RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 4, 2017

Nancy Beach
Valley Residential Serv. Inc.
P O Box 186
St Charles, MI 48655-0186

RE: License #: AS230068521
Investigation #: **2018A0466001**
Mulliken Afc Home

Dear Ms. Beach:

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) 284-9727.

Sincerely,

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

License #:	AS230068521
Investigation #:	2018A0466001
Complaint Receipt Date:	10/06/2017
Investigation Initiation Date:	10/09/2017
Report Due Date:	12/05/2017
Licensee Name:	Valley Residential Serv. Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(989) 865-9997
Administrator:	Nancy Beach
Licensee Designee:	Nancy Beach
Name of Facility:	Mulliken Afc Home
Facility Address:	9120 E Eaton Hwy Mulliken, MI 48861
Facility Telephone #:	(517) 649-2377
Original Issuance Date:	11/01/1995
License Status:	REGULAR
Effective Date:	07/26/2017
Expiration Date:	07/25/2019
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A has been leaving the Adult Foster Care (AFC) facility and wandering around the community. It is unknown how long Resident A is left unattended in the community and unknown if staff are "allowing" Resident A to leave. Law enforcement has been contacted regarding Resident A leaving the AFC. There are concerns regarding Resident A's safety.	Yes

III. METHODOLOGY

10/06/2017	Special Investigation Intake 2018A0466001
10/09/2017	Special Investigation Initiated - Telephone
10/09/2017	Contact - Document Sent Requested police reports from the Eaton County Sheriff Department.
10/09/2017	Contact - Telephone call received APS worker Penny Howard.
10/09/2017	Contact - Document Received
10/12/2017	Contact - Document Received 2nd police report from case number 2017-0006680.
10/16/2017	Contact- Telephone Call Received from Penny Howard
10/17/2017	Contact - Telephone call made interview with Rebecca Grabenstein.
10/17/2017	Contact - Telephone call made interviewed CMH case manager Robert Cheethan.
10/17/2017	Contact - Telephone call made Guardian Kristen Barber, left message.
10/17/2017	Contact - Telephone call received Kristen Barber returned call and was interviewed.
11/06/2017	Contact - Telephone call received Rebecca called to say that they did not have Resident A's documents, they were given to the new facility.

11/15/2017	Inspection Completed On-site
11/30/2017	Exit Conference with Nancy Beach

ALLEGATION: Resident A has been leaving the Adult Foster Care (AFC) facility and wandering around the community. It is unknown how long Resident A is left unattended in the community and unknown if staff are "allowing" Resident A to leave. Law enforcement has been contacted regarding Resident A leaving the AFC. There are concerns regarding Resident A's safety.

INVESTIGATION:

On 10/06/2017, Complainant reported that Resident A has been leaving the Adult Foster Care (AFC) facility and wandering around the community. It is unknown how long Resident A is left unattended in the community and unknown if staff are "allowing" Resident A to leave. Law enforcement has been contacted regarding Resident A leaving the AFC. There are concerns regarding Resident A's safety.

On 10/09/2017, I talked with Penny Howard, Adult Protective Services (APS) Eaton County Department of Health and Human Services (DHHS) who reported that Resident A is being allowed to leave the facility by staff and has been found wandering, forcing community members to contact law enforcement. APS Worker Howard reported that she went to the facility and was told that Resident A is being moved to a new AFC on 10/11/2017 due to a 30-day discharge notice.

On 10/09/2017, I reviewed an *Incident/Investigation Report* received from the Eaton County Sherriff's Department, case # 2017-006381 dated 09/17/2017 at 18:37PM. The report stated that Resident A leaves the AFC facility and goes on the neighbor's property, this has happened on several occasions and on 09/17/2017, Resident A stole an orange bouncy ball from the neighbor's deck.

