



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 8, 2025

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

RE: License #: AL330015396
Investigation #: 2025A0577056
M.A.C. House

Dear Ms. 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 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) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330015396
Investigation #:	2025A0577056
Complaint Receipt Date:	08/07/2025
Investigation Initiation Date:	08/07/2025
Report Due Date:	10/06/2025
Licensee Name:	CMHB Of CEI Counties
Licensee Address:	Suite 115 812 E Jolly Road Lansing, MI 48910
Licensee Telephone #:	(517) 346-8200
Administrator:	Melissa Doss
Licensee Designee:	Nichole Taylor
Name of Facility:	M.A.C. House
Facility Address:	634 M.A.C. East Lansing, MI 48823
Facility Telephone #:	(517) 337-9340
Original Issuance Date:	05/23/1994
License Status:	REGULAR
Effective Date:	03/12/2024
Expiration Date:	03/11/2026
Capacity:	16
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was found deceased in a park on August 04, 2025, upon leaving the facility on August 03, 2025, and direct care staff did not provide Resident A with supervision.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/07/2025	Special Investigation Intake 2025A0577056
08/07/2025	Special Investigation Initiated – Letter- Via email with Jana Lipps, AFC Licensing Consultant.
08/07/2025	Contact - Document Received via Email, Resident Record.
08/07/2025	Referral - Recipient Rights
08/07/2025	Referral - Law Enforcement- Lansing PD involved.
08/11/2025	APS Referral
08/19/2025	Inspection Completed On-site
08/22/2025	Contact - Telephone call made- DCS Interviews.
08/25/2025	Contact - Telephone call made- DCS Interviews.
08/25/2025	Contact - Telephone call made- Interview with CEI Case Manager.
08/25/2025	Exit Conference with licensee designee Nichole Taylor.
08/25/2025	Inspection Completed-BCAL Sub. Compliance
09/03/2025	Contact-Document Sent- Email to Matthew Murphy, HM.
09/03/2025	Contact-Telephone call made- India Hudson, CM-CEICMH.
09/03/2025	Contact-Document Received-Resident A's Safety Plan.
09/03/2025	Contact-Telephone call made-Interviews with DCS.

ALLEGATION: Resident A was found deceased in a park on August 04, 2025, upon leaving the facility on August 03, 2025, and direct care staff did not provide Resident A with supervision.

INVESTIGATION:

On August 07, 2025, the department was notified by the facility that Resident A left the facility on a leave of absence on August 3, 2025, and was found deceased in a local park on August 4, 2025. An autopsy was scheduled for August 5, 2025, as the cause of Resident A's death was unknown.

On August 07, 2025, via email, Jana Lipps, Adult Foster Care Licensing Consultant, provided me with a copy of Resident A's *Assessment Plan for AFC Residents (assessment plan)* completed on March 26, 2025. The assessment plan documented "Yes" under the section titled, Social/Behavioral Assessment- Moves Independently in the Community and then under section titled, Social and Program Activities- Physical Exercise documented "yes, walks in community." I also received a copy of Resident A's *Person-Centered Plan (PCP) Treatment Plan with Clinton-Eaton-Ingham Community Mental Health (CEICMH)* and per Resident A's PCP Resident A's goal is to take walks in the community at least 2-3 times a week. I also received a copy of a *Death Report Form* completed on August 04, 2025, notifying CEI-CMH of Resident A being found deceased in Reutter Park by Lansing City Police Department (LPD). The *Death Report* documented that a body was found in the park with no foul play suspected. The *Death Report* documented that beer cans were observed nearby along with a clear tube, with ends that appeared to be burned, on the ground near Resident A's body. The *Death Report* documented that an autopsy was scheduled for August 5, 2025. The *AFC Licensing Division-Incident/Accident Report (IR)* documented LPD contacted CEI-CMH and notified staff Resident A had been found in Reutter Park without signs of life, pronounced deceased and autopsy will be conducted.

Per Resident A's *Person-Centered Plan (PCP)* received on August 07, 2025, the PCP documented Resident A is in the precontemplation stage pertaining to Resident A's substance abuse. Resident A's PCP documents Resident A's goal of wanting to stop using and avoid all substances. Resident A's Assessment Plan documented "Yes" under the section titled, Social/Behavioral Assessment- Appropriately Uses Alcohol/Drugs.

