GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 1, 2025

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS330011149
Investigation #: 2025A0622056
Van Atta Rd Home

Dear Ms. Bhaskaran:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report, a six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan. 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 335-5985.

Sincerely,

Amanda Blasius, 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 #:	AS330011149
Investigation #:	2025A0622056
Complaint Receipt Date:	08/04/2025
Investigation Initiation Date:	08/04/2025
Report Due Date:	10/03/2025
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jermery Hagerman
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Van Atta Rd Home
Facility Address:	4817 Van Atta Rd Okemos, MI 48864
Facility Telephone #:	(517) 349-1244
Original Issuance Date:	03/10/1982
License Status:	REGULAR
Effective Date:	08/14/2025
Expiration Date:	08/13/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
From 7/26 to 7/31/2025, Resident A repeatedly eloped from the facility unsupervised, once naked, prompting multiple police calls and raising serious safety concerns.	Yes

III. METHODOLOGY

08/04/2025	Special Investigation Intake 2025A0622056
08/04/2025	Special Investigation Initiated – FOIA request completed through Meridian Township Police
08/06/2025	Inspection Completed On-site
08/06/2025	Phone call to Citizen 1
08/07/2025	Phone call to direct care worker Samantha Hagerman to obtain additional documents. Documentation received via email from DCW Samantha Hagerman.
08/18/2025	Documentation received from Meridian Township Police Department
08/20/2025	Contact - Document Received and email contact with Administrator, Jeremy Hagerman
08/21/2025	APS is also investigating, Phone interview with adult protective services worker Penny Howard.
08/25/2025	Documentation received from Jeremy Hagerman, Administrator.
09/03/2025	Contact - Telephone call made phone call with Tamie Stevens
09/15/2025	Phone interviews with direct care worker, Lundlynn Myers, Ronneshisa Suggs and Celencia Suggs. Documentation received from Tamie Stevens, Operations Director
09/16/2025	Phone interview with direct care worker, Lotta Kuchar.
09/18/2025	Phone interview with direct care worker, Charles Albring, Ivoryannah Jenkins and Ivvy Knowlton. Police report received from

	Meridan Township Police Department. Email request to Van Atta for incident reports for 8/1/25.
09/19/2025	AFC Licensing Division Incident Reports were received for 8/1/25.
10/02/2025	Exit Conference with licensee designee, Jennifer Bhaskaran

ALLEGATION: From 7/26 to 7/31/2025, Resident A repeatedly eloped from the facility unsupervised, once naked, prompting multiple police calls and raising serious safety concerns.

INVESTIGATION:
On 08/04/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. The complaint stated the following: "On 7/26/2025, one of the residents "escaped" from the home. Came to our front door, rang the doorbell continuously, pounded on the window and would not go away. He was very aggressive. Police were called and returned the resident to the facility. On 7/27/2025 the resident "escaped" again and came to our front door. We notified a female caregiver at the facility; they came to our home. The caregiver was able to get the resident to cooperate but not until he partially disrobed and walked half naked back to the facility. The home supervisor arrived; the police were called. Resolution unknown. On 7/30/2025, no incident. On 7/31/2025, the resident once again came to our front porch, this time totally naked. A male caregiver came and returned the resident to the facility. We are concerned about the safety of the residents as well as the caregivers."

On 08/04/2025, I requested police reports from Meridian Township Police Department. I reviewed a police report from 7/26/25 which documented that a 911 call was received on 7/26/25 at 20:25 hours stating a "subject from the mental health facility next door is ringing his doorbell." The police report documented that at 20:45, the police made contact with Resident A as he was sitting on the ground at 4875 Van Atta Rd. The report stated Resident A was transported back to 4817 Van Atta Rd.(facility address) by police and returned to direct care staff at the facility.

A police report from 7/27/25 was reviewed and noted the following information:

- ***Information:*** *"On 7/27/25 at 18:16 hours, I was dispatched to an AFC location at 4817 Van Atta Rd. for an assault. Dispatch advised they received multiple 911 unknowns from this location and could not understand what the caller was saying. Dispatch informed me that while I was enroute that they received another call from Ivy Knowlton, advising [Resident A] ran away and when staff tried to contain him, he assaulted staff members."*
- ***Officer Actions:*** *"I made contact with [Resident A] in the roadway in front of 4687 Van Atta Rd. [Resident A] was in the roadway in front near the driver's side door of a passerby's vehicle with no pants on and only a shirt. I placed [Resident A] in the back of my patrol vehicle and transported him back to*

4817 Van Atta. I turned [Resident A] back over to his caregivers. Shortly after I turned [Resident A] over to staff members, dispatched advised they were receiving more 911 unknown calls. I returned to 4817 Van Atta and a staff member Celencia Sluggs advised [Resident A] has been assaulting staff members and another resident since they moved him in on 7/23/25."

- ***Contact with victim Celencia Sluggs:*** *"I made contact with Celencia Sluggs and she advised that [Resident A] has been assaulting staff members and another resident. Celencia advised that [Resident A] went into the kitchen where [Resident B] was and began to hit her multiple times. Celencia stated that she pulled [Resident A] away from [Resident B] and [Resident A] punched her in the left eye. Celencia reported that after he punched her he took off running out of the house and went to the neighbors house and another staff member, Ivoryanah Jenkins went chasing him down the neighbors driveway. Celencia stated this was the last contact she had with [Resident A] before the officer returned him to the home."*
- ***Contact with victim Ivoryanah Jenkins****: "Ivoryanah Jenkins stated that she was in a different room giving medications to other patients when she heard the altercation going on in the kitchen. Ivoryanah stated that she went into the kitchen and saw Celencia trying to get between [Resident A and Resident B]. Ivoryanah stated that Celencia tried to separate them multiple times before [Resident A] hit Celencia in the face and ran out of the house. Ivoryanah stated that she tried to call [Resident A] back into the house but he would not listen and continued to run down the neighbors driveway. Ivoryanah advised that she followed [Resident A] down the driveway, trying to get him back, but halfway down the driveway he took his pants off and started to run again. Ivoryanah reported that she caught up to [Resident A] at the end of the driveway and [Resident A] hit her in the face multiple times near the mouth area. Ivoryanah stated that after he hit her in the face, he took off running down Van Atta, where I found him in the roadway. "*
- ***Contact with Ivvy Knowlton****: "Ivvy stated that she is the on-call manager. Ivvy stated that [Resident A] is well behaved during the day and they have minimum problems with him when she is working. Ivvy stated that the only time they have problems with [Resident A's] behavior is in the evening hours. Ivvy advised that she would like [Resident A] to go to Sparrow Hospital for psych evaluation."*
- ***Contact with [Resident B]****: "[Resident B] advised she went into the kitchen to get a drink and [Resident A] followed her. [Resident A] pinned her up against a wall near the fridge and started to hit her in the face and chest area. [Resident A] stated that Celencia got into between them and was able to separate them. [Resident B] advised her chest hurt from the altercation."*
- ***Additional information:*** *[Resident A] was transported to Sparrow Hospital for psych evaluation.*

