



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 24, 2026

Drew Kersjes  
CMHB Of CEI Counties  
Suite 115  
812 E Jolly Road  
Lansing, MI 48910

RE: License #: AM190008072  
Investigation #: 2026A0466059  
Roger G Smith Home

Dear Mr. Kersjes:

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,

A handwritten signature in dark ink, appearing to read "Julie Elkins". The signature is written in a cursive, flowing style.

Julie Elkins, 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**

|                                       |                                                    |
|---------------------------------------|----------------------------------------------------|
| <b>License #:</b>                     | AM190008072                                        |
| <b>Investigation #:</b>               | 2026A0466059                                       |
| <b>Complaint Receipt Date:</b>        | 08/18/2026                                         |
| <b>Investigation Initiation Date:</b> | 08/19/2026                                         |
| <b>Report Due Date:</b>               | 10/17/2026                                         |
| <b>Licensee Name:</b>                 | CMHB Of CEI Counties                               |
| <b>Licensee Address:</b>              | Suite 115<br>812 E Jolly Road<br>Lansing, MI 48910 |
| <b>Licensee Telephone #:</b>          | (517) 346-8200                                     |
| <b>Administrator:</b>                 | Drew Kersjes                                       |
| <b>Licensee Designee:</b>             | Drew Kersjes                                       |
| <b>Name of Facility:</b>              | Roger G Smith Home                                 |
| <b>Facility Address:</b>              | 15817 N Turner<br>Lansing, MI 48906                |
| <b>Facility Telephone #:</b>          | (517) 346-8266                                     |
| <b>Original Issuance Date:</b>        | 09/26/1990                                         |
| <b>License Status:</b>                | REGULAR                                            |
| <b>Effective Date:</b>                | 03/04/2026                                         |
| <b>Expiration Date:</b>               | 03/03/2028                                         |
| <b>Capacity:</b>                      | 8                                                  |
| <b>Program Type:</b>                  | DEVELOPMENTALLY DISABLED                           |

## II. ALLEGATION:

|                                                                                             | Violation<br>Established? |
|---------------------------------------------------------------------------------------------|---------------------------|
| Resident A has been eloping from the facility which causes safety and supervision concerns. | Yes                       |
| Additional Finding                                                                          | Yes                       |

## III. METHODOLOGY

|            |                                                                                                  |
|------------|--------------------------------------------------------------------------------------------------|
| 08/18/2026 | Special Investigation Intake 2026A0466059.                                                       |
| 08/19/2026 | APS Referral Tom Hilla assigned.                                                                 |
| 08/19/2026 | Special Investigation Initiated – Letter email to Complainant.                                   |
| 08/20/2026 | Inspection Completed On-site.                                                                    |
| 08/20/2026 | Contact - Telephone call received from house manager Matt Brady, message left.                   |
| 08/20/2026 | Contact - Telephone call made to Matthew Brady, message left.                                    |
| 08/27/2026 | Contact- telephone call received from APS Tom Hilla.                                             |
| 09/14/2026 | Contact - Telephone call made to Matthew Brady, interviewed.                                     |
| 09/14/2026 | Contact – Email sent to Matt Brady, documents requested.                                         |
| 09/14/2026 | Contact- Email sent to APS Tom Hilla.                                                            |
| 09/15/2026 | Contact- Email sent to licensee designee Drew Kersjes.                                           |
| 09/22/2026 | Contact- telephone call received from APS Tom Hilla.                                             |
| 09/22/2026 | Contact- document sent FOIA request.                                                             |
| 09/22/2026 | Contact- telephone call made to case manager Jessica Decker, interviewed.                        |
| 09/23/2026 | Contact- telephone call made to Citizen 1, could not leave a message so a text message was sent. |
| 09/23/2026 | Contact- document received- police report.                                                       |

|            |                                                                   |
|------------|-------------------------------------------------------------------|
| 09/23/2026 | Exit Conference with licensee designee Drew Kersjes by telephone. |
|------------|-------------------------------------------------------------------|

