GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 9, 2022

Megan Fry
MCAP DeWitt Opco, LLC
Suite 115
21800 Haggerty Road
Northville, MI 48167

RE: License #: AM190404598
Investigation #: 2022A0790031
Addington Place of DeWitt 1

Dear Ms. Fry:

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,

Rodney Gill, 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 #:	AM190404598
Investigation #:	2022A0790031
Complaint Receipt Date:	08/01/2022
Investigation Initiation Date:	08/02/2022
Report Due Date:	09/30/2022
Licensee Name:	MCAP DeWitt Opco, LLC
Licensee Address:	Suite 115 21800 Haggerty Road Northville, MI 48167
Licensee Telephone #:	(517) 484-6980
Administrator:	Megan Fry
Licensee Designee:	Megan Fry
Name of Facility:	Addington Place of DeWitt 1
Facility Address:	1177 Solon Road DeWitt, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	11/02/2020
License **Status:**	REGULAR
Effective Date:	05/02/2021
Expiration Date:	05/01/2023
Capacity:	12

Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility and ended up in Oklahoma City, Oklahoma.	Yes

III. METHODOLOGY

08/01/2022	Special Investigation Intake 2022A0790031
08/02/2022	Special Investigation Initiated - On Site
08/02/2022	The APS referral made was denied for investigation on 07/31/2022.
08/02/2022	Inspection Completed On-site- Interviewed director of nursing Lacey Fegan, direct care worker (DCW) Becky Lamb, and Resident A.
08/02/2022	Contact - Document Received- Director of nursing Lacey Fegan emailed supporting documents.
08/04/2022	Inspection Completed-BCAL Sub. Compliance
08/04/2022	Contact - Telephone call made to Guardian A1.
08/04/2022	Exit Conference with licensee designee Megan Fry.

ALLEGATION:

Resident A eloped from the facility and ended up in Oklahoma City, Oklahoma.

INVESTIGATION:

Complainant stated Resident A is a 65-year-old female residing at Addington Place of Dewitt 1. Resident A has been diagnosed with dementia and bi-polar. Resident A's

guardian is her daughter. On 7/30/2022, Resident A was reported missing after leaving Addington Place at approximately 1:30 PM according to Complainant. Complainant stated direct care worker (DCW) Becky Lamb did not follow proper policy and procedure prior to allowing Resident A to leave the premises. Complainant disclosed Resident A was observed getting into a Black SUV and was later located in an airport in Oklahoma City, Oklahoma. According to Complainant, Resident A is at a Holiday Inn Hotel in Oklahoma City with law enforcement and Resident A's guardian is aware of Resident A's location. Adult Protect Services in Oklahoma has been contacted according to Complainant. Complainant said it is unknown if Adult Protective Services in Oklahoma is going to get involved. Complainant said Resident A will need assistance getting back to Michigan.

I conducted an unannounced onsite investigation on 08/02/2022. I interviewed director of nursing Lacey Fegan. Ms. Fegan stated Resident A's daughter and direct care worker DCW Mindi Willett, who functions as their admissions director, flew to Oklahoma City on 07/31/2022, spent the night, and flew back yesterday with Resident A.

Ms. Fegan said she was briefed on the events leading up to Resident A eloping from the facility. She said on 07/30/2022, Resident A told DCW Becky Lamb she was going to her daughter's house for a birthday party. Ms. Fegan said Resident A told Ms. Lamb her daughter was busy preparing for the party, so her daughter was sending a friend to pick her up.

Ms. Fegan said at approximately 1:30 p.m. an SUV arrived at the facility to pick up Resident A. She said residents and visitors must be let out of the facility by staff. Ms. Fegan said Ms. Lamb went to the front door, opened the door for Resident A out and allowed her to walk by herself to the SUV. Ms. Fegan stated Ms. Lamb did not ask who the individual was picking Resident A up, did not have them sign Resident A out, nor call Resident A's daughter to ensure it was okay to allow Resident A to go with the individual picking her up.

Ms. Fegan said the facility has a procedure in place DCWs are to follow when a resident is going on an outing. She stated DCWs are to adhere to the following protocol before allowing a resident to leave the facility:

- Ask who the individual is picking up the resident and how they are affiliated with the resident (family/friend/etc.).
- If it is the resident's guardian, they are to have the guardian sign out the resident.
- If it is not the resident's guardian, they are to call the guardian and get verbal permission to allow the resident to leave with the individual picking them up.

Ms. Fegan said they were later informed Resident A called Uber and requested a driver pick her up, booked a flight to Oklahoma City and a two night stay at a Holiday Inn Hotel in Oklahoma City. She said they are not certain how Resident A obtained the money to

do this but believe she either opened a credit card or used her daughter's bank card which was linked to her phone to pay the Uber driver and book the flight and hotel stay.