On 8/06/2025, I completed an unannounced onsite investigation to Van Atta AFC. During the unannounced onsite investigation, I viewed eight *Community Mental Health of Clinton-Eaton-Ingham Counties General Incident Reports* (Incident

Reports) dated 7/23/25, which was the first day Resident A was admitted to the facility. The Incident Reports for 07/23/25 are summarized as follows:

- 3:30pm-Resident A attempted to grab phone from another resident and then started hitting her. Staff attempted to re-direct, but Resident A kept going around staff to continue hitting Resident B. Staff was able to separate them.
- 3:30pm- Resident A was pulling fire alarms. Staff tried to re-direct and he kept hitting staff continuously.
- 6:10pm- Resident A lunged at Resident B resting on the couch and started hitting her. They both started fighting each other. Staff had to separate them.
- 6:18pm- Resident A was laughing and ran up and pulled the fire alarm and then ran away.
- 6:19pm- Resident A went into Resident B's room when staff was trying to turn the alarm off. Resident A started hitting Resident B. Resident A and B started fighting and staff needed to separate them.
- 6:22pm- Walked down hallway, pulled the alarm and ran away laughing.
- 6:25pm- Resident B was walking out of the kitchen when Resident A jumped at Resident B and started punching her. Staff jumped between them and separated them.
- 6:55-6:58- Resident A was aggressive towards Resident B and tried to fight her three times. Staff attempted to get Resident A to use his calming techniques, but was unsuccessful. At 7pm, Resident A was given a PRN for aggression.

A *Community Mental Health of Clinton-Eaton-Ingham Counties General Incident Report (incident report)* was reviewed from 7/26/25 at 8:30pm-8:45pm and documented that while staff were passing medications, Resident A threw his tablet over the back of the fence and then requested help from staff to retrieve it. The incident report documented that the staff member who was administering told Resident A she would assist him after she was done. The incident report documented that the staff member could not locate Resident A after she finished administering medications, so she and another direct care staff looked outside until Resident A was located at a neighbor's home to left of the facility. The neighbors were upset and expressed concern. The incident report stated that the neighbors called 911.

A *Community Mental Health of Clinton-Eaton-Ingham Counties General Incident Report* was reviewed dated 7/26/25 at 11:35pm which documented that while direct care staff were cleaning a mess made by Resident A, he snuck off, took Resident B's phone and called 911 ending in police arriving at the facility.

A *Community Mental Health of Clinton-Eaton-Ingham Counties General Incident Report* was reviewed dated 7/27/25. This report confirmed the incident documented in the police report dated 7/27/25 described above. The only additional detail provided in this incident report was that Resident A was going through the neighbor's car before running down their driveway.

A *Community Mental Health of Clinton-Eaton-Ingham Counties General Incident Report* was reviewed from 7/28/25 at 7:35-7:45pm. Resident A snuck into Resident B's room and started hitting her. Staff redirected him out of the room, but at 7:40pm, Resident A snuck back into Resident B's room and began beating Resident A again. Staff attempted to redirect Resident A and then he started hitting staff. A PRN was given for aggression.

A *Community Mental Health of Clinton-Eaton-Ingham Counties General Incident Report* was reviewed from 7/28/25 at 7:55pm. Resident B was sitting outside on the phone when Resident A came outside and hit her on the back of her head. Staff redirected him and he ran over to a resident's guest and said "pow, pow." Staff redirected him and he tried to do it again.

During the unannounced onsite investigation, I interviewed Resident A. He showed me his tablet and had pictures of police cars. Resident A was unable to answer any questions related to the investigation.

During the unannounced onsite investigation I interviewed direct care worker, Zarie Parrotee. She reported that two direct care staff are on duty at all times. She reported that Resident A has been eloping, hitting other residents and staff members, and going into other residents' rooms without permission. She explained that staff are trying to keep an eye on him but he will try to go out any door that is available. DCW Parrotee explained that no bells or alarms on the doors to alert staff of the door being used. DCW Parrotee reported that "[Resident A] will pull his pants down, poop, puke and pee on items."

During the unannounced onsite investigation, I interviewed direct care worker, Darlene Sroufe who reported that she was told the basics about Resident A's behaviors and physical aggression before he was admitted. She reported that Resident A wants to run and take his clothes off, but they attempt to redirect and calm him when this happens. DCW Sroufe stated that she normally works first shift and her co-worker, DCW Nicere Lewis spends most of the day specifically with Resident A. DCW Sroufe reported that she has been punched by Resident A. DCW Sroufe stated that since Resident A requires so much attention, she has noticed that some of the other residents are lacking attention and displaying more behaviors. DCW Scroufe confirmed Resident A had a medication change which included adding a new medication twice daily, instead of it being prescribed as an as needed medication. Resident A is now prescribed Hydroxyzine 50mg twice day. I confirmed this change in his medication, by viewing the doctor's order.

