GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 22, 2025

Nichole Taylor
CMHB Of CEI Counties
Suite 115
812 E Jolly Road
Lansing, MI 48910

RE: License #: AM230249434
Investigation #: 2025A1024035
Arch Road Home

Dear Nichole Taylor:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On July 2, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM230249434
Investigation #:	2025A1024035
Complaint Receipt Date:	06/02/2025
Investigation Initiation Date:	06/04/2025
Report Due Date:	08/01/2025
Licensee Name:	CMHB Of CEI Counties
Licensee Address:	Suite 115 812 E Jolly Road Lansing, MI 48910
Licensee Telephone #:	(517) 346-8200
Administrator:	Nichole Taylor
Licensee Designee:	Nichole Taylor
Name of Facility:	Arch Road Home
Facility Address:	1081 Arch Road Eaton Rapids, MI 48827
Facility Telephone #:	(517) 346-8408
Original Issuance Date:	11/14/2002
License Status:	REGULAR
Effective Date:	05/01/2024
Expiration Date:	04/30/2026
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility without staff knowing his whereabouts for 3 days and without staff notifying his guardian.	Yes

III. METHODOLOGY

06/02/2025	Special Investigation Intake 2025A1024035
06/02/2025	APS Referral- not warranted
06/04/2025	Special Investigation Initiated – Telephone with home manager Paul Ruggerio
06/04/2025	Contact - Document Received- *AFC Licensing Division Incident/Accident Report, Sign In/Out Log*
06/05/2025	Contact - Telephone call made with Guardian A1
06/09/2025	Contact-Document Received-*Letter of Guardianship*
06/27/2025	Inspection Completed On-site with direct care staff member Angela Bell and Michelle Dorton
06/30/2025	Contact - Telephone call made with direct care staff members Alicia Dean, Alyssa Kogut, Shannon Campbell
06/30/2025	Exit Conference with licensee designee Nichole Taylor
06/30/2025	Inspection Completed-BCAL Sub. Compliance
06/30/2025	Corrective Action Plan Requested and Due on 7/15/2025
07/02/2025	Corrective Action Plan Received
07/02/2025	Corrective Action Plan Approved

ALLEGATION: Resident A eloped from the facility without staff knowing his whereabouts for 3 days and without staff notifying his guardian.

INVESTIGATION:

On 6/2/2025, I received this complaint through the LARA-BCHS online complaint system. The complaint alleged Resident A eloped from the facility without staff knowing his whereabouts for three days and without staff notifying his guardian.

On 6/4/2025, I conducted an interview with direct care staff member Paul Ruggerio who stated that Resident A left the facility on 5/19/2025 without signing out on the sign-out log sheet. Paul Ruggerio stated that residents are required to sign this log when going out into the community. Paul Ruggerio stated the information tracked on the sign out log includes: the resident's destination, who the resident is visiting, and expected return date and time. Paul Ruggerio stated the sign out log allows direct care staff to keep track of the general whereabouts of residents. Paul Ruggerio stated Resident A routinely signs out on the log when he goes on routine overnight visits with his father. Paul Ruggerio stated when Resident A left the facility on 05/19/2025, he assumed that Resident A was going on an overnight with his father as he usually does. However, Paul Ruggerio stated when he returned to work on 5/22/2025, he learned that Resident A had not yet returned to facility after leaving on 5/19/2025 and no direct care staff member had heard from him. Paul Ruggerio stated that on 5/23/2025 he still had not heard from Resident A so he called 911 to report that Resident A was missing. Paul Ruggerio stated later on 05/23/2025, local police informed direct care staff that Resident A was found with his girlfriend in Olivet, Michigan, however he was refusing to return to the facility. Paul Ruggerio stated direct care staff members were aware that Resident A had left the facility for four days and did not have any contact with Resident A during that four-day span, however, did not report his elopement nor did they search for Resident A because they assumed Resident A was with his dad on a visit. Paul Ruggerio stated there was no information or contact with Resident A to confirm this assumption.