On 10/12/2017, I reviewed *Incident/Investigation Report* received from the Eaton County Sherriff's Department, case # 2017-006680 dated 09/27/2017 at 18:21PM. The report stated that Resident A was in the neighbor's house and "bit the head off of a doll in the home." The report reflected that the homeowner reported that this is not the first time that Resident A has come into the home uninvited, Resident A has also urinated in the home.

On 10/17/2017, I contacted Rebecca Grabenstein, direct care worker (DCW) who reported that Resident A has moved to another AFC. DCW Grabenstein reported that a 30-day discharge was issued because DCWs could not maintain Resident A within their eyesight when he ran out of the facility. Resident A would go down the

drive way into the ditch/street or to the neighbor's house/yard that is in close proximity to the AFC. DCW Grabenstein reported that Resident A is twenty-two years, full of energy and very fast. DCW Grabenstein reported that additional staff were added to assist in the supervision of Resident A, so the staffing pattern was three DCWs overseeing six residents. Community Mental Health (CMH) Case Worker, Robert Cheethan and Guardian Kristen Barber were contacted for intervention ideas, outdoor motion lights were offered to be added, but were not approved by CMH and Resident A continued to elope. DCW Grabenstein reported that a privacy fence was installed on 10/05/2017 as a final effort to assist Resident A in understanding the facility's perimeter, however since Resident A moved on 10/11/2017, it was unknown if the fence could decreased Resident A's number of elopements. DCW Grabenstein reported that the written *AFC Resident Care Agreement* had been completed however when Resident A moved all of his original AFC paperwork was given to the new facility so it was not available to be reviewed. DCW Grabenstein reported that Resident A did not have a behavior management plan despite his challenging behaviors and the facility requesting one from community mental health.

On 10/17/2017, I interviewed CMH Case Manager Robert Cheethan who confirmed that Resident A did not have a behavioral plan. Mr. Cheethan reported that Resident A has difficult behaviors and it was a challenging situation, however everyone did the best that they could under the circumstances. Mr. Cheethan confirmed that Resident A is non-verbal and that he would not be able to be interviewed for the purpose of this investigation due to his limitations.

On 10/17/2017, I interviewed Guardian Kristen Barber who reported that Resident A has a history of elopement and Ms. Barber thought that the facility did all that they could to protect and meet Resident A's needs under the circumstances. Ms. Barber reported being informed about the incidents as they occurred and believed that the DCWs had responded appropriately.

On 11/15/2017, I conducted an unannounced on-site investigation and interviewed DCW Tasha DeLeon who reported that Resident A did elope from the facility about four or five times and Resident A always eloped to the next door neighbor's except once he eloped while the facility was having a picnic at Community Lake Park on 09/05/2017. DCW DeLeon reported that the Portland Police Department was contacted and assisted in locating Resident A. DCW DeLeon reported that once Resident A was located the officer drove Resident A and a DCW back to the facility. DCW DeLeon stated that Resident A attempted to leave the facility in the presence of the Portland Officer so he called for an ambulance so that Resident A could be transported for assessment for hospitalization. DCW DeLeon reported that Resident A was aggressive towards staff which resulted in DCW April Calahan being injured and placed on workers compensation and DCW Kaitlyn Brighton sustained a wrist injury. DCW DeLeon reported that Resident A would hit other residents and Resident B was seen at urgent care when Resident A put his hand in Resident B's mouth and pulled on his lips, however no injury was obtained. DCW DeLeon