On 08/06/2025, I interviewed Citizen 1 via phone. He reported that Resident A has been eloping to his home almost daily. Citizen 1 stated that on 7/26/25, Resident A came to his door around 6:45pm fully dressed, with no direct care staff supervision, and the police were called. Citizen 1 stated Resident A also came on to his home again on 7/31/25 but was naked and with no direct care staff supervision. Citizen 1 stated Resident A was pounding on his door and he had to go get a direct care staff

member to get Resident A, as Resident A would not leave his property. He stated the police were not called on 7/31/25. Citizen 1 reported that Resident A came over to his home three times on 8/1/25 with no direct care staff supervision. The first time was at 6:38pm, the second was at 7pm and the last time was at 8:38pm. Citizen 1 stated that the police were called for all three times as a direct care staff did not come over to obtain him. Citizen 1 reported Resident A came inside his home uninvited, had no pants on and was aggressive. Citizen 1 stated that his dog was upset and was injured trying to get to Resident A. Citizen 1 reported that during one of the incidents, Resident A urinated on his porch. Citizen 1 stated that recently he had a visit from two managers, and they discussed putting up a privacy fence to prevent Resident A from coming over.

On 08/07/2025, I followed up with DCW Samantha Hagerman via phone. DCW Hagerman identifies as the home manager for Van Atta and stated that she is collecting the documents that I requested. DCW Hagerman reported that on 8/01/2025, direct care staff member Lundynn Myers left her shift without approval and without informing the other staff member. DCW Hagerman reported that Lundynn Myers was placed on leave for leaving the home without approval.

I received an additional police report from Meridian Township Police Department dated 8/1/25 and included the following information:

- ***Information: "****On 08/01/25 at 2042 hours, I was dispatched to 4875 Van Atta for a troublesome subject compliant. The caller [Citizen 1] advised that an unknown male was standing on his front porch. [Citizen 1] advised that the male was wearing a purple shirt with no pants. Dispatch advised that this is a return trip for PD and that the male is from a nearby AFC home."*
- ***Officer Actions:*** *"Upon arrival I took custody of [Resident A]. Due to a prior incident, I knew that this person resided at the AFC home 4817 Van Atta. This incident is the third time today that [Resident A] has left the home without permission."*
- ***Contact with Celencia Suggs:*** *"I made contact with [Resident A's] caregiver at 4817 Van Atta. Celencia advised that she is the only caregiver at the facility today. Celencia advised that due to having other patients she is unable to properly observe [Resident A]. She stated that he continues to leave the property while she is giving medications to others. She also advised that due to her being the only caregiver working, she is unable to leave the home to find [Resident A]. Celencia stated that they do not have a way to lock the doors to prevent [Resident A] from leaving."*
- ***Additional Information:*** *"There have been multiple trips to this address for [Resident A] leaving the AFC home. On 08/01/2025, PD was called on three separate occasions to bring [Resident A] home. On three separate occasions, [Citizen 1] was the reporting party. The Van Atta staff did not report him missing on any of these occasions."*

On 08/07/2025, I reviewed documents received from DCW Samantha Hagerman including an email dated 7/21/25 at 2:51pm sent from Liesel Reinke, CSDD

Residential Coordinator from Clinton, Eaton and Ingham Community Mental Health, inviting Tamie Stevens, operations manager for Van Atta, licensee designee, Jennifer Bhaskaran and administrator Jeremy Hagerman to a zoom call to discuss placement of [Resident A]. Attached to the email was Resident A's treatment plan and assessment.

I reviewed an email dated 7/21/25 at 3:54pm from Tamie Stevens to licensee designee, Jennifer Bhaskaran and cc'd administrator, Jeremy Hagerman which discussed Resident A's placement and action steps. The following information, in part, was documented in the email:

- *"[Resident A] is 24 and Arabic is his first language, however he is learning English and needs paper and pen at all times to communicate with staff."*
- *"He has some aggression, but could be due to medical issues going on and the environment. History of eloping and calling 911 (for attention.)"*
- *"He has an obsession with food and the quantity available in the fridge will need to be reduced."*
- *"He is diabetic (takes medication) not insulin dependent, has GERD, sleep apnea, deaf, and anemic."*
- *"He has a psychologist who follows him through CMH."*
- *"His father is guardian and is currently in Cairo Egypt, he can sign all the paperwork via sign now."*

I reviewed another email dated 7/28/25 from Tamie Stevens, Director of Operations from Van Atta, which was in regard to Resident A's aggressive behavior. The email was asking a Community Mental Health employee with first name "Bridget", last name unknown, the following:

- *"Do you still offer the class Personal Safety Skills? I have a home that has some aggressive clients and was looking for some training for staff to learn some techniques that might help them. I think back in the day I took this class or something similar and would like to offer this to the staff if possible. Please let me know if this is a possibility."*

On 08/17/2025, an additional police report was received regarding residents at Van Atta AFC. The police report stated the following; on 8/17/25 at 1825 hours, the police were dispatched to 4817 Van Atta Rd. for an assault complaint. Resident B advised that Resident A struck her in the head several times. It was noted in the report that the police have dealt with Resident A multiple times for running away and prior assaults. Adult protective services have been contacted on other occasions due to the foster home not being able to provide for Resident A's needs. Resident B was interviewed and reported that she was in the kitchen and Resident A struck her in the head twice and chest once with closed fists. Resident B reported that she does not feel safe living in the home and would like to pursue charges against Resident A. The police report stated that no visible injuries were observed and Resident B complained of a headache and chest pain. Interviews with both direct care workers, Charles Albring and Ronneisha Suggs confirmed that Resident A punched Resident B several times within the kitchen. Both caregivers advised that they had to separate Resident A and B. The police

contacted home manager, Samantha Hagerman and she reported that she had no solutions for the ongoing problems with Resident A. The officer attempted to contact Guardian A1, but was unsuccessful.

On 08/18/2025, an additional police report was received regarding residents at Van Atta AFC. The police summarized a complaint made by Resident B that Resident A slapped her in the face. The police report stated no injuries were reported and that the officer planned to follow up with the home manager to “discuss other options to help create a safe environment for all residents.”