**ALLEGATION: Resident A has been eloping from the facility which causes safety and supervision concerns.**

**INVESTIGATION:**

On August 18, 2026, Complainant reported that Resident A (55 years old) resides in a licensed Adult Foster Care (AFC) home. Complainant reported that Resident A is non-verbal and on August 17, 2026 Resident A was in a neighbor's garage and started their lawn mower. Complainant reported that there is a history of Resident A wandering onto people's property without permission or supervision. Complainant reported that Resident A has traveled 20-30 yards to get to his neighbor's property. Complainant reported that the police were called to the Family Dollar over a week ago because Resident A had stolen a watch while out wandering on his own. Complainant reported concerns for the ongoing lack of supervision and concerns for Resident A's safety wandering onto neighborhood properties. Resident A is non-verbal and cannot communicate with others. Complainant reported that facility staff are aware of Resident A going to Family Dollar and wandering outside, but it continues to occur as it occurred again last night (August 17, 2026).

On August 20, 2026, I completed an unannounced investigation and upon arrival, I observed that although the yard is fully fenced, the gate to the fenced yard was open.

I interviewed Direct Care Worker (DCW) Gaven Dole, who reported that he has worked at the facility for a total of five years, though not continuously. DCW Dole stated that Resident A is nonverbal and that the recent elopement behavior is new for him. He explained that Resident A appears to be testing boundaries to see what he can get away with, noting that historically Resident A would only go as far as the stop sign, a short distance from the home, and then return immediately. DCW Dole reported that he was not on duty when the most recent elopement occurred but confirmed that he was informed about the incident by other staff. He acknowledged that Resident A's behavior has changed from his prior pattern and now includes unsupervised departures (elopements) from the facility.

I interviewed DCW Connor Ball, who reported that he has worked at the facility for six months and that Resident A has lived at the home for 28 years. DCW Ball stated that Resident A is nonverbal but will slam doors when he is frustrated. DCW Ball reported that Resident A has never eloped while he was on shift. He explained that Resident A used to be satisfied with going on short walks independently, as there had previously been no issues. DCW Ball stated that recently, a couple of weeks ago, Resident A was found in the park by the police, so a DCW who was on shift went to pick Resident A up from police custody. DCW Ball also reported that

Resident A was found in someone's house. He stated that DCWs have been encouraged to walk with Resident A or redirect him to the backyard, since it is fenced in. DCW Ball reported that he did not have any additional information about whose house Resident A entered, and he had no knowledge of Resident A starting a lawn mower while in a neighbor's garage.

I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* (assessment plan). The assessment plan was completed on 11/21/2025 and signed by Guardian A1 and licensee designee Drew Kersjes. In the "moves independently in the community" section of the assessment plan it documented "no", "needs staff's assistance to move safely though the community." In the "manages money" section of the report it stated, "no, needs assistance from staff to buy items." In the "recreation" section of the written *Assessment Plan for AFC Residents* it stated, "enjoys going for walks."

Although direct care workers reported during interviews that Resident A was going on walks independently off the facility's property, the written assessment plan documented that Resident A requires staff supervision when in the community, including during walks. This discrepancy indicates that staff actions were inconsistent with Resident A's assessed supervision needs as documented in the assessment plan.

I interviewed Adult Protective Services (APS) worker Tom Hilla by telephone on August 27, 2026. APS Hilla reported that he had been at the facility on August 18, 2026, and implemented a safety plan that day to ensure that Resident A was no longer in the community unsupervised. APS Hilla reported that house manager Matthew Brady and the direct care workers on duty all agreed to implement the safety plan immediately.