Per a second email communication between Nichole Taylor, Licensee Designee (LD) and Ms. Lipps, AFC Licensing Consultant, on August 7, 2025, Ms. Taylor reported Resident A passed away on August 4, 2025, and was not in the AFC facility at the time of his death. Ms. Taylor stated Resident A had signed out the afternoon before and had taken his prescribed medications with him out in the community. Ms. Taylor reported Resident A apparently passed away while outside of the AFC facility, and the AFC facility and CMH were informed by LPD. Ms. Taylor stated they were awaiting the results from the scheduled autopsy.

On August 19, 2025, I completed an unannounced onsite investigation and interviewed Matthew Murphy, Home Manager, (HM) who reported on August 3, 2025, Resident A signed out of the AFC facility and reported he would return around 5:00pm on August 3, 2025, but Resident A did not return. On August 4, 2025, Mr. Murphy reported he was notified that Resident A was found deceased in a local park. Mr. Murphy reported that when Resident A first was admitted into the facility back in 2022, Resident A left the facility for three or four days at a time without returning. Mr. Murphy reported over the past year Resident A has been more responsible about returning by the time he puts on the sign out sheet. Mr. Murphy reported the residents in the facility are independent and often come and go as they choose without the need for supervision in the community. Mr. Murphy reported Resident A went into the community a few times a week on a regular basis. Mr. Murphy reported Resident A does not have a phone so direct care staff cannot reach him, nor can Resident A call the facility. Mr. Murphy reported that the facility has an absence without an official leave (AWOL) policy, reporting that each resident is given a time frame during which if the resident does not return to the facility then direct care staff do not need to look for the resident or consider the resident absent or eloped. Mr. Murphy reported Resident A's time period is 24 hours from the time Resident A put he will return on the sign out log. Mr. Murphy reported that the 24-hour AWOL timeframe for Resident A is not documented in his assessment plan or PCP, it is only written and highlighted on the *AFC-Resident Information Identification Record*. I received and reviewed a copy of Resident A's *AFC-Resident Information Identification Record*, which documented and highlighted at the top of the form AWOL 24Hrs. I also reviewed and received a copy of the facility sign out log and on August 03, 2025, Resident A signed out with an expected return of 5:00pm. Mr. Murphy reported direct care staff working at 5:00pm on August 03, 2025, did not attempt to locate Resident A due to the AWOL policy in place. Mr. Murphy reiterated that Resident A does not have a personal cell phone so direct care staff could not call him to determine his location. Mr. Murphy also stated no direct care staff went looking for Resident A or called management to report Resident A did not return to the facility at 5pm as documented on the sign-out log. Mr. Murphy reported Resident A's spending money goes directly to Resident A from his Payee and Resident A is responsible for his spending.

During the onsite investigation, Mr. Murphy provided me with a copy of Clinton-Eaton-Ingham County Community Mental Health AWOL/Missing Consumer Reporting Form which the direct care staff use as a guideline when a resident becomes missing. Mr. Murphy reported this form was not used or completed by direct care staff due to Resident A's assigned 24-Hour AWOL policy allowing Resident A to be away from the facility for 24 hours before direct care staff start looking for him.

On August 22, 2025, I interviewed Charity Hursey, Direct Care Staff (DCS) who reported she worked second shift on August 03, 2025, and arrived at the facility after Resident A signed out to go into the community. DCS Hursey reported Resident A has a history of signing out and not returning to the facility for 24 hours or so. DCS Hursey reported Resident A protocol is not to contact police, look for Resident A, or contact

case manager until Resident A has been gone for 24 hours. DCS Hursey reported she did not take any steps to contact or look for Resident A and does not think any other direct care staff did. DCS Hursey reported she is aware of Resident A having a substance abuse issue and stated, "rarely would [Resident A] return to the facility sober."

