November 22, 2022

Steven Wilson
Whispering Pines 2 AFC, LLC
1878 Soules Rd.
Afton, MI 49705

RE: License #: AM160386603
Investigation #: 2023A0009005
Whispering Pines 2

Dear Mr. Wilson:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM160386603
Investigation #:	2023A0009005
Complaint Receipt Date:	11/01/2022
Investigation Initiation Date:	11/01/2022
Report Due Date:	12/01/2022
Licensee Name:	Whispering Pines 2 AFC, LLC
Licensee Address:	1878 Soules Rd. Afton, MI 49705
Licensee Telephone #:	(231) 238-9715
Administrator:	Dorthy Wilson
Licensee Designee:	Steven Wilson
Name of Facility:	Whispering Pines 2
Facility Address:	1878 Soules Rd. Afton, MI 49705
Facility Telephone #:	(231) 238-9715
Original Issuance Date:	06/05/2017
License Status:	REGULAR
Effective Date:	12/05/2021
Expiration Date:	12/04/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was allowed to leave the facility by himself. He ended up wandering for several hours.	Yes

III. METHODOLOGY

11/01/2022	Special Investigation Intake 2023A0009005
11/01/2022	Special Investigation Initiated – Telephone to Resident A's Guardian
11/04/2022	Inspection Completed On-site Interview with direct care worker James Pasini, administrator Dorthy Wilson and Resident B
11/04/2022	Contact - Telephone call received from licensee designee Steven Wilson
11/04/2022	Exit Conference Licensee Steven Wilson
11/22/2022	APS Referral

ALLEGATION: Resident A was allowed to leave the facility by himself. He ended up wandering for several hours.

INVESTIGATION: I spoke with Resident A's Guardian by phone on November 1, 2022. She said that she was concerned because Resident A was allowed to leave the facility without staff supervision. It was her understanding that Resident A went to a worksite with another resident. Resident A became upset about something that happened at work so he just walked away and was missing for six hours. They finally found him several miles away from the worksite. Resident A's guardian told me that she was aware of how Resident A had lived before coming into care. She knew that he could not take care of himself and could not be away from the facility without supervision. She has indicated to the facility that she does not want Resident A leaving without supervision.

I made an unannounced site visit at the Whispering Pines 2 adult foster care (AFC) home on November 4, 2022 and spoke with administrator Dorthy Wilson. She reported that Resident A was currently with Mr. Wilson on an outing. I asked her about Resident A being allowed to wander for several hours the other day. Ms.

Wilson said that she knew that Resident A went with another resident to a worksite for employment. Resident A became angry while there so he walked off. She said that she wasn't sure exactly what happened, but that direct care worker James Pasini had worked that day.

I then spoke with direct care worker James Pasini. He said that he hadn't worked early in the day but had arrived later. He said that Resident A's guardian had verbally given Resident A permission to leave the facility without supervision in the past. He stated that Resident A does not work on a regular basis, only sporadically. Mr. Pasini acknowledged that he did not know whether Resident A's guardian had given verbal permission that particular day for Resident A to leave unsupervised. He said that he believes that Resident A has good independent skills. Regarding the day that Resident A wandered, Resident A and Resident B both went to work at a worksite. Resident A became upset on the worksite because of something that was said there. Resident A would not do what the employer was asking him to do. The employer had already decided that he would bring Resident A back to the facility, but Resident A walked off the worksite before he could do so. This happened around 1:00 p.m. Mr. Pasini stated that he had left to take another resident to an appointment so he could not immediately leave to locate Resident A. He said Resident A has "gone to town" by himself before and has hitchhiked or asked people for rides. Resident A always has money on him. On the day in question, Resident B had come home later in the day without Resident A. Mr. Pasini said that he left at that time to find Resident A. He found Resident A at a gas station not far from the worksite late in the afternoon. Resident A had asked people at the gas station for a ride back to the facility but had not been successful in that endeavor.

I spoke again with administrator Dorthy Wilson. She said that she was not aware of anything in Resident A's guardianship papers or his Community Mental Health paperwork that said he could not leave the facility unsupervised. I asked for Resident A's Assessment Plan for AFC Residents (BCAL-3265). I looked under the Social/Behavioral Assessment Plan of Action section. For Moves Independently in Community, it was checked "No". In the Comment section it was written, "Needs 24/7 Supervision". Someone had whited out a check mark that had been in the "Yes" box and had checked "No". Ms. Wilson stated that she had not seen that the guardian had changed that. She had sent the document to Resident A's guardian who had returned it. I told Ms. Wilson that she needed to make sure she is aware of anything that is in a resident's assessment. If she does not agree with something, that is the time to discuss it with the other party. I told her that since the Assessment indicated "No" and that Resident A "Needs 24/7 Supervision", he should not have been going into the community by himself. Ms. Wilson indicated that she understood.

Resident A was not present at the facility during the time of my site visit, but Resident B was there. I spoke with Resident B at that time. He said that Resident A was not working so the boss said that he was going to take Resident A back home. Before that could happen, Resident A "took off". They did not see him leave and did

not know what direction he had gone. He said that he and the boss looked for him but could not find him. He then called direct care worker James Pasini and told him what had happened.

I then received a phone call from licensee designee Steven Wilson later that day. He admitted that they had not seen that Resident A's Assessment Plan had been changed by the guardian when it came back. He said that he would make sure that they did that going forward.

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:	It was confirmed through this investigation that Resident A's written assessment plan indicated that he could not move independently in the community and required "24/7 Supervision". The plan was not followed when Resident A was allowed to go offsite without staff supervision. Resident A ended up walking off a worksite where he and another resident had gone for employment. Resident A wandered for several hours and was not able to find his way back to the facility on his own.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with licensee designee Steven Wilson by phone on November 4, 2022. I told him of the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

11/22/2022

Adam Robarge Date
Licensing Consultant

Approved By:

11/22/2022

Jerry Hendrick Date
Area Manager