On September 14, 2026, I interviewed DCW Matthew Brady, whose role is as house manager, by telephone. He reported that in April 2026, Resident A regularly walked unsupervised to the stop sign and back to the facility. Mr. Brady stated that Resident A gradually began walking farther from the home, with staff watching him as he did so. He confirmed that beginning in June 2026, Resident A started testing boundaries and continued walking farther away from the facility and outside of DCW supervision. Mr. Brady reported that after the facility was notified that Resident A had been located at Family Dollar without the direct care workers on duty being aware that he had left the home, staff began following or redirecting Resident A whenever he attempted to leave the facility unsupervised. Mr. Brady denied having any knowledge of Resident A stealing a watch at Family Dollar, but he did confirm that Resident A had gone onto other people's property and on another occasion started a lawn mower while in someone else's garage. Mr. Brady stated that Resident A is nonverbal, and that since APS involvement began, there have been no new elopements. He explained that direct care workers now follow Resident A when

he attempts to leave, and that Resident A returns home because he wants to be in the community alone.

I interviewed Resident A's case manager, Jessica Decker, by phone on September 12, 2026. Case manager Decker is employed with Community Mental Health (CMH) of Clinton, Eaton, and Ingham Counties (CEI). She reported that Resident A's elopements are a new behavior. Case manager Decker stated that Resident A had been doing well with walking unsupervised down the driveway and back, then walking to the stop sign and back, but eventually began walking farther away to the point that he was eloping from the facility unsupervised. Case manager Decker reported that she was aware of two elopement situations. She stated that the first incident occurred on July 12, 2026, when the Clinton County Sheriff's Office brought Resident A back to the facility after finding him walking through people's yards on State Road. She reported that on August 19, 2026, while she was conducting an onsite appointment with Resident A at the facility, she was informed that Resident A had again been brought home by police after being located near the Granger Recycling Center. Case manager Decker stated that she did not know the exact date of this second incident, only that she was notified that police had returned Resident A to the facility twice within two months. Case manager Decker reported that she had not been informed that Resident A stole a watch at Family Dollar, started a lawn mower in a garage, or entered unknown houses. She further stated that she referred Resident A for psychological services on August 24, 2026, and confirmed that Resident A requires staff supervision while in the community.

On September 23, 2026, I reviewed an *Incident/Investigation Report dated 8/18/2026* and written by Officer Megan Parviainen. A summary of the *Incident/Investigation Report* is below: "Community members in the neighborhood reported that [Resident A] has been repeatedly wandering onto private property unsupervised. Community members stated that he has entered a neighbor's garage, started a lawn mower, walked through yards, and has been found by police in multiple off-property locations. Neighbors expressed concerns about their own safety, their children's safety, and Resident A's wellbeing due to his unpredictable wandering and inability to communicate. They reported that these incidents appear to be increasing in frequency and believe that adequate supervision is not being maintained."

| <b>APPLICABLE RULE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>R 400.685</b>       | <b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                        | <p><b>(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following:</b></p> <p><b>(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>ANALYSIS:</b>       | <p>Complainant reported multiple incidents in which Resident A, who is non-verbal and unable to communicate his needs, eloped from the facility. These incidents included being in a neighbor's garage and starting a lawn mower, traveling onto neighboring properties, being found by police in the community, allegedly stealing a watch from a local store, and wandering 20–30 yards off the property.</p> <p>Resident A's CEI-CMH case manager Decker confirmed that Resident A requires staff supervision in the community and that the elopements represent new and escalating safety risks.</p> <p>Staff interviews confirmed that Resident A's elopement behavior began in June 2026 after Resident A walked further away from the home. Reported elopement incidents include the police bringing Resident A back to the facility after finding him wandering through yards and near the recycling center. DCWs reported that they began following or redirecting Resident A after multiple elopement incidents had occurred.</p> <p>Resident A's written <i>Assessment Plan for AFC Residents</i> documented that he requires staff assistance to move safely through the community and because he was unsupervised in the community on multiple occasions a violation has been established.</p> |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

#### **ADDITIONAL FINDINGS:**

#### **INVESTIGATION:**

On August 20, 2026, an unannounced onsite investigation was conducted, and Resident A's record was reviewed. The record contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* documenting that the assessment plan was

completed on 11/21/2025. The document included Guardian A1 and licensee designee signatures. Guardian A1's signature was present but not dated, so there was no verification of when the guardian signed or participated in the assessment plan completion. Licensee Designee, Drew Kersjes' signature is dated 2/06/2026, which is approximately two and a half months after the stated completion date.

