GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2023

Phillip Mastrofrancesco
Mastrofrancesco AFC Inc
Suite #5
23933 Allen Road
Woodhaven, MI 48183

RE: License #: AS580067669
Investigation #: 2023A0116020
Binkley Manor

Dear Mr. Mastrofrancesco:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS580067669
Investigation #:	2023A0116020
Complaint Receipt Date:	01/26/2023
Investigation Initiation Date:	01/27/2023
Report Due Date:	03/27/2023
Licensee Name:	Mastrofrancesco AFC Inc
Licensee Address:	Suite #5 23933 Allen Road Woodhaven, MI 48183
Licensee Telephone #:	(734) 671-3654
Administrator:	Phillip Mastrofrancesco
Licensee Designee:	Phillip Mastrofrancesco
Name of Facility:	Binkley Manor
Facility Address:	5041 Northfield Dr Monroe, MI 48161
Facility Telephone #:	(734) 241-1694
Original Issuance Date:	11/06/1995
License Status:	REGULAR
Effective Date:	07/21/2022
Expiration Date:	07/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 01/20/23, I received a recipient rights report that documented on 10/18/22, staff, Danielle Corser and Destiney Jennings were asleep/not alert and Resident A eloped from the home without their knowledge. On 10/19/22, staff, Joanna Kortas and Julie Wagner were asleep/not alert and Resident A eloped from the home again without staff knowledge.	Yes

III. METHODOLOGY

01/26/2023	Special Investigation Intake 2023A0116020
01/26/2023	Referral - Recipient Rights Received.
01/27/2023	Special Investigation Initiated - On Site Interviewed home manager Keely Green, visually observed Resident A, and interviewed Guardian (A).
01/31/2023	Contact - Telephone call made Interviewed licensee designee, Phillip Mastrofrancesco.
02/06/2023	Contact - Telephone call made Interviewed staff, Julie Wagner.
02/06/2023	Contact - Telephone call made Interviewed staff, Destiney Jennings.
02/06/2023	Contact - Telephone call made Left a message for staff, Danielle Corser, requesting a return call.
02/06/2023	Inspection Completed-BCAL Sub. Compliance
02/10/2023	Exit Conference With licensee designee, Phillip Mastrofrancesco.

ALLEGATION:

On 01/20/23 I received a recipient rights report that documented on 10/18/22, staff, Danielle Corser and Destiney Jennings were asleep/not alert and Resident A eloped from the home without their knowledge. On 10/19/22, staff, Joanna Kortas and Julie Wagner were asleep/not alert and Resident A eloped from the home again without staff knowledge.

INVESTIGATION:

On 01/26/23, I received and reviewed the recipient rights summary report. In summation, the report substantiated neglect class III against the four staff members responsible for the care of Resident A on 10/18/22 and 10/19/22. The report details that on 10/18/22, Destiney Jennings and Danielle Corser were asleep/not alert while on shift and Resident A eloped from the home without their knowledge. The report further documents that on 10/18/22 at 5:03 a.m. Monroe County Central Dispatch received a call that a female in a wheelchair was in the middle of the roadway and was almost hit by the caller. Officers returned the resident to the group home without incident. On 10/19/22, at 4:35 a.m. Monroe County Sheriff's Deputy Jacob Bates, documented that he was dispatched to S. Dixie Road for a woman in a wheelchair in the middle of the roadway. Deputy Bates spoke with the caller who stated observing the female in a wheelchair in the road and reported she was almost hit by traffic. Deputy Bates returned the female to the group home and the two female staff members were unaware that she had gotten out of the home. Deputy Bates documented that the resident did not have any injuries but was exposed to cold temperatures for quite some time, was outside in a short sleeve t- shirt and had no socks or shoes on. Deputy Bates documented that he contacted Adult Protective Services (APS) and reported the incident.

On 01/27/23, I conducted an unscheduled onsite inspection and interviewed home manager, Keely Green, visually observed Resident A as she is non-verbal, and interviewed Guardian (A). Ms. Green reported that both occurrences happened during the midnight shift (11:00 p.m.-7:00 a.m.) and reported she was not working during those times. Ms. Green reported that staff, Destiney Jennings, and Danielle Corser failed to inform her about the incident on 10/18/22, with Resident A getting out of the home without their knowledge and reported they later told her they were scared that they would lose their jobs. Ms. Green reported that she did not know about the 10/18/22, incident until 10/19/22, after being informed that the same thing had happened while staff Julie Wagner and Joanna Corser were working the midnight shift. Ms. Green reported she immediately notified the rights office and contacted Resident A's guardians to inform them of both incidents. Ms. Green reported that Ms. Corser, Ms. Jennings, and Ms. Wagner were all written up. She reported that Ms. Kortas was terminated as there were additional issues with her work performance.

