GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 19, 2022

Michael Garland
PO Box 423
Hubbell, MI 49934

RE: License #: AM310310003
Investigation #: 2022A0873004
Hubbell Haven AFC Home

Dear Mr. Garland:

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) 643-7960.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 250-9318

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM310310003
Investigation #:	2022A0873004
Complaint Receipt Date:	07/01/2022
Investigation Initiation Date:	07/01/2022
Report Due Date:	08/30/2022
Licensee Name:	Michael Garland
Licensee Address:	27012 West 21st Street Hubbell, MI 49934
Licensee Telephone #:	(906) 296-0041
Administrator:	Michael Garland
Licensee Designee:	N/A
Name of Facility:	Hubbell Haven AFC Home
Facility Address:	27012 West 21st Street Hubbell, MI 49934
Facility Telephone #:	(906) 296-0041
Original Issuance Date:	02/24/2011
License Status:	REGULAR
Effective Date:	08/24/2021
Expiration Date:	08/23/2023
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was found by police in the middle of the night wandering the street in a storm.	Yes
Additional Findings	No

III. METHODOLOGY

07/01/2022	Special Investigation Intake 2022A0873004
07/01/2022	Special Investigation Initiated - On Site
07/01/2022	APS Referral
07/06/2022	Contact - Document Received Received IRs, copies of notes from Resident A to Licensee, Care Agreement, Assessment Plan, Behavioral Health Info via USPS
07/29/2022	Contact - Document Received Received copy of eviction letter to Resident A via USPS
08/02/2022	Contact - Telephone call made Spoke to Home Manager who reports Resident A is currently hospitalized in Ann Arbor. Also left a message to have Licensee call back.
08/07/2022	Inspection Completed-BCAL Sub. Compliance
08/11/2022	Contact - Telephone call received Spoke with home manager about Resident A's new placement.
08/17/2022	Exit Conference - Spoke with Mike Garland, Licensee
08/17/2022	Corrective Action Plan Requested and Due on 09/01/2022
8/19/2022	Exit Conference - Spoke to Mr. Garland about the second rule violation included in the report

ALLEGATION: Complaint alleges Resident A was picked up by police at 2:30am on the side of the road during a rainstorm. Staff was not aware of Resident A's whereabouts.

INVESTIGATION: On 6/30/22 I received an incident report from Hubbell Haven AFC which reported that at 2:30am on the morning of 6/30/22, Mike Garland, licensee, received a call from a Houghton County Deputy that Resident A was found walking barefoot in the rain on Highway 26. According to the incident report, Resident A told police that she wanted to go to the local hospital. The Deputy drove her to the hospital where she was admitted. At 8:30am that same day Mr. Garland called the hospital and verified Resident A was there. At 10:30am Resident A was discharged from the hospital and Mr. Garland picked her up and brought her back to the home. The incident report details that no corrective measures were taken to prevent this from reoccurring and that the "VA and AFC are looking for alternative living places for [Resident A]."

On 7/1/22, I conducted an unannounced, onsite investigation to address the complaint. I spoke with Mr. Michael Garland, licensee, as well as Ms. Michelle Mace, home manager. Mr. Garland reiterated what was in the incident report about what happened that night. I was told that Resident A has not been living at the home long but it quickly became apparent to the staff that her needs were too high to be met by the home. I was told that the home, as well as Veterans Affairs, were working on finding Resident A more suitable placement. Mr. Garland reported he has, in the past, had residents with dementia and this has helped him realize the home's limitations in caring for certain individuals with higher needs. Mr. Garland reported that residents are free to come and go as they please and there is no sign-out sheet in the home for residents to report that they left the home or report when they may return.

That same day I reviewed a copy of Resident A's Assessment Plan for AFC Residents which details Resident A is allowed to move independently through the community. Further, the Assessment Plan states that Resident A's hobbies and special interests include walking and that for both physical exercise and recreation Resident A enjoys walking.