Ms. Fegan said Resident A was alone the entire time. She stated Resident A did not meet up with anyone and did not plan to return to Michigan. Ms. Fegan said Ms. Lamb is still employed at the facility as a DCW and is working today.

Ms. Fegan stated since Resident A eloped, management has shared the facility's procedure to be followed before allowing a resident to go on an outing on their Team Chat and posted it by the exit. Ms. Fegan said all DCWs must read and sign below the posted procedure indicating they have read and understand the steps required before allowing a resident to leave the facility. Ms. Fegan stated they also purchased and set out new sign in/out books for DCWs to use.

I interviewed DCW Becky Lamb who said she was the only DCW working in Addington Place of DeWitt 1 on 07/30/2022 when Resident A eloped. Ms. Lamb stated it is normal to have one DCW working at a time at the facility. Ms. Lamb said she arrived right at 12:00 p.m. on 07/30/2022 and Resident A came to her at 12:30 p.m. right after lunch and told her she was going to her daughter's house for a birthday party. Ms. Lamb stated she helped Resident A get cleaned up. She said Resident A had something on her shirt from lunch, so she helped Resident A change and braided her hair. Ms. Lamb said Resident A came back out of her room at around 1:15 p.m. and said she needed to take her insulin and 5:00 p.m. medication which is Metformin with her when she leaves. She stated Resident A said she would be back at the facility around 8:00 p.m. so would be back for her 9:00 p.m. medication.

Ms. Lamb stated Resident A was standing at the front door around 1:20 p.m. waiting for her ride. She noticed Resident A had her suitcase with wheels. Ms. Lamb stated she asked Resident A why she had the suitcase and Resident A said she needed to take a change of clothes and some adult briefs with her and taking it in her luggage with wheels was the easiest way she could think to transport it due to instability when she walks. Ms. Lamb said Resident A is often unsteady on her feet. Ms. Lamb said an SUV showed up at the facility to pick Resident A up at approximately 1:30 p.m. She said she unlocked the front door for Resident A and watched her walk on her own to the SUV. Ms. Lamb stated a man exited the vehicle, picked up Resident A's suitcase and put it in the backseat. She said Resident A got in the front passenger seat and the man got back in the driver's side of the vehicle and they drove away.

Ms. Lamb said she worked the remainder of her shift and when the third shift DCW came in she told her Resident A was gone, was at her daughter's house for a birthday party, would be back at around 8:00 p.m. and would need her 9:00 p.m. medication.

Ms. Lamb said she first found out something was wrong when police knocked on her door at 1:00 a.m. on 07/31/2022 questioning her about what had happened with Resident A while she was working the evening of 07/30/2022. Ms. Lamb stated she told the police exactly what she told me, and they left her residence. She said she then

noticed she had several missed calls from Ms. Fegan and the facility number. Ms. Lamb stated she had to work early the next morning and Ms. Willett told her police found Resident A in Oklahoma City and they are trying to help her get back to Michigan.

Ms. Lamb said she has not been disciplined for the incident, but management posted the procedure to be followed before allowing a resident to go on an outing on their Team Chat and posted it by the exit where DCWs enter and leave the facility. She said all DCWs must read and sign below the posted procedure indicating they have read and understand the steps required before allowing a resident to leave the facility.

Ms. Lamb stated she knows now what steps she should have followed before allowing Resident A to leave the facility on 07/30/2022 but did not at the time. She said she should have asked who the individual was picking up Resident A and how they know her. Ms. Lamb said since the individual was not Resident A's guardian, she should have called Resident A's guardian and received verbal permission to allow Resident A to leave the facility with the individual. Ms. Lamb said if she received permission from the guardian, she should have had the individual sign Resident A out.

Ms. Lamb said DCWs assist Resident A with all her activities of daily living, and she did not think Resident A could arrange and carry out such an elaborate plan. She said she feels bad and knows Resident A could have been harmed because she did not follow the established procedure when allowing a resident to go on an outing.

I observed the posted protocol on residents leaving the facility and at the bottom of the copy paper with the procedure written it read in bold lettering:

- **"Please read and sign below that you are aware of the protocol for residents leaving the building."**

I witnessed signatures and dates written on the bottom of the paper of DCWs who had reviewed the procedure.