I reviewed *Timeline Notes* received from home manager, direct care worker, Samantha Hagerman and noted that the following information regarding Resident A’s behaviors was reported to the licensee:

- *7/21/2025- 2pm, Zoom Meeting regarding [Resident A] emergency housing need-[Resident A] was currently in the hospital and was being discharged and needed placement. His history involved eloping to the front of the residential house but not leaving the property, physical aggression toward others, but was like a slow motion hit and not very hard, history of calling 911 or police so he could chat with them. He previously lived at another AFC for 4 years and was stable until recently and that AFC was having staffing difficulty and were no longer able to have sufficient staff on duty. He was very close to a few staff members at the previous AFC, but they had left or died. He needs assistance with personal care, food prep and supervision in the community. His primary language is Arabic but learning English. He can read and write and uses a pen and paper to communicate if staff do not understand him. He has some hearing loss but refuses to wear any aids. He is diabetic but not insulin dependent and needs dietary supervision for weight loss. CMH Psychologist had just been assigned to [Resident A] and needed to do some observations for the behaviors before getting some guidelines around.*

- *7/23/2025- [Resident A] was admitted into the Van-Atta home, he grabbed the staff cell phone and contacted 911, speaking in Arabic. 911 authorities contacted the home and spoke with DCW Samantha Hagerman, it was determined no assistance was needed. [Resident A] also pulled the fire pull station several times which made the alarms go off.*

- *7/25/2025-DCW Samantha Hagerman spoke with Mary Ellen, new CMH case manager via phone inquiring again about the primary care dr and that he was discharged from hospital with no PRN medications or a primary care physician, also discussed increase in behaviors and [Resident A] contacting the police via texting app and/pr phone, Samantha also spoke with CMH psychologist Justin Caughey via phone discussed increase in behaviors and defecating on the floor and running around naked.*

- *7/28/2025-Tamie Stevens, Operations Director emailed the CEI -CMH training unit inquiring about any classes they could offer the staff on personal safety skills and working with aggressive consumers.*

- *8/1/2025-Jeremy Hagerman, Administrator called Tamie Stevens, Operations Director and reported that [Resident A] had went to the neighbors and the police escorted him back and Jeremy found out that one staff member had left the house to go home and change her clothes due to having a personal incident happen while on shift, the staff did not get permission from management so was suspended immediately and is currently still on suspension.*

- *8/5/2025-Jeremy Hagerman, Administrator and Tamie Stevens, Operations Director have kept each other informed of all situations going on and brainstorming ideas on how to serve [Resident A] safely and without infringing on his rights. We cannot drag him back from the neighbors and we cannot restrict his movement as that would violate his rights. It takes time for a consumer to adjust to a new environment and feel comfortable in the environment and comfortable with the staff. We have informed CMH of all things happening and have written IR's for each incident."*

On 08/25/2025, I received additional *AFC Licensing Division Incident/Accident Reports* outlining incidents involving Resident A.

- On 08/08/2025 at 8:10pm, an *AFC Licensing Division Incident/Accident Report* was completed. The incident report stated, Resident A was outside eating a snack with staff and he ran to the neighbor's house. Staff tried to redirect and yelled to notify other staff who ran out to assist with re-directing him. Resident A declined to leave. Staff continued to try and re-direct him and he would not leave. Police were contacted to bring Resident A home. Corrective action measures taken, were to continue working with Resident A when leaving and implement CEI guidance once received.

- On 08/15/25 at 7:20pm an *AFC Licensing Division Incident/Accident Report* was completed. The doorbell rang and the police and EMS were at the door. They stated that they were there, as a housemate called the police due to an incident earlier in the day. Staff assisted the police with talking to Resident A.

- On 08/16/25 at 9:30pm an *AFC Licensing Division Incident/Accident Report* was completed. Resident A ran to the neighbor's home and staff were unable to re-direct him. The police were called to assist with getting Resident A to come home. Corrective action measures taken were to continue working with CEI specialists on developing some sort of behavioral guidance for leaving the home and contacting the authorities when declining to return home.

- On 08/17/25 at 7:00pm an *AFC Licensing Division Incident/Accident Report* was completed. Due to an incident prior in the day, the police arrived to speak with

Resident A. Corrective action measures taken, continue monitoring interactions between housemates, prompting health and safety at all times. This incident was due to Resident A pulling a housemate's hair earlier in the evening. Housemate called the police.

- On 08/18/25 at 7:00pm an *AFC Licensing Division Incident/Accident Report* was completed. Resident A was being aggressive towards staff and a housemate. Resident A was using the bathroom and then ran into a housemates bedroom to attack her. Corrective measures taken, continue working with CEI specialist on re-direction techniques and monitoring for health and safety.

I reviewed an *Assessment* for Resident A completed by Jessica Decker, BA, LSST, from Community Mental Health, Clinton, Eaton and Ingham Counties dated 8/23/2024.

- ***New and ongoing presenting problems since last annual assessment:***

"[Resident A] has hearing loss in both of his ears. He was assessed for hearing aids in the past and his guardian bought a set. The hearing aids unfortunately got lost in the move reported guardian. He speaks English and continues to learn the English language daily. He also communicates by writing words when he is confused or cannot verbally express himself to others. He continues to engage in challenging behaviors as evidenced by staff documentation of attacking staff, hitting his housemates and calling 911."

- ***Desired Outcomes for the Coming Year:***

"[Resident A] has difficulty maintaing boundaries with vistors and is supported by his AFC staff for guidance of appropriate social interactions. He is provided with choices and opportunites for daily activities within his home."

- ***Summary of Progress and Invlovment of Treatement:***

"[Resident A] has been stable during the past year with no hospitalizations. [Resident A's mental health is supported by CSDD medication clinic with Dr. Brown. He has been psychiatrically stable this year. There have been no changes in his psychiatry medication regimen this year as evidenced by psychiatry service notes. He continues to learn skills to decrease his challenging behaviors. He has learned to write down his concerns when others do not understand his verbal communication. He continues to engage with case manement to express his wants and needs. He continues to work with DD nutrition since his enrollment in June of 2022."

- ***Community Inclusion Summary:***

"[Resident A] requires full support while his in the community. He requires to have someone with him at all times during community outings to keep him safe and others safe. He is unable ot navigate the community independently. He will use the phone to call the police, but he does not know when it is appropriate. It is important for [Resident A] to have access to a writing utensil and paper so he can communicate in written form."

- ***Challenging Behaviors Summary:***

"[Resident A] presented behaviors of attacking staff, elopment and hitting others when he moved into Mulliken AFC in 2021. He has not eloped from the AFC in the past year. [Resident A] can be stubborn, argumentative and easily frustrated. He can attack staff when redirection is placed on food. He has a strong drive for food and he can be aggressive toward others as evidenced by incidents of charging, hitting and pulling hair.