On 6/4/2025, I reviewed the facility's *AFC Licensing Division Incident/Accident Report (IR)* which stated on 5/19/2025 Resident A told staff members he was leaving the facility and would return later. The IR stated Resident A did not return and on 5/22/2025 Guardian A1 sent an email to notify staff that she contacted Resident A and he was unwilling to return to facility. The IR stated direct care staff gave Resident A one more day to return and filled out an attempt to locate with Eaton County Sherriff's office on 5/23/2025 at 5:00pm at which time he was located but still declined to return. The corrective measure listed on the IR documented that direct care staff will be "retrained on consumers who has absconded and contact guardian immediately."

I also reviewed the facility's *Sign In/Out Log* which did not document that Resident A signed out on 5/19/2025 when he left the facility.

On 6/5/2025, I conducted an interview with Guardian A1 who stated that Resident A is a court ward and on 5/22/2025 she learned that Resident A had been missing from the facility since 5/19/2025. Guardian A1 stated that she contacted Resident A on his phone on 5/22/2025 and Resident A told her that he had been gone from the facility since 5/19/2025 and was staying with his girlfriend in Olivet, Michigan. Guardian A1 stated Resident A did not have permission from her to do so. Guardian A1 stated after she talked to Resident A, she called the facility at which time a direct care staff member, whose name she did not remember, informed her that they did not know the whereabouts for Resident A, and stated the reason Guardian A1 was not informed that Resident A had left and not returned to the facility was because Resident A has a right to leave the facility if he chooses. Guardian A1 stated that Resident A has legal restrictions in place and cannot make independent decisions therefore she is very concerned direct care staff did not make reasonable efforts or any efforts to ensure Resident A was safe when he did not return to the facility. Guardian A1 stated she was also concerned direct care staff did not immediately notify her that Resident A had not returned to the facility and had been gone or missing for multiple days. Guardian A1 stated that when she expressed these concerns to Paul Ruggerio and licensee designee Nichole Taylor, they stated to her again that Resident A has the right to leave and be gone away from the facility without her permission. Guardian A1 stated that Resident A is diagnosed with schizophrenia and while he was away from the facility, he also did not have any medications on him which could have caused him to demonstrate dangerous behaviors.

On 6/9/2025, I reviewed Resident A's *Letter of Guardianship* dated 8/13/2024 which stated that Guardian A is appointed full guardianship over Resident A by Ingham County Probate Court.

On 6/27/2025, I conducted an onsite investigation at the facility with direct care staff members Angela Bell and Michelle Dorton who both stated that they were not working when Resident A left the facility on 5/19/2025 without signing out. Both stated that when they worked later in that week, Resident A had not returned to the facility and Resident A continued to refuse to return to the facility, while he was away with his girlfriend. Both stated they learned of Resident A's whereabouts from Guadian A1.

On 6/30/2025, I conducted an interview with direct care staff member Alicia Dean who stated that she worked the week of 5/19/2025 and was told that Resident A eloped, had been gone for a few days and no one knew of his whereabouts. Alicia Dean stated that to her knowledge no direct care staff member, including herself, searched for Resident A while he was gone, nor did she or any other direct care staff member notify the police that he was missing. Alicia Dean stated that although she understands that it is Resident A's right to leave, she was very concerned that no one had been able to contact Resident A on his phone. Alicia Dean also stated she was concerned for Resident A's well-being because he is vision impaired and has a traumatic brain injury therefore, she called the police on 5/23/2025 and asked them to conduct a welfare check. Alicia Dean stated she later learned that police were able to contact Resident A,

however, did not know where he was. Alicia Dean stated she is not sure if anyone contacted Guardian A1 when Resident A left on 5/19/2025 and didn't return and she is not sure if staff members were familiar with the elopement protocol which includes completing an elopement form that she recently learned about and heard was in place at the facility.

