GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2025

Mary Fussman
Central Mich Non-Profit Housing
P.O. Box 631
Mt. Pleasant, MI 488040631

RE: License #: AM370404603
Investigation #: 2025A1029041
McVey Street Home

Dear Mrs. Fussman:

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 licensee designee 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.

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM370404603
Investigation #:	2025A1029041
Complaint Receipt Date:	06/03/2025
Investigation Initiation Date:	06/03/2025
Report Due Date:	08/02/2025
Licensee Name:	Central Mich Non-Profit Housing
Licensee Address:	901 McVey St, PO Box 631 Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 772-0574
Administrator:	Mary Fussman
Licensee Designee:	Mary Fussman
Name of Facility:	McVey Street Home
Facility Address:	901 McVey, Mt Pleasant, MI 48858
Facility Telephone #:	(989) 772-3359
Original Issuance Date:	01/25/2021
License Status:	REGULAR
Effective Date:	06/28/2023
Expiration Date:	06/27/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 06/02/2025 Resident A eloped from McVey Street Home and was found outside the home on the sidewalk crying and asking for help.	Yes

III. METHODOLOGY

06/03/2025	Special Investigation Intake 2025A1029041
06/03/2025	Special Investigation Initiated – Telephone to complainant
06/03/2025	Contact - Telephone call made to direct care staff member Denise Wohlscheid
06/04/2025	Referral - Recipient Rights - Made ORR referral
06/04/2025	APS Referral made to Centralized Intake
06/05/2025	Contact - Telephone call received - ORR Angela Wend
06/05/2025	Contact - Telephone call made to APS Alison Witucki, Guardian A1, and direct care staff member Cathy Watson
06/06/2025	Inspection Completed On-site - Face to Face with ORR Angela Wend, Deb Tremain, Jennifer Hodges, Resident A at McVey Home.
06/13/2025	Contact - Telephone call received from APS Alison Witucki
06/17/2025	Contact - Telephone call made to licensee designee Mary Fussman, direct care staff member Tiara Kyser, Alexis Sperry, and Jennifer Hodges
06/17/2025	Exit Conference with licensee designee Mary Fussman

ALLEGATION: On 06/02/2025 Resident A eloped from McVey Street Home and was found outside the home on the sidewalk crying and asking for help.

INVESTIGATION:

On 06/03/2025, a complaint was received via Bureau of Community and Health Systems online complaint system alleging Resident A eloped from McVey Street Home and was found outside the home at the neighbor's home on the sidewalk crying and asking for help. According to Complainant, a community member went to the door at McVey Street Home, asked if there was a resident missing, and direct care staff member Ms. Watson came out, saw Resident A, and stated "Yes, that's one of ours." According to the complaint allegations, Resident A had blood on her leg but direct care staff member Ms. Watson did not seem to be concerned about her bleeding and told her coworker, "She decided to go out and go for a walk. She is bleeding from somewhere but don't know where." Office of Recipient Rights (ORR) advisor Angela Wend and Adult Protective Services (APS) Alison Witucki were also assigned to investigate the allegation.

On 06/03/2025 I contacted Citizen 1. Citizen 1 stated she observed Resident A outside near McVey Street Home and noticed Resident A on the ground outside at the neighbor's home near the curb with one slipper on. Citizen 1 stated she watched her and then went over to see if she needed assistance and when she went up to her, Resident A was crying and saying "help". Citizen 1 stated she could see that Resident's A's other slipper was toward the AFC so she figured that is where she walked from. Citizen 1 stated she went to the door of McVey Street AFC and asked if they were missing a resident but the direct care staff member Ms. Watson was unaware a resident was missing. Citizen 1 stated she walked with Ms. Watson to Resident A and pointed out there was blood by Resident A's ankle. Citizen 1 stated that Ms. Watson just said, "oh okay" and Citizen 1 assisted Ms. Watson with standing Resident A up. Citizen 1 stated she does not know how long Resident A was outside however, it was less than 2 hours because when they left the area at 5 PM she was not outside but she was found around 7 PM.

On 06/05/2025 I interviewed APS worker Ms. Witucki. Ms. Witucki stated she completed a visit to McVey Street Home and she met with direct care staff member whose role is home manager Denise Wohlscheid who did not know about the incident of Resident A getting out of the home and being found outside. Ms. Witucki stated there was no documentation completed regarding the incident in the progress notes and she was not notified this occurred. Ms. Witucki stated there was documentation they had to redirect Resident A a couple times in the house during the day but nothing about her leaving the home unsupervised.