The lapse of time between the documented completion date (11/21/2025), and the licensee designee's signature date (2/06/2026) combined with the missing date on the guardian's signature, results in no verifiable documentation that the assessment plan was completed with the joint participation of both the licensee and the resident's designated representative as required. There was no supplemental documentation in the record demonstrating that the guardian and licensee designee together participated in the assessment process at the time it was completed.

| <b>APPLICABLE RULE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>R 400.685</b>       | <b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                        | <b>(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>ANALYSIS:</b>       | Resident A's written <i>Assessment Plan for AFC Residents</i> was completed on "11/21/2025" which is documented in the section titled, "date assessment plan was completed." Resident A's designated representative signed the assessment plan, but the signature was not dated. Licensee Designee, Drew Kersjes signature is dated 2/06/2026, which is approximately two and a half months after the stated completion date. Resident A's record did not contain any documentation demonstrating that the guardian and licensee participated in the assessment process at the time it was completed. Due to the absence of dated signatures and the lapse of time between the assessment completion date and the licensee designee's signature, there is insufficient documentation confirming joint participation in the assessment process. |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

#### **INVESTIGATION:**

On August 20, 2026, an unannounced investigation was conducted, and Resident A's record was reviewed. The record did not contain any *AFC Incident/Accident Reports* (IRs) documenting episodes in which Resident A left the facility

unsupervised. During interviews with DCW Gavin Dole and DCW Conner Ball although neither was on shift at the time of the elopements both reported that Resident A had left the facility independently without staff knowledge or supervision. They further reported that police contacted the facility after locating Resident A at Family Dollar, confirming that an elopement occurred.

On September 14, 2026, I requested copies of the IRs from direct care staff member, whose role is also house manager, Matthew Brady, both by phone and by email. Mr. Brady reported that he was uncertain how to obtain or provide the IRs. The following day, September 15, 2026, I requested the IRs from the licensee designee, Drew Kersjes via email who did not respond to the email request, and no IRs were provided.

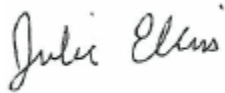
| <b>APPLICABLE RULE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>R 400.693</b>       | <b>Incident notification, incident records.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                        | <b>(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:</b><br><b>(e) Elopement from the facility if the resident's location is unknown.</b><br><br><b>(3) An incident must be recorded on a department-approved form, or a facility form that contains the same information, and retained in the facility for 2 years.</b><br><br><b>(4) The department may review incident reports during a renewal inspection or special investigation. This does not prohibit the department from requesting an incident report if determined necessary by the department. If the department requests an incident report, the licensee shall provide the report in electronic form within 24 hours after the request. The department shall maintain and protect these documents in accordance with state and federal laws, including privacy laws.</b> |

|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ANALYSIS:</b>   | There were no <i>AFC Incident/Accident Reports</i> in Resident A's record documenting the multiple times Resident A eloped in the facility as required. Despite multiple attempts to obtain these documents from both DCW/house manager Matthew Brady and licensee designee Drew Kersjes, no <i>AFC Incident/Accident Reports</i> were received. Since the <i>AFC Incident/Accident Reports</i> were not completed and/or in Resident A's record a violation has been established. |
| <b>CONCLUSION:</b> | <b>VIOLATION ESTABLISHED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

On September 23, 2026, I conducted an exit conference with licensee designee Drew Kersjes, who acknowledged understanding of the violations established during the special investigation.

#### IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan I recommend no change in license status.



09/23/2026

Julie Elkins  
Licensing Consultant

Date

Approved By:



09/23/2026

Dawn N. Timm  
Area Manager

Date