He seeks out phones that are unattended and he will grab them to call 911. He thinks calling the police is funny as evidenced by laughing when he is caught. He is unable to interact appropriately with strangers and he requires adequate attention and support from staff to have safe interactions."

- ***Other:***

"[Resident A] may elope and staff should be prepared to follow him outside and redirect him back home. This has not been a current issue, but it has been in the past. Do not engage in power struggles, instead offer options. Staff should redirect [Resident A] when he wants to call 911. If he talks about 911, staff can ask him when it is appropriate to call 911 and he will talk or write down on paper when someone should call 911."

I reviewed Resident A's *Assessment Plan for AFC Residents*. According to his plan dated 7/28/25, the following was documented:

- *Moves independently in the community: No, needs full support while in the community to stay safe.*
- *Communicates needs: yes, can read and write*
- *Follows instructions: reminders to stay on task. Staff should approach with enthusiasm.*
- *Controls aggressive behavior: no, can strike out to staff when upset or frustrated.*
- *Gets along with others: staff to be aware of signs of aggression.*

On 08/20/2025, administrator, Jeremy Hagerman confirmed that Resident A's treatment plan was received prior to placement and also that discharge paperwork from Resident A's most recent AFC placement and hospital stay were received. Administrator Jeremy Hagerman did not know how long Resident A had been hospitalized. Administrator Jeremy Hagerman also confirmed that Resident A has not been given a 30 day discharge notice due to recent aggressive behaviors and episodes of elopement, the licensee plans to continue Resident A's placement while working with Community Mental Health. Administrator Jeremy Hagerman stated that a privacy fence had not yet been installed.

On 09/15/2025, a Person Centered Plan and Individual Plan of Service inservice staff sign in sheet was received. After reviewing the sign in sheet, it was noted that direct care worker, Lundynn Myer did not sign the form confirming that she has reviewed the assessment or had been trained. According to the staff schedule, DCW Myers worked on July 25th, 29th, 30th 31st and August 1st. She was placed on leave after the 1st of August for leaving the home during shift without approval.

On 08/21/2025, I interviewed adult protective services worker, Penny Howard via phone. She confirmed that she has two cases open regarding Resident A and Resident B. She stated that she will be closing her case on Resident B. Ms. Howard reported that she observed Resident A and Resident B laughing together and Resident B can go to her bedroom and lock the door to protect herself from Resident A. She also explained that Resident A will say "no hit, no hit" and then hit Resident B. Ms. Howard also explained that Resident B is provoking Resident A by being in his personal space and wanting attention from staff members. She reported that Resident A is getting more

aggressive and thinks everything is a game and is testing the staff members. Ms. Howard reported that he also tries to elope and was outside when she arrived. She explained that three staff members were outside with him. Ms. Howard also stated that Resident A does not want to leave the neighbor's house, because he wants police intervention. Ms. Howard reported that she will be closing Resident A's case also, as he will display these behaviors at any home and direct care staff are willing to work with him. Ms. Howard reported that she also plans to reach out to Guardian A1 and request that he be more involved in Resident A's care.

On 8/25/25, I received the discharge paperwork for Resident A when he was placed in the hospital prior to Resident A's admission to Van Atta AFC. According to the discharge paperwork the following was documented:

- *"[Resident A] was admitted to the hospital on 7/17/25 at 1600 hours for agitation and psychosis with his chief complaint being "it hurts" pointing to his abdomen. The resident is presenting to Sparrow hospital for worsening aggression at the AFC home. The patient has a history of multiple prior ER visits for aggressive behavior and has been seen by our service in the past with similar presentation. Per history, the patient was placed at a new group home on 7/12/2025. He has a history of aggression and displayed these behaviors since he began to live there, but behaviors worsened with the patient punching staff members and assaulting another member of the group home. In the hospital, the workup was largely unremarkable aside from elevation in LFT's; AST of 35 and ALT of 63. Most recently, the patient was seen in the hospital on 7/7/25 for agitation, including pulling the fire alarm at his AFC home, eloping from the home and visiting neighbors without clothes on." "On 7/18/2025, social worker spoke with CEI CMH Crisis Services. Discussion involved need for CMH to work with AFC home to intiate a behavioral plan for the patient versus relocation to a home that can meet the patients' needs. On 7/18/25, the patient required IM versed and droperidol for safety, given that he became violent with staff in the hospital. On 7/20, the patient became agitated, removed his clothes in common areas of the hospital and was not redirectable, he received IM Haldol and required restraints at that time. On 7/21/25, social worker has been in contact with AFC home to obtain clarification as to whether patient will be able to return to the AFC home."*

On 09/03/2025, I interview Van Atta operations director, Tamie Stevens via phone. Ms. Stevens reported that all staff were informed that Resident A will grab at their personal phones and to keep them out of sight. She explained that Resident A then downloaded an electronic application on his tablet to call 911 and since direct care staff cannot take away Resident A's tablet, Resident A calls 911 too often and for unnecesary reasons. Ms. Stevens stated that recently he has been going on YouTube and is talking with a crisis group and asks those members to call 911. She explained that she plans to ask Guardian A1 to put restrictions on his tablet, so he can't download new programs or access certain websites, since the home is not allow to restrict his access as it's not in his personal care plan. Ms. Stevens stated that she and administrator Jermey Hagerman were trained on his personal care plan and they were told in their zoom