On 06/05/2025 I interviewed Guardian A1 who stated she was not aware of the concerns until she spoke with APS Ms. Witucki. Guardian A1 stated to her knowledge Resident A has not wandered off before but sometimes she will go outside and sit in the sun. Guardian A1 stated she did not receive an *AFC Incident / Accident Report* for this

incident. Guardian A1 stated she has not had any concerns about the supervision before this incident but is now concerned if Resident A elopes again from the home because she has recently had asthma and pneumonia and she is concerned about aspiration. Guardian A1 stated Resident A is mostly nonverbal and she cannot go out in the community on her own as she would not be able to ask for assistance if she was lost.

On 06/05/2025 I interviewed direct care staff member Cathy Watson. Ms. Watson stated there are usually two staff with Resident A when they go for outings "because she likes to wander off in the community." Ms. Watson stated she does not typically wander when she is in the AFC. Ms. Watson stated, "there are 9 other clients to keep an eye on but they try their best to keep an eye on them." Ms. Watson stated typically Resident A likes to sit in the recreation room and watch games shows. Ms. Watson stated sometimes they take her for walks outside around the house but she is not able to go for walks alone. Ms. Watson stated she was there on the evening of 06/02/2025 when Resident A was found in the street and she was surprised because she thought she was in the recreation room. Ms. Watson stated she was in the office completing the progress notes and charts for the day and the other direct care staff member Tiara Kyser was doing laundry. Ms. Watson stated in the past they have had alarms on the doors however they are not working at this time. Ms. Watson stated when she was doing the paperwork, Resident A must have left from the garage door because she did not see her walk by the office to the front door. Ms. Watson stated she did not realize Resident A had left the home until there was a knock on the door from a community member who stated, "are you missing a client?" and she showed her where Resident A was sitting on the curb in front of the neighbor's home. Ms. Watson stated she was able to get Resident A up off the curb while Ms. Kyser was walking out to meet her and they were able to assist Resident A back into McVey Street Home. Ms. Watson stated she does not know if Resident A fell or was tired and just sat down on the curb but she believes she sat down. Ms. Watson stated she does not know if she stubbed her toe or had a scratch on her ankle but her foot had a few drops of blood on it but it was not bleeding by the time she got back to the house. Ms. Watson stated she did not do any first aid on her foot or clean the area that was bleeding when they were inside. Ms. Watson stated she did not know how long Resident A was at the neighbor's home but it was possibly around 3-4 minutes because they just walked through the rec room and she was in there watching television. Ms. Watson stated she documented in Resident A's progress notes that earlier on 06/02/2025, Resident A was trying to get outside on multiple occasions. Ms. Watson stated she did not add the details of this incident to Resident A's progress notes for 06/02/2025. Ms. Watson stated they did not do an *AFC Incident / Accident Report,* update Resident A's progress notes to include this incident, or notify Guardian A1 that Resident A left the facility.

On 06/06/2025 ORR advisor Ms. Wend and I completed an unannounced on-site investigation at McVey Street Home and interviewed direct care staff member whose role is assistant administrator, Jennifer Hodges. Ms. Hodges stated she was informed yesterday by Ms. Wohlscheid about the incident after APS Ms. Witucki came to visit. Ms. Hodges stated the direct care staff members working at the time where Kathy

Watson, Alexis Perry, and Tiara Kyser. Ms. Hodges stated there are always two or three direct care staff members assigned to each shift. Ms. Hodges stated Resident A's *Person Centered Plan* (PCP) clearly states Resident A needs line of site supervision in the community. Ms. Hodges stated there was also no mention of the incident to third shift so they could keep an eye on Resident A if she tried to leave the facility again. Ms. Hodges stated there has been a recent decline in Resident A's health because cognitively she does not understand and she has been confused and trying to wander more lately. Ms. Hodges stated they were in the process of setting up an appointment with a neurologist.

I was able to observe Resident A. Ms. Wend and I looked at her foot and we did not see any scrapes on it. Resident A shook her head "no" when asked if she remembered any blood or scrapes in her foot or going outside. Resident A was observed to be smiling and happy. Due to her diagnosis, she was unable to complete an interview regarding the allegations.

During the on-site I reviewed the following documents in Resident A's resident record:

1. Resident A's *Assessment Plan for AFC Residents* stated Resident A does not move independently in the community and "Staff will assist her getting out in the community."
2. *Adult Foster Care Incident/ Accident Report* written by Denise Wohlscheid completed on 06/05/2025 which was after the incident.
3. I also reviewed the progress notes written by Ms. Watson for second shift (3 PM – 11 PM) on 06/02/2025:

   "[Resident A] was wandering / walking around house when staff arrived. She was redirected two times from opening doors to go outside. She was showered and changed into PJ's. She ate 100% of dinner. She drank all fluids. She watched TV, ate snack, received meds, assisted into bed and is now sleeping at end of shift."