On 7/1/22, I interviewed Resident A who confirmed everything happened as written in the incident report. Resident A reported that at approximately 9pm on June 29th she decided she wanted to take a walk. Resident A reports that she has been diagnosed with schizophrenia which often manifests to her as hearing voices. Resident A reported that walking helps to alleviate the symptoms of her mental health diagnosis. Resident A reported that she will take very longs walks for several miles and often of several hours. On the night of June 29th Resident A reported that after leaving the home at 9pm and walking for several hours, it began raining at approximately 2:30am, now the morning of June 30th. At this point Resident A reports she took her boots off and began to walk barefoot. Resident A was reluctant to go home and wanted to go to the hospital. Resident A stated that at this point she

was walking along the highway. A vehicle stopped and a man in the vehicle began a conversation with Resident A, telling her that she should not be walking on the side of the road because he almost hit her with his car. The driver offered to call the police. Resident A then walked a bit further to a fire station and sat there until the police arrived. As the incident report states, Resident A was then taken to the hospital.

Resident A reported to me that she feels safe at the home and enjoys living there. While I was there, I noticed other residents preparing for lunch. All seemed to be well taken care of content in their surroundings.

On 7/29/22, I received a copy of the eviction letter the licensee gave to the resident. The eviction letter states the licensing rules that explain the circumstances in which a licensee can evict a resident. The letter goes on to list many instances of Resident A self-harming, being physically aggressive and violent toward the licensee, and instances in which Resident A engaged in property destruction. Resident A's behavioral health information from Chippewa County War Memorial Behavioral Health Center also details Resident A's risk to herself along with diagnoses of schizoaffective disorder, PTSD, and generalized anxiety disorder.

On 8/2/22, I called the home and spoke with Ms. Mace, the home manager, who reported that Resident A is no longer at the home, having been committed to a psychiatric facility in Ann Arbor. The home manager also informed me that once she is released from this facility, she will be placed at a separate residential facility in Iron Mountain, Michigan.

On 8/17/22, I conducted an exit interview with Mr. Garland. I explained to Mr. Garland the necessity of a corrective action plan because of this incident, specifically, because no one at the home was aware of Resident A's whereabouts while she was walking along the highway in a rainstorm. Per the licensing rule outlined below, in instances such as this, the resident should have been reported to the police as missing from the premises. Instead, the police contacted the licensee in the middle of the night. Mr. Garland is aware of the need for a corrective action plan and is currently at work developing a process to prevent incidents like this from happening in the future.

On 8/19/22, I spoke with Mr. Garland about modifying the report to include two rule violations instead of just one. The second rule violation pertaining to knowing the general whereabouts of residents. Mr. Garland reported to me that he understood and will continue to work on the corrective action plan.

APPLICABLE RULE	
MCL 400.707	**Definitions; R to T.** **(7)"Supervision" means guidance of a resident in the activities of daily living, including all of the following:** **(d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.**
ANALYSIS:	Because there was no sign out sheet for residents to report when they were leaving and when they would be back, staff at the home were not aware where Resident A was nor when she would be back.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(b) Contact the local police authority.**
ANALYSIS:	After conducting an investigation, it became apparent that no one at the home knew of Resident A's whereabouts on the night of June 29th/morning of June 30th. As the licensing rules state, in the event of a resident absence, it is incumbent upon the staff of the home to contact the local police authority. In this case, the police contacted the home to report they had found Resident A walking along the highway, shoeless, in a rainstorm.
CONCLUSION:	**VIOLATION ESTABLISHED**

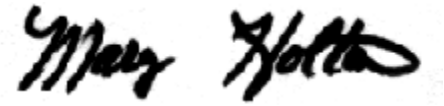
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the status of this home's license.

8/19/2022

Garrett Peters — Date
Licensing Consultant

Approved By:



08/19/2022

Mary E Holton — Date
Area Manager