meeting with Community Mental Health, Clinton, Eaton and Ingham Counties that elopement has not been a recent behavior. Ms. Stevens stated she was told about Resident A taking his clothes off while outside of the home. Ms. Stevens stated that at their pre-placement phone call, they were told that he was being discharged from the hosptial, as he was sick and was also being aggressive towards other residents. Ms. Stevens reported that recently they have requested that staff be with Resident A at all times in the common rooms, know where he is located at all times and check on him every 15 minutes. She stated that when Resident A is leaving the property, staff are always with him, but he will refuse to leave the neighbors home until they call the police. Ms.Stevens reported that if she would have been informed prior to his placement, that he was constantly running away from the home, she would not have accepted him. Ms. Stevens stated that Resident B teases Resident A and they will fight with eachother, but at times Resident B and Resident A get along well. Ms. Stevens explained that some interventions they have just put in place to address Resident A's behavios include: more visits with Guardian A1, have a schedule board with staff pictures up in the home, use social stories and have more white boards available within the home for Resident A to write on for communication purposes. Ms. Stevens stated that within the last week, Resident A has not had any attempts at leaving the property and he was also put on a new medication. Ms. Stevens stated that since they have installed a temporary fence, Resident A has not attempted to go over or around the fence. She has also instructed staff members to take Resident A out in the community, go for walks or for car rides more often. Ms. Stevens stated that Resident A's CMH Psychologist, Justin Caughey came to a staff meeting on 9/3/25, so direct care workers could express their concerns regarding Resident A and Mr. Caughey stated that staff need to remove residents away from each other. Mr. Caughey also informed direct care workers, that they need to continue ABC charting, notice Resident A's triggers and act before he has a behavior, keep Resident A busy, give him choices and change how they respond to Resident A. Ms. Stevens stated that they have not added a third staff member to each shift as they don't have enough staff members available. Ms. Stevens reported that she feels management took reasonable action, as Community Mental Health recommended a fence, but then would not fund the fence, therefore Van Atta put up a temporary fence to prevent Resident A from eloping. Ms. Stevens also reported that she was properly evaluating residents prior to admission, as she had denied a previous referral due to the behaviors not being appropriate for the home or having the appropriate staff members to handle the behaviors.

On 9/15/2025, I interviewed DCW Lundlynn Myers via phone. She reported that she was let go from Van Atta AFC in early August. DCW Myers reported that she was not trained or informed of any information on Resident A prior to him arriving. She reported that she did not read his treatment plan, nor was she informed that Resident A elopes or attacks other residents and staff members. DCW Myers reported that she just tried to keep talking with Resident A and keep him busy. DCW Myers stated that she had to leave the home due to an emergency on 8/1/25 and informed the other staff member she was leaving. DCW Myers stated that she was gone for about 30 minutes and during that time, Resident A eloped from the home three times. DCW Myers reported that when she returned, the police were at the home. She explained DCW Sam Hagerman

arrived soon after she returned to the facility. DCW Myers stated that the main thing she was informed about Resident A was that he was left at the hospital because AFC home could not handle his behavior. DCW Myers stated that having a one-on-one staff member for Resident A would have been helpful.

On 09/15/2025, I interviewed DCW Ronneshisa Suggs via phone. She stated that she works second shift from 6pm-6am, but has put in her two weeks notice and her last day will be next week. DCW Suggs explained that she is “sick of being hit and spit on while working.” DCW Suggs reported that she was not trained on how best to address Resident A’s behavior but she was given his treatment plan to review. DCW Suggs stated that she was not aware that Resident A was coming until she arrived for work on 7/23/25. DCW Suggs reported that no specific insturctions were given when Resident A arrived regarding his behaviors of elopment and hitting staff and residents. DCW Suggs explained that after Resident A started eloping, direct care staff were told to follow Resident A, redirect him back to the facility if possible, and if Resident A won’t listen then call police for assistance. Within the last two weeks, DCW Suggs stated that stop signs were placed at the doors and on the fence outside. DCW Suggs explained that no specific instructions were given to attmept to re-direct Resident A from hitting staff and other residents. DCW Suggs stated that recently, staff were told to put a pillow between Resident A and any other resident he is hitting. DCW Suggs stated Resident A is also to have eyes on when in the common room and five minute checks while in the bedroom. DCW Suggs stated direct care staff try to re-direct Resident A, but most interventions are not successful. She stated that she has had to pull Resident A physically off other residents, as he hits Resident B, Resident C and D, along with pulling hair. DCW Suggs stated that Resident A does not display behaviors during first shift, but exhibits behaviors during second shift as he tries to elope and hits others. DCW Suggs stated direct care staff have requested for Resident A to be moved from the facility but she feels that managers are not listening to them, therefore staff members are quitting. DCW Suggs stated that a staff member is needed to supervise Resident A 24/7 to try and prevent these behaviors. DCW Suggs stated that Resident A goes to bed around 11:30pm/12am and does not try to elope once its dark out, as he is afraid of the dark.

On 09/15/2025, I interviewed DCW Celencia Suggs via phone. DCW Celencia Suggs stated she was unaware that Resident A exhibited eloping behaviors but was told that he hits others but gives a warning before doing so. DCW Celencia Suggs stated that she had to read his treatment plan when he first arrived. She explained that sometimes Resident A will say “no pow pow” before he hits and then other times he will not give any warning before hitting. DCW Celencia Suggs confirmed the information provided in police reports and incidents reports described previously about Resident A’s elopements and aggressive outbursts towards staff and other residents. DCW Celencia Suggs reported she was trained to re-direct him, but it’s very difficult because not much works. She explained that Resident A is constantly hitting other residents despite redirection and has recently started trying to touch staff and other residents on their buttocks. DCW Celencia Suggs stated that they are recommending that one staff member have eyes on Resident A at all times, but even with two staff members, they cannot consistently follow Resident A around as the other residents need assistance

too. DCW Celencia Suggs reported that recently Resident A ran away again at the end of August or early September. She reported that staff were told to try and ignore Resident A when he is trying to elope, as it's being done for attention. She reported that she was hiding behind a car, so Resident A would not see her, but she lost track of him and he somehow he ran to the main road. DCW Celencia Suggs stated that this all occurred at 9:55pm. She reported that the police were called and they found him on Van Atta Rd. and returned him to the home. She explained that the little fence that was put up to block Resident A from going to the neighbors home has helped to decrease his elopments. DCW Celencia Suggs reported sometimes Resident A tries to run away constantly and staff can't really do anything to prevent him besides follow him and then call the police. She explained that she feels that Resident A would be better served in a facility that has a locked gate or fence and/or had one direct care staff member designated just for Resident A.

