrickson reported she has been working with Tri County Office On Aging (TCOA) Supports Coordinator, Chris Hornburg, to develop a plan for having Resident A moved to a more secure facility due to his exit seeking behaviors. She reported that on 4/28/22 she had received a response from Ms. Hornburg that TCOA was going to approve an additional six hours of care support for Resident A, to assist with supervision. LD Selleck-Fredrickson reported midnight staff were sleeping in the downstairs apartment but are now staying on the main floor since Resident A's most recent elopement on 4/25/22. She also reported installing a door alarm on Resident A's bedroom door to alert direct care staff when he is leaving his room. LD Selleck-Fredrickson noted Resident A did not exhibit exit seeking behaviors upon admission to the facility. It was reported this behavior has started recently and has escalated.

During on-site investigation, on 4/28/22, I interviewed Resident B. Resident B reported she has observed Resident A leaving the facility and had to get help from direct care staff to intervene. She further reported that sometimes the direct care staff need to call the police for assistance in getting Resident A back to the facility. Resident B noted that she is aware of the door alarms that are being used to alert staff to Resident A's exit seeking behaviors but feels the alarms are not deterring this behavior.

During on-site investigation, on 4/28/22, I interviewed Resident C who reported, "when doesn't he leave?" when discussing Resident A's exit seeking behaviors. Resident C reported she has witnessed Resident A walking away from the facility and had to report this to direct care staff. She reported Resident A has discussed

leaving the facility and noted to her that he would like to go to Charlotte. Resident C reported she informed Resident A that he is "stressing the staff out" when he leaves.

During on-site investigation, on 4/28/22, I interviewed Resident A. Resident A reported that when he leaves the facility he is hoping to walk to Charlotte. He reported no plan of what he will do when he arrives in Charlotte. He reported he previously resided in Charlotte, and he wishes to return. He further stated he understands direct care staff do not want him leaving without supervision.

During on-site investigation, on 4/28/22, I interviewed DCS Blankenberg who reported Resident A continues to be an elopement risk at the facility. She reported multiple occurrences of Resident A leaving the facility. She reported there were some instances direct care staff did not know Resident A was gone but she thinks he was never gone for more than an hour at a time before GLPD would bring him back to the facility. She reported that on one occasion she tried to stop Resident A from leaving the facility and he "cussed in my face." DCS Blankenberg reported she thinks the facility can manage Resident A's physical care needs but not his exit seeking behaviors.

I reviewed Resident A's resident record on 4/28/22. Resident A's *Assessment Plan for AFC Residents* was completed on 11/4/21. On page 1, under heading I. *Social/Behavioral Assessment*, subsection *A. Moves Independently in the Community,* it was marked "yes" with a notation, "Staff check log times." On page 2, under heading II. *Self Care Skill Assessment,* subsection *G. Walking/Mobility*, it was marked "No" for "Needs Help" with a notation, "falls frequently stand-by assist." I found an updated *Assessment Plan for AFC Residents* form in Resident A's resident record. On page 1, under heading I. *Social/Behavioral Assessment*, subsection *A. Moves Independently in the Community,* it was marked "No" with a notation "1:1 staffing." This form had not been dated or signed by LD Selleck-Fredrickson or Guardian A1 nor was there any other documentation in the file indicating their participation in the completion of the form.

On 4/28/22 I reviewed the IRs on file for Resident A. There were five IRs found in Resident A's file concerning episodes of elopement, dated 3/29/22, 3/30/22, 4/13/22, 4/17/22, 4/25/22. I reviewed the staff logbook for Resident A. The logbook noted eleven incidents when Resident A left the facility without giving notice to staff.

- On 1/16/2022 DCS Blankenberg noted in resident logbook, "Another resident told me that [Resident A] went walking w/o supervision at 6pm. [Resident A] found walking in the corn field next to Dollar General. Had no money on him, no phone. Told him he cannot walk anywhere w/o assistance. He has Covid and is a fall risk to cold, too icy. [Resident A] couldn't tell me where he was going or what he needed. Very scary."
- On 1/17/22 DCS Rhodabeck wrote in the resident logbook, "left AFC to "go buy cigarettes, he has no money or ID."