4. Resident A's *Person Centered Plan* which states:

   "[Resident A] has learning difficulties requiring increased support and supervision for safety and monitoring for going ahead of the group when in the community. [Resident A] has poor judgement and does not pay attention to her surroundings in the community. Line of sight would be necessary for [Resident A] due to her chance of potentially wandering off, and to mitigate any fall risk on uneven ground. [Resident A] does not always pay attention when out in the community when crossing streets or in parking lots."

On 06/17/2025 I interviewed direct care staff member Tiara Kyser. Ms. Kyser stated she was in the laundry room while Ms. Watson and Ms. Sperry were in the office. Ms. Kyser stated she does not know how Resident A got out of the door without them seeing Resident A but she heard the knock on the door from a neighbor who asked if a resident was missing. Ms. Kyser stated she does not know where Resident A was found because they were on their way up the driveway when she went outside. Ms. Kyser stated she is not sure if Resident A has ever eloped before. Ms. Kyser stated there have been times that Resident A has went to the door and tried to go out but usually

they can stop her before she leaves. Ms. Kyser stated she does not know what documentation was completed about this incident. Ms. Kyser stated now they are completing 30 minute checks and there must be at least one direct care staff member out on the floor always paying attention to the 10 residents. Ms. Kyser stated the actual garage door is usually open when she's working and she was told it's a fire exit so it has to stay open. Ms. Kyser stated after the incident, she did not complete any documentation or contact Guardian A1. Ms. Kyser stated Ms. Watson should have documented this in the progress notes for the shift. Ms. Kyser stated there is now a sheet in Resident A's book to document how many times Resident A tries to leave the facility. Ms. Kyser stated Resident A has made multiple attempts since this incident but she has never made it outside.

On 06/17/2025 I interviewed direct care staff member Alexis Sperry. Ms. Sperry stated she was in the office doing notes but stated she was told by direct care staff member Ms. Watson that "she (Resident A) got outside and had a scrape on her knee." Ms. Sperry stated she asked Ms. Watson if they should have done an *AFC Incident / Accident Report* because of the scrape and her getting outside, and Ms. Watson told her "no". Ms. Sperry stated she is a fairly new direct care staff member so she was asking for clarification. Ms. Sperry stated she does not know what door Resident A went out of but she stated she did hear the doorbell when the neighbor came and asked if they were missing a resident. Ms. Sperry stated she does not know how long Resident A was outside but her supervision guidelines state that she has to go outside with another direct care staff member.

On 06/17/2025 I interviewed licensee designee Mary Fussman. Ms. Fussman stated she did not know anything about the incident until APS Ms. Witucki completed her visit and informed Ms. Wohlscheid of the incident. Ms. Fussman stated she is surprised by this because Ms. Watson is an experienced direct care staff member and she knows the procedures. Ms. Fussman stated she does not know why it was not documented because she always tells the direct care staff members when in doubt to document it. Ms. Fussman stated during the day there was documentation that direct care staff had to redirect Resident A several times because she was trying to leave so they should have been more aware. Ms. Fussman stated this is a relatively new behavior for Resident A so they are working with CMH and the Behavioral Treatment team to address these concerns and possibly use the alarms again. Ms. Fussman stated Resident A does not move that fast so it probably took her longer than a few minutes to get to the neighbor's home. Ms. Fussman stated she was not aware there was a scratch on her. Ms. Fussman stated there is no excuse for what occurred or the lack of documentation and that she would continue to work with CMH to create a behavioral plan. Ms. Fussman also stated she will work on the Corrective Action Plan to address this issue from occurring in the future.

On 06/17/2025 I spoke to ORR Ms. Wend who stated she will be citing for Neglect II because Resident A was hurt while she was outside and direct care staff members did not follow the *Person Centered Plan*. I was able to verify that Ms. Watson, Ms. Sperry, and Ms. Kyser all signed the Individual Plan of Service Training Record stating they

understood Resident A's *Person Centered Plan*. On 06/17/2025 APS Ms. Witucki also informed me she would also be substantiating for neglect.

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:	Resident A was not provided supervision according to her *Assessment Plan for AFC Residents* or *Person Centered Plan* because she needs to have one on one direct supervision in the community. During this incident, Resident A was able to leave the facility, walked down to the neighbor's house and was found on the sidewalk by a community member without the three direct care staff members knowing she had left the AFC. Ms. Watson was informed Resident A had left because a community member knocked on the door and asked if they were missing a resident. No incident report was completed, Guardian A1 was not notified, and management was unaware of the incident until APS completed an on-site investigation. Earlier in the shift, Resident A was trying to exit the facility and she was finally able to do so without a direct care staff member noticing.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jennifer Browning

____ _____06/18/2025_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 06/18/2025

_____

Dawn N. Timm Date
Area Manager