On 9/16/2025, I interviewed DCW Lotta Kuchar via phone who reported that she was brought over from a different AFC facility owned by the licensee to assist with staffing. She stated that when Resident A arrived, she was told that he was an attention seeker and if he did not get the attention, it would result in Resident A eloping and/or stripping off his clothes. She stated that she read his treatement plan, but was unaware that Resident A hit staff or residents, until he hit her. DCW Kuchar stated that Resident A punched her in the nose and mouth. DCW Kuchar reported that she has worked for the company for eight years, so she is familiar with blocking a resident from hitting her. She explained that management did not discuss with her any recommendations to prevent Resident A from hitting staff or residents, but she just tries to disfuse the situation by figuring out what Resident A needs. DCW Kuchar stated that Resident A has not hit another resident while she has been working. DCW Kuchar explained that Resident A has left the property twice while she was working. She stated that one time, she followed him to the neighbors backyard, but was unable to redirect him back to the house, therefore she called for assistance from the police. DCW Kuchar stated that she was able to get Resident A to sit down and wait for the police to arrive and then he was given a toy car and returned home. DCW Kuchar stated that the most recent time was on 9/5/25 and she was administering medications, therefore another co-worker followed Resident A. The co-worker lost sight of Resident A outside as it was dark outside. DCW Kuchar stated direct care staff could not locate Resident A, therefore they called the police. The police found Resident A on Van Atta Road off from the property. DCW Kuchar stated DCW Celencia Suggs did not have a flashlight, therefore she could not see Resident A. DCW Kuchnar reported that the home now has flashlights outside for the staff to grab if needed. She explained that Resident A was gone from 10pm-10:30pm. She reported that Resident A was upset over a snack, as Resident A wanted a cheese snack and asked DCW Celencia Sugg to open it for him. According to DCW Kuchar, she told him she would and then ran to the living room away from Resident A, therefore he became upset and eloped. DCW Kuchar stated that now staff are to go outside within five minutes to check on the other staff member and Resident A if he has attempted to elope. DCW Kuchar expalined that Resident A is very smart, but does not have impulse control and some staff members get easily frustrated as they think Resident A is doing these behaviors on purpose. She explained that she has heard that

Resident A sleeps until 3pm and does not eat most of the day, which could leave him hungry in the evening. DCW Kuchar stated that she has found medication administration time to be changelleing as Resident A often has more behaivors during this time. DCW Kuchar also stated that since he started seeing his father more, it has helped his behavior. She explained that she works well with her co-worker, DCW Zaire Parrotte as she does a great job re-directing Resident A. She stated that DCW Parrotte used to work first shift, but was moved to second shift and they have very few behaviors from Resident A when working together.

On 09/18/2025, I interviewed DCW Charles Albring via phone who reported that he was brought over to assist from another AFC facility owned by the licensee and worked about 6 or 7 shifts from 6pm-6am at Van Atta. DCW Alrbing stated that he was not told to much regarding Resident A and he skimmed his assessment plan and was told that he elopes and hits others. DCW Alrbing stated that Resident A only eloped to the driveway while he was working and he had to follow him once. He explained that Resident A tried to hit him, but never made contact. DCW Albring stated that on his first day at Van Atta, Resident A attacked Resident B. He explained that he was in the kitchen and Resident A started saying, “I’m sorry” to Resident B and then he pulled her hair and she went to the ground. DCW Albring explained that he stepped in and instructed Resident A to let go of her hair and he eventually let go. He explained that Resident A is very quick and Resident B let Resident A get close to her. DCW Albring reported that he has never seen a white board at the home for Resident A to communicate, but there are new cards with pictures on them to help Resident A communicate and Resident A also uses his tablet. DCW Albring reported that Resident A called 911 often and he snuck into Resident B’s room during his shift and grabbed her phone.

On 09/18/2025, I interviewed DCW Ivoryannah Jenkins via phone who stated that she has not worked at the Van Atta home within the last month after being moved to a different AFC facility owned by the licensee. DCW Jenkins stated that she was not trained how to handle any of Resident A’s behaviors and was told through another co-worker that Resident A eloped and made sexual advances towards staff. She reported that she reviewed his assessment plan. DCW Jenkins explained that staff tried to give tips and pointers, like to give Resident A what he wants or offer a car ride to Resident A, but they did not work. DCW Jenkins reported that Resident A tried to elope every shift she worked. She stated once when she was passing medications, Resident A started attacking another staff member and then eloped from the home. DCW Jenkins reported that the police were called. DCW Jenkins explained that she tried to work with him, but it was mentally draining and his prescribed as needed medication was no longer working. DCW Jenkins stated Resident A acted out by calling the police, pulling the fire alarm, which would then cause other residents to go into behavior, and it became too much. She explained that Resident A and Resident B fought almost every day, as Resident A tried to take Resident B’s phone or tried to get into Resident B’s bedroom without her permission. DCW Jenkins explained that the second shift was much worse for Resident A, as he would sleep all day and often started acting out around 6pm. DCW Jenkins stated that it was too much for only two staff to manage and that Resident A needed a

one-on-one staff member to provide attention to him and monitor him. She also stated she thought Resident A would benefit from a day program to assist him with getting outside of the home more often.

On 09/18/2025, I interviewed DCW Ivvy Knowlton via phone who stated she did not know too much about Resident A when he first arrived other than that Resident A had some behaviors, but were not aware of his eloping. She stated that she reviewed his assessment plan. DCW Knowlton stated that his caseworker didn't come for the first week, so much of the information they gained about Resident A was from experiencing it first hand. She explained that Resident A always had a notebook and pen at the beginning, but now she can communicate with him without it, but white boards are located around the home for assistance. DCW Knowlton reported Resident A's behaviors increase when there are new staff or staff with whom he is unfamiliar to see how far he can push them. She explained that she has built some trust and a bond with Resident A now and she understands how to communicate properly with him. DCW Knowlton gave the example of trying to distract him with something new, staying calm, not overreacting, giving short answers or directions and turning hitting into encouraging fist bumps and high fives. DCW Knowlton reported that Resident A's behavior has improved since being placed, but he will have behaviors when is Guardian A1 does not come for scheduled visits. DCW Knowlton reported that if the home had the proper knowledge of his behaviors before he arrived, they could have taken more precautions to prevent them. DCW Knowlton stated that they have not had consistent staff members as many are quitting due to his behaviors, therefore it's hard for Resident A to adjust. She reported that his calls to 911 have decreased, but he has eloped a few times in the evening recently. DCW Knowlton stated that he has not hit any other residents in a long time either while she has been working.