Ms. Green reported that since the incident a chair has been placed in the hallway during midnight shift that one of the two staff sit in to provide closer monitoring of Resident A. Ms. Green reported that if Resident A attempts to elope, she would have to come out to that hallway to get to the front door. Ms. Green reported that according to staff Resident A has not attempted to elope since the initial incident. Ms. Green further reported that the exit doors have been alarmed, and she is executing unannounced visits to the home during midnight shift to ensure staff is awake and alert. Ms. Green further reported that a staff meeting was held informing

staff of the ramifications of sleeping on shift and reiterated staff requirements to report all incidents to her, regardless of fear of disciplinary action or termination.

Ms. Green reported that APS came to the home in October ’22 and investigated the allegations. Ms. Green reported she was unaware of the outcome of their investigation.

I visually observed Resident A and she appeared clean and was neatly dressed. Resident A was excited as she was going home for the weekend.

I interviewed Guardian (A) and he reported that he was informed by Ms. Green of both incidents of Resident A getting out of the home without the staff being aware. Guardian (A) reported that he is just glad she was not harmed. Guardian (A) reported he is not upset with the staff and reported that Resident A has a history of eloping while she lived at home, and it was difficult to prevent. Guardian (A) reported that he is pleased with the measures the home has put in place and reported that he is happy that it has not happened again.

On 01/31/23, I interviewed licensee designee, Phillip Mastrofrancesco and he reported that he was aware of both incidents and stated three of the staff were written up and one was terminated. Mr. Mastrofrancesco also reported that there has not been a recurrence and that the measures he and Ms. Green have implemented in the home have worked.

On 02/06/23, I interviewed staff, Julie Wagner, and she reported that she is currently on medical due to some health issues. Ms. Wagner agreed to be interviewed and reported that was worked midnights on 10/19/22, with staff Joanna Corser. Ms. Wagner admitted that they both fell asleep on shift and were awakened by the police sometime around 4:45 a.m. Ms. Wagner reported the officer informed them that Resident A had gotten out of the house and was in the street unattended and they were returning her home. Ms. Wagner accepted full responsibility for the matter and reported she was not going to make any excuses for what happened.

On 02/06/23, I interviewed staff Destiney Jennings and she reported that she and Danielle Corser worked the midnight shift on 10/18/22 and admitted that they both fell asleep. Ms. Jennings reported that sometime during the early morning hours the police called the house and were outside with Resident A. Ms. Jennings reported that Ms. Corser went outside, spoke with the officers, and brought Resident A in the home. Ms. Jennings admitted her wrong and reported had she and Ms. Corser informed Ms. Green about Resident A getting out, they could have prevented it from happening the following night. Ms. Jennings added that she is glad that Resident A was not harmed and reported that she is not sleeping on shift and is keeping a closer eye on Resident A.

On 02/10/23, I conducted the exit conference with licensee designee, Phillip Mastrofrancesco and informed him of the findings of the investigation and the

specific rule violation cited. Mr. Mastrofrancesco reported an understanding and stated that upon receipt of the report he would submit a corrective action plan to address the violation.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff 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:	Based on the findings of the investigation, which included review of the recipient rights summary report, interviews of Ms. Green, Ms. Wagner, and Ms. Jennings, I am able to corroborate the allegations. Ms. Green confirmed that on 10/18/22 and 10/19/22 Resident A eloped from the home while the staff on shift were asleep. Ms. Wagner admitted that she and Ms. Kortas were the staff on shift on 10/19/22 and were responsible for the care of Resident A. Ms. Wagner admitted that both she and Ms. Kortas were asleep during their shift and were not aware that Resident A had eloped until the police returned her to the home. Ms. Jennings admitted that she and Ms. Corser were the staff on shift on 10/18/22 and were responsible for the care of Resident A. Ms. Jennings admitted that both she and Ms. Corser fell asleep during their shift and were not aware that Resident A had eloped from the home until the police returned her. This violation is established as the home did not have sufficient staff on duty at all times for the supervision, personal care and protection of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

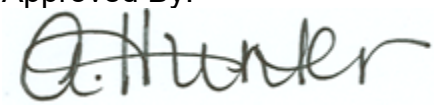
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

02/10/23

Pandrea Robinson — Date
Licensing Consultant

Approved By:



02/15/23

Ardra Hunter — Date
Area Manager