- On 2/7/22 DCS Blankenberg wrote in resident logbook, “[Resident A] left w/o telling anyone where he was going or what was needed. Staff went out searching was told to notify police. Was found @ Prestons bar.”
- On 2/8/22 DCS Blankenberg wrote in resident logbook, “[Resident A] tried to leave property again. Was found on the road, he stated, “I was caught.” Tried telling me he was going for cigs w/ no ID.”
- On 2/20/22 DCS Rhodabeck wrote in resident logbook, “[Resident A] left again; GLPD found him on W. Saginaw near the Ford dealership. After talking w/ him he wants to be relocated to Charlotte because he’s been there for 20+years. I told him we need to go thru the proper channels to make changes & that we are here to help him. I told him I was happy he’s home safe and warm…his reply was “the nights still young” but he promised me he wouldn’t leave again tonight.”
- On 3/28/22 it was written in resident logbook, “left AFC, returned home by Eaton County Sheriff.”
- On 3/29/22 DCS Blankenberg wrote in resident logbook, “[Resident A] took off at 9:11pm. A resident saw him leave the premises.I walked down the street to see if I could see him, and I could not. I told a resident I was going to wait for 10mins to see if he went to DG. After this I contacted the police and Guardian. He was found and brought home @10:45pm. He was out by QD on Jefferson.”
- On 3/30/22 DCS Blankenberg wrote in resident logbook, “GLPD found [Resident A] walking out by GL high school. Was brought home around 9:30pm. No one saw him leave.”
- On 4/12/22 DCS Blankenberg wrote in resident logbook, “left AFC, returned home by GLPD.”
- On 4/16/22 DCS Rhodabeck wrote in resident logbook, “left AFC, brought home by GLPD, staff and GLPD counseled him and warned him he’ll end up in lockdown facility.”
- On 4/25/22 DCS Rhodabeck wrote in resident logbook, “left AFC, returned by GLPD @ 1am.”

On 4/28/22 I reviewed the log sheet the facility had instituted on 4/27/22 to conduct 15-minute safety checks on Resident A. Between the times of 9:30pm on 4/27/22 and 6:45am on 4/28/22 there were no noted initials indicating Resident A’s safety checks had been completed during those times.

On 4/28/21 I reviewed the *Vendor View for MICIS, Assessment Report* found in Resident A’s file*. This report was* completed by Tri County Office on Aging Supports Coordinator, Chris Hornburg, RN, and Elizabeth Hartel, LMSW, on 12/03/21. On page 3 of this report, under *Section E: Cognitive Patterns*, the report reads, “Moderately impaired – Decisions consistently poor or unsafe; cues/supervision required at all times.” On page 14 of this report, under the *Section T: Nursing Notes,* the report reads, “1C This means you cannot be left alone. Staff at your place of

residence must be available to you as planned or follow established emergency procedures."

On 5/9/22 I interviewed Ms. Hornburg via telephone. Ms. Hornburg reported Resident A was moved to The Mitten Adult Foster Care facility after an incident involving Resident A wandering miles away from a motel he was residing and not knowing where he was or how to return. Ms. Hornburg reported Adult Protective Services became involved and Resident A was referred for TCOA services to assist with his care at The Mitten Adult Foster Care facility. Ms. Hornburg reported potentially the facility did not view Resident A as an elopement risk when he arrived at the facility in November of 2021 as he was ill when he arrived, but they were aware of his history with wandering. Ms. Hornburg reported she has not received any written incident reports regarding Resident A. The reports she has received concerning his elopement behaviors were by phone and occurred at an unidentified date in February 2022, 4/11/22, 4/15/22 and 4/25/22. Ms. Hornburg reported the first communication she received that this resident would need to be moved from The Mitten Adult Foster Care facility was a phone conversation with LD Selleck-Fredrickson on 4/22/22. Ms. Hornburg also reported that her communication, regarding Resident A's elopements, was most often reported to her when she made her monthly progress calls to the facility not at the time the elopement occurred.