On August 22, 2025, I interviewed DCS Elaysha Willis who reported she worked from 4pm-11pm on August 03, 2025, and Resident A had already signed out. DCS Willis reported Resident A does have a history of abusing substances but cannot remember the last time Resident A returned to the facility sober or not under the influence of a substance. DCS Willis reported she was aware that Resident A was in the community when she arrived to work and knew his expected return time was 5pm. DCS Willis reported Resident A usually does not return at his expected return time rather Resident A usually arrives back to the facility around 11pm. DCS Willis reported Resident A had not returned by the end of her shift, but DCS Willis stated this was not a cause for alarm because Resident A often returns when he desires rather than at the time documented on the sign out log. DCS Willis reported prior to leaving her shift, she did not attempt to look for Resident A, nor did she notify management that Resident A had not returned by his expected time six hours earlier or by the time her shift ended.

On August 25, 2025, I interviewed DCS Tracy Jenkins who reported on August 03, 2025, she worked 11pm-7am and upon the start of her shift, Resident A was not in the facility during the entire shift and upon shift change was told Resident A had not returned to the facility from his afternoon outing. DCS Jenkins reported this is normal for Resident A to sign out and not return at the time he documented on the sign out log. DCS Jenkins reported Resident A is known to use substances while out in the community and does have a substance abuse issue but has been doing really well with not using substances while out in the community. DCS Jenkins reported Resident A has been returning to the facility in a timely manner, around the documented return time on the sign-out sheet and often is under the influence of substances.

On August 25, 2025, DCS Will McCormick reported he worked from 7:30am-2:30pm on August 04, 2025. DCS McCormick reported upon starting his shift he was made aware that Resident A had not returned to the facility from his outing the previous afternoon. DCS McCormick reported he is aware of Resident A having a history of using substances while in the community. DCS McCormick stated he had a conversation with co-workers about Resident A's AWOL protocol and that if Resident A does not return to the facility within 24 hours of leaving the facility, then direct care staff are to notify the police, supervision, and Resident A's case manager. DCS McCormick stated, "as far as I know, there had not been any communication with supervision during the time [Resident A] had not returned, this was normal for [Resident A] to be gone for 24 hours from the facility."

On August 25, 2025, I attempted to interview India Hudson, Case Manager (CM) with CIECMH, left a message with no return call. On September 03, 2025, I interviewed India Hudson, CM-CEICMH who reported Resident A does have a known substance abuse

issue. Ms. Hudson reported when Resident A first moved into the facility in 2022, Resident A had a habit of not returning by the time reported on the sign-out sheet and would be gone for hours and sometimes days after signing out. Ms. Hudson reported that in 2023 a *Safety Plan #836969* was developed and is still in effect today. Ms. Hudson reported the *Safety Plan* was developed to ensure Resident A's safety while in the community and comply with medications. Ms. Hudson reported recently Resident A has been returning to the facility by the return time on the sign-out sheet or within a couple of hours of the reported return time. Ms. Hudson reported Resident A does not go out into the community as often as he used to, stating, "maybe he goes into the community three times a week." Ms. Hudson reported the facility does not need to report to her when Resident A returns to the facility and is under the influence of substances. Ms. Hudson reported Resident A probably does use substances when out in the community. Ms. Hudson reported Resident A has been doing really well with the structure of living in the facility and complying with medications, and the use of substances has decreased.

On September 03, 2025, Ms. Hudson, CM-CEICMH via email sent me a copy of Resident A's *Safety Plan #836969* completed on May 23, 2023, documenting the *Safety Plan* was created with Resident A and case manager to ensure the safety of Resident A while in the community and compliant with medications. The *Safety Plan* documented Resident A is to sign out when leaving the home and sign in when returning; inform staff when leaving and provide a return plan; if Resident A does not return to the home an hour after return plan (the time noted on the sign out log) an "attempt to locate (ATL)" will be called in. Ms. Hudson reported no ATL was called into CEICMH either within an hour after Resident A did not return or at any time until notified of Resident A's death.

