GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 11, 2022

Rose Martin
Choice Care IV Inc
12-14 Mary St
Battle Creek, MI 49014

RE: License #: AM130065342
Investigation #: 2022A1024048
Choice Care IV Inc

Dear Mrs. Martin:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Ondrea Johnson

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM130065342
Investigation #:	2022A1024048
Complaint Receipt Date:	08/17/2022
Investigation Initiation Date:	08/19/2022
Report Due Date:	10/16/2022
Licensee Name:	Choice Care IV Inc
Licensee Address:	12-14 Mary St Battle Creek, MI 49014
Licensee Telephone #:	(269) 964-2801
Administrator:	Rose Martin
Licensee Designee:	Rose Martin
Name of Facility:	Choice Care IV Inc
Facility Address:	12-14 Mary Street Battle Creek, MI 49014
Facility Telephone #:	(269) 964-2801
Original Issuance Date:	04/17/1997
License Status:	REGULAR
Effective Date:	06/27/2022
Expiration Date:	06/26/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide safety and protection because Resident A eloped from the facility.	No

III. METHODOLOGY

08/17/2022	Special Investigation Intake 2022A1024048
08/19/2022	Special Investigation Initiated – Telephone left voicemail for Relative A1
08/22/2022	Contact - Telephone call made with Relative A1
09/16/2022	Inspection Completed On-site with direct care staff member Debby Weaver
09/17/2022	Contact - Telephone call made with staff member Andie Martin and licensee designee Rose Martin
09/21/2022	Contact - Telephone call made Battle Creek Police Department
09/28/2022	Contact - Document Received-Police Report 22-002136
10/07/2022	Exit Conference with licensee designee Rose Martin

ALLEGATION:

Staff failed to provide safety and protection because Resident A eloped from the facility.

INVESTIGATION:

On 8/17/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged direct care staff failed to provide safety and protection because Resident A eloped from the facility.

On 8/22/2022, I conducted an interview with Relative A1 regarding this allegation. Relative A1 stated she found out Resident A eloped from the facility during the

night and was returned by the police after they found her wandering in downtown Battle Creek. Relative A1 stated Resident A was lost and alone in the dark and was in a strange place. Relative A1 further stated the staff wasn't aware Resident A had eloped from the facility. Relative A1 stated she believes Resident A had a seizure which is the reason for her walking away from the facility during the night.

On 9/16/2022, I conducted an onsite investigation at the facility with direct care staff Debby Weaver. Ms. Weaver stated that on 3/25/2022 Resident A received her medication and went into the living room to watch television at 10:00pm. Ms. Weaver stated Resident A was observed to go to her bedroom at 10:30pm. Ms. Weaver stated Resident A does not require supervision during the night and she had no history of elopement. Ms. Weaver stated she believes around 1am law enforcement came to the home with Resident A and explained Resident A was found walking in downtown Battle Creek which is nearby the facility. Ms. Weaver stated she was not aware Resident A had left the facility, nor did she hear or see Resident A leave the facility. Ms. Weaver stated she was under the impression Resident A went to her sleep when she went to her bedroom. Ms. Weaver stated Resident A was discharged shortly after this incident and Ms. Weaver believes the family made a complaint against the home because Resident A was given a 30-day discharge notice for Resident A to go to a more appropriate setting.

I reviewed Resident A's *Assessment Plan for AFC Residents* (plan) dated 7/15/2021. According to this plan, Resident A moves independently in the community and does not require supervision at night.

I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 3/26/2022. According to this report, on 3/25/2022 Resident A has focal seizures and wandered from the home after she took her nighttime medications after 10:45pm when movie night ended. The report stated Resident A has never done this before and guided the police back to the home when she was found wandering by the police. The report stated a 30-day discharge notice was issued to the family as Resident A needs to be moved to a more appropriate setting.

On 9/17/2022, I conducted an interview with administrator Andie Martin and licensee designee Rose Martin who both stated that when Resident A was admitted to the facility it was reported that she had no issues with elopement or needed specialized supervision. Ms. Andie Martin stated Choice Care IV Inc is an adult foster care facility for residents who can move independently in the community and does not require specialized supervision therefore a 30-day discharge was given to Resident A as the home is not equipped to manage residents who have issues with elopement. Ms. A. Martin and Ms. R. Martin both stated this was the first time Resident A has ever eloped from the facility and she does require specialized supervision at night. Ms. Andie Martin stated the biggest concern with Resident A was working with her family members. Ms. Andie Martin stated that Resident A's family did not provide rent payment regularly and was default on rent which is

another reason why a 30-day discharge notice was provided to Resident A.

On 9/28/2022, I reviewed *Police Report 22-002136*. According to this report, law enforcement was dispatched to conduct a welfare check on Resident A as she walked away from her AFC home and was transported back to the home by the police. This incident occurred on 3/26/2022.

R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation which included interviews with direct care staff member Debby Weaver, administrator Andie Martin, licensee designee Rose Martin, Relative A1, review of Resident A's assessment plan and the facility's incident report there is no evidence to support the allegation staff failed to provide safety and protection because Resident A eloped from the facility. Ms. Weaver, Ms. Andie Martin and Ms. Rose Martin all stated that Resident A has no history of having elopement issues and does not require supervision at night. According to the assessment plan Resident A moves independently and does not require supervision at night. According to the facility's incident report Resident A walked away from the facility after 10:45pm and was later returned by the police. Resident A eloped from the facility after staff believed Resident A went to sleep in her bedroom. Resident A had no prior incidents of eloping therefore there was no reason for staff to believe Resident would leave the facility after going into her bedroom. Safety and protection for Resident A has been provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/7/2022, I conducted an exit conference with licensee designee Rose Martin. I informed Ms. Martin of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

10/7/2022

Ondrea Johnson — Date
Licensing Consultant

Approved By:

10/11/2022

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Dawn N. Timm — Date
Area Manager