The protocol read as follows:

1. Person picking up resident must come inside and introduce themselves.

2. Signature of POA/Guardian is required in the resident sign out book.

3. Make sure that Guardian/POA are notified if someone else besides them are picking up resident.

4. Time resident left the building.

5. Medications to be released and signed for to family (if applicable).

6. Ask for timeframe of when resident should be arriving back to the facility.

7. Phone number for Guardian/POA are listed in the emergency book.

8. Make sure that the oncoming shift is aware of the resident is out of the building and who the resident is with.

9. Make sure that the resident is signed back in as soon as they arrive.

I interviewed Resident A and she appeared shaky and weak. She said she is doing fine. Resident A stated she has diabetes and takes medication daily to control it. Resident A explained she does not like it at the facility, and she is not happy here because she feels "cooped up." She said she likes being outdoors and now she really is not going to get out. Resident A said the DCWs take care of her, and her needs are met. She stated she has been traveling all her life and wanted to go back to Oklahoma where she lived most of her life. Resident A said that is why she left the facility. She said she arranged for an Uber driver to pick her up and take her to the airport. Resident A said she also booked the flight to Oklahoma City before leaving the facility.

I reviewed Resident A's *Assessment Plan for AFC Residents* which documented Resident A is not able to move independently in the community. The *Assessment Plan for AFC Residents* also documented Resident A is not to manage her own money rather her guardian is to provide financial assistance.

I interview Resident A's guardian (Guardian A1) on 08/04/2022. Guardian A1 explained Resident A did reside in Oklahoma most of her adult life. She said Resident A suffers from mental illness (bipolar disorder) and diabetes and because Resident A's mental health and medical condition were getting so severe, she finally helped Resident A move to Michigan and with help got her a room at Addington Place of Dewitt 1. Guardian A1 said Resident A is well cared for at the facility and she has had no concerns prior to this incident regarding supervision. Guardian A1 said she had picked Resident A up on 07/29/2022 to spend some time at her house. She said she usually takes Resident A to her house or on an outing twice weekly. Guardian A1 stated she rings the doorbell and a DCW comes to the door and lets her into the facility. She said she has always been instructed to sign Resident A out of the facility by providing the date, her signature, an estimated time Resident A will be returning to the facility, and her phone number.

Guardian A1 said she received a call at 12:00 a.m. on 07/31/2022 from the night nurse at the facility asking when she planned to bring Resident A back. She told the night nurse Resident A was not with her. Guardian A1 said she was informed Resident A had left the facility with an unknown gentleman in an SUV at approximately 1:30 p.m. on 07/30/2022. Guardian A1 stated she later found out Resident A had contacted a friend she used to live with in Bath, MI and told her she had a very important bank statement she must have delivered to the friend's house because no one else can know about it. Guardian A1 said the friend dropped off the letter from the bank to Resident A, which later was found to contain a bank card Resident A had applied and was approved for from a bank in Oklahoma where she has always done her banking. Guardian A1 stated

Resident A used the bank card to pay the Uber Driver, book the plane ticket to Oklahoma City, as well as other expenses.

Guardian A1 said the facility contacted Dewitt Township Police Department and they put out an all-points bulletin (APB) for Resident A. She said Dewitt Township Police received a call shortly after from law enforcement in Oklahoma City indicating Resident A had landed there, gotten off the plane looking confused and disoriented so airport employees approached her asking if she needed assistance. Guardian A1 said Resident A requested help finding a place to stay explaining she just arrived from Michigan. Law enforcement and Adult Protective Services were contacted, set Resident A up in a Holiday Inn Hotel, and remained with her until Guardian A1 and Ms. Willett arrived in Oklahoma City on 07/31/2022. Guardian A1 said they spent the night and returned with Resident A on 08/01/2022.

Guardian A1 said she feels the incident was a major oversight on the part of the facility and Resident A could have been harmed, but facility DCWs and administrators also played a major role in getting Resident A home safely.

The APS referral made was denied for investigation on 07/31/2022.

I conducted an exit conference with licensee designee Megan Fry on 08/04/2022 and informed her a violation was established during the investigation. Ms. Fry agreed with the outcome of the investigation and said she would complete and implement a Corrective Action Plan (CAP) within the required timeframe.

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 information gathered during this special investigation through review of documentation and interviews with director of nursing Lacey Fegan, DCW Becky Lamb, Resident A, and Guardian A1 there is evidence indicating adequate supervision was not provided as defined in the act and as specified in the resident's written assessment plan. Resident A was not able to move independently in the community according to her *Assessment Plan for AFC Residents*. DCW Becky Lamb allowed Resident A to leave the facility on 07/30/2022 and did not follow the facility's established protocol before permitting her to leave. Resident A ended up taking an Uber to an airport and flying to Oklahoma City, Oklahoma, without any supervision and therefore was allowed to move independently in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

08/04/2022

Rodney Gill Date
Licensing Consultant

Approved By:

08/09/2022

Dawn N. Timm Date
Area Manager