On September 03, 2025, I interviewed DCS Latrice Blackman who reported she worked first shift on August 03, 2025, and it was a normal day for Resident A as he was happy and in a good mood. DCS Blackman reported Resident A signed out and told direct care staff he was leaving but would not provide specifics of where he was going. DCS Blackman reported this is normal for Resident A to not report where he is going while in the community. DCS Blackman reported Resident A took his 4:00pm medications with him into the community so there were no concerns of him not returning at 5:00pm for his 5:00pm medication administration. DCS Blackman stated Resident A was due to receive medications again at 8:00pm but DCS Blackman stated her shift ended by that time. DCS Blackman reported all direct care staff were aware of Resident A's substance abuse issues. DCS Blackman reported that about 50% of the time when Resident A returned to the facility after being out in the community unsupervised, he returned under the influence of a substance.

On September 03, 2025, I interviewed DCS Abby Diaz who reported she worked the morning of August 03, 2025, when Resident A signed out. DCS Diaz reported she was aware of Resident A having a substance abuse issue and was aware of Resident A going into the community and using substances. DCS Diaz reported Resident A is responsible for his own spending money and once he gets paid he spends in on drugs and alcohol. DCS Diaz reported she did not have any concerns regarding Resident A's

mental health on August 03, 2025. DCS Diaz reported Resident A often goes into the community and does not return upon the reported time and often returns four or five hours after the expected time.

APPLICABLE RULE	
R 400.15303	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:	<p>Based on the information gathered during the investigation, Resident A left the facility on August 3, 2025, around 2pm and was found deceased in a park in the morning hours of August 4, 2025. Resident A signed out of the facility with an expected return time of 5pm on August 03, 2025. Per Resident A's <i>Safety Plan</i>, if Resident A does not return to the AFC facility an hour after his expected return time, call will be made to community mental health (ATL call) and this was not completed. Also, no direct care staff member took any action to locate Resident A including driving to the location noted on the sign out log, calling supervision, or calling known friends, relatives or police, after he did not return at the expected time of 5:00pm. Further, all direct care staff interviewed along with Resident A's CEICMH case manager were aware that Resident A uses illegal substances and alcohol while out in the community and often returns under the influence yet no action was taken to locate Resident A or assure his safety after he did not return by the time written on the sign out log.</p> <p>Lastly, residents living in an adult foster care facility must receive 24-hour supervision, protection and personal care by statute and the use of an "AWOL Policy", allowing residents to be absent without knowing the resident's whereabouts for lengthy periods of time and without direct care staff taking action, is not allowed.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On August 07, 2025, I received a copy of Resident A's *Assessment Plan for AFC Resident* under section titled Health Care Assessment: A-Taking Medications- Medications administered by AFC Staff. Resident A's PCP also documented Resident A requires AFC staff to administer medications.

Per email communication from Nichole Taylor, Licensee Designee (LD) with Ms. Lipps, AFC Licensing Consultant on August 07, 2025, Ms. Taylor reported Resident A passed away on Monday, August 04, 2025, was not in the residence at the time, he had signed himself out on August 03, 2025, and had taken his medications with him to self-administer while out in the community.

On August 19, 2025, I completed an unannounced onsite investigation and interviewed Matthew Murphy, Home Manager (HM) who reported Resident A administers his own medications while out in the community. Mr. Murphy reported Resident A's *Assessment Plan for AFC Resident and Persona Center Plan* does not reflect Resident A having the ability to administer his own medications while in the community. Mr. Murphy reported the facility does have a physician's order for Resident A to administer his own medications while in the community. Mr. Murphy reported the direct care staff will put a single medication in an envelope and write the prescription instructions on the envelope and send with Resident A.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information gathered during the investigation, it has been found Resident A is able to administer his own medications while in the community, but the medications being sent with Resident A into the community are not in the original pharmacy-supplied container.
CONCLUSION:	VIOLATION ESTABLISHED

On August 25, 2025, I completed an exit conference with Licensee Designee, Nichole Taylor, who reported Resident A does have a physician's order to administering his own medications while in the community. Ms. Taylor provided a copy of the physicians' order signed on March 31, 2023, documenting Resident A is legally permitted to leave the AFC at any time, at the discretion of the AFC Staff, the AFC may provide this residents the quantity of medications necessary to cover the leave of absence.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, I recommend continuation of the current status of the license of this AFC adult large group home.

Bridget Vermeesch

09/08/2025

Bridget Vermeesch
Licensing Consultant

Date

Approved By:

Dawn Timm

09/08/2025

Dawn N. Timm
Area Manager

Date