On 5/11/22 I interviewed Guardian A1 via telephone. Guardian A1 reported Resident A had previously been residing, independently, in a motel in Charlotte but was found wandering away from the motel on 11/1/21. She reported Resident A had walked from Charlotte to Olivet, where he was found by authorities. She reported Resident A was found to be confused and unsure how to return to the motel. She reported Adult Protective Services became involved, and she was appointed as Resident A's guardian on 11/24/21. Guardian A1 reported that The Mitten Adult Foster Care facility had informed her, by telephone, on the dates 2/8/22, 3/29/22, 4/13/22, 4/18/22 that Resident A had wandered away from the facility. She reported she was contacted by Officer Thomas, with the GLPD, on 4/25/22 regarding another incident of elopement from the facility. Guardian A1 reported she did not receive any written reports regarding incidents of elopement with Resident A from the facility staff. She reported she was provided a 30-day discharge notice for Resident A on 4/21/22. Prior to 4/21/22, it was reported by Guardian A1, that the facility had not spoken with her about moving Resident A to another facility. Guardian A1 reported LD Selleck-Fredrickson had asked her what they should do to keep Resident A safe and Guardian A1 reported she advised LD Selleck-Fredrickson to call the police if Resident A leaves the facility again. Guardian A1 reported that when she became Resident A's guardian in November 2021, she was okay with him walking to the local Dollar General and back to the facility. She reported not being aware of eleven incidents of elopement regarding this resident.

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 interviews with DCS Blankenberg, DCS Rhodabeck, LD Selleck-Fredrickson, Guardian A1, Ms. Hornburg and Residents A, B, and C, Resident A's protection and safety needs were not attended to by facility direct care staff members after Resident A eloped 11 times between 01/16/2022 and 04/25/22. DCS continued to sleep during midnight shifts, in the lower-level apartment of the facility rather than providing awake supervision to Resident A during nighttime hours. Also, fifteen-minute safety checks were not initiated until 4/27/22 for Resident A. Resident A was assessed by TCOA on 12/3/21 and it was noted on this report that his level of care required "supervision at all times." However, Resident A's *Assessment Plan for AFC Residents* was not updated to reflect this change in assessment. Guardian A1 was not informed of this change in care by providing Guardian A1 an updated assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Resident A's *Assessment Plan for AFC Residents* which was dated 11/4/21. On page 1, under heading I. *Social/Behavioral Assessment*, subsection *A. Moves Independently in the Community,* it was marked "yes" with a notation, "Staff check log times." On page 2, under heading II. *Self Care Skill Assessment,* subsection *G. Walking/Mobility*, it was marked "No" for "Needs Help" with a notation, "falls frequently stand-by assist." I found an updated *Assessment Plan for AFC Residents* form in Resident A's resident record. On page 1, under heading I. *Social/Behavioral Assessment*, subsection *A. Moves Independently in the Community,* it was marked "No" with a notation "1:1 staffing." This form had not been dated or signed by LD Selleck-Fredrickson or Guardian A1 nor was there any other documentation in the file indicating their participation in the completion of the form. As stated above, the TCOA assessment for Resident A that was completed on 12/3/21 provided the following statement noting Resident A was "Moderately impaired – Decisions consistently poor or unsafe; cues/supervision required at all times." The most recent, collaborative version of Resident A's *Assessment Plan for*

AFC Residents, signed by Guardian A1 on 12/3/21, did not include this updated assessment information for Resident A.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on review of Resident A's record, it is established that Resident A's *Assessment Plan for AFC Residents* was not updated to reflect his change in status. Resident A was assessed by TCOA on 12/3/21 and it was noted on this report that his level of care required "supervision at all times." Resident A's Guardian A1 was not informed of this change in care by providing Guardian A1 an updated assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed the IRs in Resident A's resident record. There were five completed IRs related to elopements. Resident A's resident logbook noted eleven incidents of elopement related to Resident A. Interviews with Ms. Hornburg and Guardian A1 concluded that neither party was informed of Resident A's exit seeking behaviors through written IR's.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
ANALYSIS:	Based on review of Resident A's record it was determined that Resident A had eleven documented elopements from the facility as recorded in his resident logbook by DCS Blankenberg and DCS Rhodabeck. Resident A's record contained five completed IRs related to elopement. After interviews with Guardian A1 and Ms. Hornburg it was established that the facility did not submit written IRs to either party regarding the elopements.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend no change to the status of this license.

05/24/2022

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Jana Lipps Date
Licensing Consultant

Approved By:

05/26/2022

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Dawn N. Timm Date
Area Manager