reported that after the first elopement to the neighbor's property, the facility used caution tape to separate the lots to distinguish the property lines for Resident A, a social story was completed by CMH to help Resident A understand the boundaries and the areas that were "off limits" for his safety. DCW DeLeon reported that photographs were provided by the facility of "safe places" and places that were "off limits" and the CMH Speech Therapist authored the social story. DCW DeLeon reported that a meeting with CMH took place for the purpose of developing a behavioral plan on 09/06/2017, the meeting occurred, however the plan was not developed so the facility issued a 30 day discharge on 09/06/2017 as the facility needed specialized intervention to care for Resident A and the facility had concerns for Resident A's safety and well-being. DCW DeLeon reported that another meeting was scheduled with the neighbors, guardian and CMH on 09/25/2017, however that meeting was cancelled by CMH and not rescheduled. DCW DeLeon reported that Resident A never had a behavioral plan despite the facility asking for one. DCW DeLeon reported that the written *AFC Resident Care Agreement* had been completed however when Resident A moved all of his original AFC paperwork was given to the new facility instead of copies so no AFC paperwork could be reviewed. DCW DeLeon could not provide a copy of the written 30 day discharge notice for review as all of the emails that are sent and received from CMH are deleted after 30 days as part of CMH's security measures.

On 11/15/2017, I conducted an unannounced on-site investigation and interviewed DCW Mary Bline. DCW Bline reported that Resident A eloped from the facility to the neighbor's house. DCW Bline reported that stop and go signs were immediately put on the doors of the facility as triggers for Resident A, battery operated alarms were installed on windows and doors with different sounds so that DCWs would be able to determine from the sound where Resident A had exited from. DCW Bline reported that Resident A's admission date was 08/31/2017 and on 09/06/2017 an emergency discharge notice was given due to the facility not being able to safely maintain Resident A in the facility. While awaiting Resident A's discharge, a perimeter fence was installed on 10/05/2017 as an additional effort to try to maintain Resident A at the facility. DCW Bline reported that CMH moved Resident A to a different facility on 10/11/2017.

On 11/15/2017, I reviewed fourteen *AFC Incident Reports,* four *Valley Residential Services, Inc., Emergency Procedure Drill Reports,* nine *Employee Accident Reports* and one *Portland Police Department Report,* incident number 17-000870 dated 09/05/2017 12:30:00, all that all involved Resident A. These documents reflected Resident A's aggressive behaviors, elopement and efforts made by the facility to ensure Resident A's safety and well-being.

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:	Law enforcement had been contacted regarding Resident A leaving the AFC on 09/05/2017, 09/17/2017 and 09/27/2017. In an effort to stop Resident A from eloping, DCW Grabenstein reported that additional staff were added to assist in the supervision of Resident A, consequently the facility was staffed with three staff members for six residents. Additional steps to stop Resident A from eloping included creating a "social story" for Resident A outlining the boundaries of the facility for Resident A in pictorial format, adding alarms to all of the exit doors, adding stop and go signs to exit doors, caution tape, and finally installing a perimeter fence. DCWs DeLeon, Bline, and Grabenstein all denied that Resident A was allowed to freely leave the facility without supervision and all tried to follow him whenever he attempted to elope from the facility. Resident A's guardian was satisfied with the care he received and reported that the staff members took all of the appropriate steps to stop him from eloping. Once it became clear that Resident A could not be maintained safely in the facility, a 30-day discharge notice was issued to Resident A. During this time, the facility continued to make efforts to keep Resident A safe by adding the perimeter fence on 10/05/2017. Also, DCW Grabenstein, DCW DeLeon, DCW Bline and Mr. Cheethan all reported that despite Resident A's challenging behaviors that no behavior management plan was in place for the facility to follow despite their request for one from CMH. DCW DeLeon reported that a meeting was scheduled to develop a behavior plan on 09/06/2017 and although the meeting took place, no behavioral plan was developed. Consequently, staff members continued to attend to Resident A's safety needs until his discharge on 10/11/2017.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:
During the investigation, I was not able to review Resident A's resident record because the facility had provided Resident A's new placement with all of his resident records from this AFC facility.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide

	information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.** **(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from the home.**
ANALYSIS:	At the time of the investigation, Resident A's resident record was not available for review because the facility had given Resident A's records to his next placement and had not maintained any copies of the required documents.

CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

12/04/2017

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Julie Elkins Date
Licensing Consultant

Approved By:

12/04/2017

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Dawn N. Timm Date
Area Manager