I interviewed direct care staff member Alyssa Kogut who stated that she worked during the week of 5/19/2025, and it was reported to her that Resident A eloped from the facility on 05/19/2025, had been gone for about 3 days without having contact with staff, and therefore Resident A was considered AWOL. Alyssa Kogut stated although there was no contact made with Resident A while he was gone and his whereabouts were unknown, direct care staff members assumed it was appropriate for Resident A to be away from the facility for that length of time since he has a right to leave the facility therefore no search of any kind was conducted to confirm Resident A's whereabouts to her knowledge. Alyssa Kogut stated she and other direct care staff members were never given any instructions by management or the licensee designee to follow when a resident elopes therefore, they did not search for Resident A, notify the police that he was missing, or contact Guardian A1 because direct care staff did not have Guardian A1's contact information.

I interviewed direct care staff member Shannon Campbell who stated she was working on 05/19/2025 when Resident A stated he was leaving and left the facility without signing out on the sign out log. Shannon Campbell stated Resident A can access the community without staff supervision therefore she did not ask Resident A where he was going and assumed he would be returning home later in the day. Shannon Campbell stated when she returned to work the next day on 5/20/2025, Resident A had not returned to the facility. Shannon Campbell stated Resident A left the facility without giving notice of his return and whereabouts in the past, therefore neither she nor any other direct care staff member, including management, believed Resident A was in any danger and staff assumed he went to visit his father. Shannon Campbell stated that since Resident A did not have his cell phone on him, there was no way of contacting Resident A while he was gone and no search was conducted to her knowledge to locate Resident A. Shannon Campbell further stated that staff members do not have Guardian A1's telephone number therefore no staff contacted Guardian A1 while Resident A was gone. Shannon Campbell stated that staff were not familiar with any elopement protocol that was in place at the facility to address residents who elope from the facility therefore proper procedures were not followed while Resident A was away from the facility without notice.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Paul Ruggerio Angela Bell, Michelle Dorton, Alicia Dean, Alyssa Kogut, Shannon Campbell, Guardian A1, review of incident report, facility's sign out log, and *Letter of Guardianship* there is evidence to support the allegation Resident A eloped from the facility without staff knowing his whereabouts for at least three days and no efforts from direct care staff, including telephone calls to relatives or Guardian A1, searches conducted on foot or in a vehicles or calling police, were made to locate Resident A. There was no protocol in place for direct care staff to follow after a resident elopes from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(e) Elopement from the home if the resident's whereabouts is unknown.** **(2) If an elopement occurs staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred staff shall contact law enforcement.**

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Paul Ruggerio Angela Bell, Michelle Dorton, Alicia Dean, Alyssa Kogut, Shannon Campbell, Guardian A1, review of incident report, facility's sign out log, and *Letter of Guardianship* there is evidence to support the allegation Resident A eloped from the facility without staff knowing his whereabouts for 3 days and without staff notifying his guardian. Guardian A1 stated that Resident eloped from the facility without notice and no staff members contacted her to report that Resident A was gone with his whereabouts unknown. All staff members interviewed stated that Resident A left the facility without notice for at least three days and staff did not make reasonable efforts to search for Resident A nor did staff contact Guardian A1 or law enforcement in a timely manner. A written report was not made and sent to Guardian A1 to give notification of elopement nor was an immediate search or efforts conducted by staff after Resident A eloped from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/30/2025, I conducted an exit conference with licensee designee Nichole Taylor. I informed Nichole Taylor of my findings and allowed her an opportunity to ask questions and make comments.

On 7/2/2025, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was submitted therefore I recommend the current license status remain unchanged.

Ondrea Johnson

Ondrea Johnson
Licensing Consultant

7/21/2025
Date

Approved By:

Dawn Timm

07/22/2025

Dawn N. Timm
Area Manager

Date