On 09/18/2025, I received documentation from Meridian Township Police Department. According to the report, on 09/05/2025 at 22:11 hours, a 911 call was received stating that Resident A took off running 10 minutes ago, down the long driveway. According to the report, it stated that Resident A ate too much cheese and staff took it away, which made him upset. At 22:17, another call came in stating that Resident A was on a ring camera and was trying to get inside another home near 4780 Wellington Drive. The second caller stated that she would like him picked up as they were on there way home with young children. The police were able to find Resident A and returned him to 4817 Van Atta Rd. at 22:36 hours.

Special Investigation Report #2025A0622012, cited Rule 400.14206 (2) on 02/05/2025 after it was a determined a resident had eloped from the facility three times and no adjustments were made to the staff schedule to provide additional protection supervision for this residents. Based on the information provided during the investigation, Van Atta Rd. Home did not have enough staff available on all shifts to provide appropriate personal care, supervision and protection for all six high need residents. A corrective action plan was received on 2/14/2025, stating that the resident was discharged, a new home manager was hired and Alternative Service Inc. has increased strategic recruitment efforts by raising the wage, posting additional job ads,

developing a quarterly performance bonus option and Sign-On Bonuses as well as utilizing trained staff from other homes to provide coverage.

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 upon interviews conducted and documentation reviewed it can be determined that there is adequate evidence to confirm that direct care workers were unable to meet the protection and safety needs of Resident A and Resident B. Resident A continued to elope from the home from 7/27/25 through 9/5/2025, therefore law enforcement intervention was needed to return Resident A to the home. On multiple occasions Resident A was physically aggressive towards Resident B, which resulted in Resident B calling law enforcement due to not feeling safe in the home. Therefore, a violation was established as direct care workers on second shift were unable to provide for Resident A and B's protection and safety at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 upon interviews conducted and documentation reviewed it can be determined that Van Atta Rd AFC did not have sufficient direct care staff on duty on the following dates when Resident A eloped; 07/26/25, 07/27/2025, 07/31/25 according to Citizen 1, 08/01/2025 and 09/05/2025. Resident A's elopement behaviors included running to nearby neighboring houses, pounding on the door, and at times removing clothing leaving Resident A partially nude. Resident A also entered a neighboring home without permission and tried to break into their car as well. Resident A also ran near the road. These incidents usually required police involvement because either direct care staff were not aware that Resident A had eloped from the facility or because Resident A did not respond to redirection. Per my review of pertinent documentation along with interviews with administrator Jeremy Hagerman and Van Atta operations director Tamie Stevens, both were aware of Resident A's elopement behavior, physical aggression, and inappropriate use of 911 prior to his admission to the facility yet did not assure that direct care staff were fully trained on how best to respond to Resident A's behaviors nor did they schedule additional staff to assist with monitoring Resident A and/or assisting with Resident A's challenging behaviors. Due to Resident A consistently eloping from the facility between 7/26/25-9/05/25 and Resident A's aggressive behavior towards Resident B during the first month of placement, along with direct care workers reporting that additional staff members were needed to provide appropriate care and supervision to Resident A and the other residents within the home, coupled with direct care workers quitting due to his behaviors, a violation was established as Van Atta AFC does not have sufficient direct care staff on duty, especially during the evening hours, when Resident A's behaviors were increasing.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2025A0622012 and CAP dated 2/14/2025.]**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the

	resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	Upon review of the *Timeline Notes* submitted by Tamie Stevens, Operations Director, during a zoom call with Community Mental Health the following information was provided prior to the licensee prior to Resident A's admission: history of eloping, physical aggression toward others, and history of calling 911 or police so he could chat with them. Administrator Jermery Hagerman also had access to Resident A's hospital discharge summary from a 07/17/25 hospital stay which highlighted the following: "resident is presenting to Sparrow hospital for worsening aggression at the AFC home. The patient has a history of multiple prior ER visits for aggressive behavior and has been seen by our service in the past with similar presentation. Per history, the patient was placed at a new group home on 7/12/25. He has a history of aggression and displayed these behaviors since he began to live there, but behaviors worsened with the patient punching staff members and assaulting another member of the group home. Most recently, the patient was seen in the hospital on 7/7/25 for agitation, including pulling the fire alarm at his AFC home, eloping from the home and visiting neighbors without clothes on." Interviews with multiple direct care workers at Van Atta Rd AFC documented that direct care staff felt unprepared and were untrained on Resident A's behaviors when he was admitted on 7/23/25. Direct care workers report they were not provided with appropriate information and skills to provide supervision for Resident A, nor was additional guidance or behavioral plans put in place to assist with Resident A's elopements and aggression towards Resident B and staff members. Despite multiple elopements and response from police, a temporary property fence was not added to the side yard to prevent Resident A from entering the neighbors yard until 8/26/25, one month after his admission. However, this has not stopped Resident A from eloping rather than only changed his course. Resident A eloped on 9/5/25 to a different neighbors home farther away from the facility. The travel to this location on 9/5/25, required Resident A to take a main road at 10:11pm. Consequently, the licensee did not have the appropriately skilled staff members or the physical accomdations in place to meet Resident A's needs both now and at the time of Resident A's admission. The licensee continues to struggle with retaining staff members who have high level de-esclation skills to provide for Resident A's safety in the home as evidenced by his continued elopements and aggressive behaivors towards residents and staff members.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas: **(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home.**
ANALYSIS:	Upon review of Resident A's person centered plan and individual plan of service inservice staff sign in sheet, it was determined that direct care worker Lundynn Myer did not review Resident A's person centered plan, nor was she given additional training on how care for Resident A. DCW Myer confirmed during a phone interview that she did not read his person centered plan and was unaware that he eloped or hit others before experiencing his behaviors first hand during her shift. Resident A was placed on 7/23/25 and DCW Myers worked on July 25th, 29th, 30th 31st and August 1st without training. Other direct care workers interviewed reported that they read the person centered plan during shift, but felt unprepared on how to handle his aggressive and eloping behaviors as no in-depth training was provided and the tips provided were not effective with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license due to the quality-of-care violations.

09/30/2025

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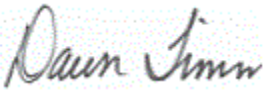
Amanda Blasius Date
Licensing Consultant

Approved By:



10/01/2025

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Dawn N. Timm Date
Area Manager