GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 03, 2023.

Stella Agonor
Bettercare AFC Inc.
2120 Cawdor Ct
Lansing, MI 48917

RE: License #: AS330390693
Investigation #: 2023A0466018
Bettercare AFC Inc.

Dear Ms. Agonor:

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 #:	AS330390693
Investigation #:	2023A0466018
Complaint Receipt Date:	01/09/2023
Investigation Initiation Date:	01/11/2023
Report Due Date:	03/10/2023
Licensee Name:	Bettercare AFC Inc.
Licensee Address:	2120 Cawdor Ct Lansing, MI 48917
Licensee Telephone #:	(517) 410-4331
Administrator:	Stella Agonor
Licensee Designee:	Stella Agonor
Name of Facility:	Bettercare AFC Inc.
Facility Address:	444 West Street Lansing, MI 48915
Facility Telephone #:	(517) 410-4331
Original Issuance Date:	05/01/2018
License Status:	REGULAR
Effective Date:	11/01/2022
Expiration Date:	10/31/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION:

	Violation Established?
Resident A was found unsupervised at a local restaurant, Panda Express, even though he requires supervision from direct care staff members while out in the community.	No
Additional Findings	Yes

III. METHODOLOGY

01/09/2023	Special Investigation Intake-2023A0466018.
01/11/2023	Contact - Telephone call made to Complainant, message left.
01/11/2023	Contact - Document Sent, Email to Complainant.
01/11/2023	Special Investigation Initiated - On Site.
01/11/2023	Contact- Telephone call received from licensee designee Stella Agonor, interviewed.
01/12/2023	Contact - Telephone call made to social worker Taylor Knickerbocker, East Lansing Police Department interviewed.
01/12/2023	Contact - Telephone call made to Officer Harrison, interviewed.
02/22/2023	APS Referral made- Complaint denied.
02/24/2023	Contact - Telephone call made to DCW Francisca Farris, message left.
02/28/2023	Contact - Telephone call made to case manager Heather McClelland, interviewed.
02/28/2023	Contact- Document sent to licensee designee Stella Agonor.
03/01/2023	Contact- Document recevied from licensee designee Stella Agonor.
03/01/2023	Exit Conference with licensee designee Stella Agonor.

ALLEGATION: Resident A was found unsupervised at a local restaurant, Panda Express, even though he requires supervision from direct care staff members while out in the community.

INVESTIGATION:
On 01/11/2023, Complainant reported that East Lansing Police was dispatched the local restaurant Panda Express due to a report that an older gentleman at the restaurant did not know his name, where he was or where he lived. Complainant reported upon arriving on scene Resident A provided identification and stated he did not know where he lived but wanted to go home. Complainant reported Resident A stated he took the bus from an unknown location and ended up at Panda Express. Complainant reported after speaking to Resident A for some time it became obvious Resident A struggles with memory issues as he had difficulty with recall and did not know basic facts such as his name and address. Complainant reported calling the group home where Resident A resides to get additional information after locating a business card in Resident A's wallet. Complainant reported the direct care worker on duty (name unknown) did not know that Resident A had left the home and insisted that Resident A was in his room sleeping. Complainant reported she again told the direct care worker on duty that Resident A was at Panda Express. Complainant expressed concern Resident A was not accounted for at the group home and that he should clearly not be in the community alone due to obvious cognitive difficulties.

On 01/11/2023, I conducted an unannounced onsite investigation and I reviewed Resident A's record which contained an *Adult Foster Care* (*AFC) Resident Information and Identification Record* that documented Resident A was admitted to the facility on 08/08/2019 and was 74 years. Resident A's record contained a *Health Care Appraisal* dated 08/19/2022 and documented that he is diagnosed with Major depressive disorder (MDD) and diabetes (DM) type 2. Resident A's record contained an *Assessment Plan for AFC Residents* completed on 10/19/2022. In the "Moves independently in Community" section of the report both 'yes' and 'no' were marked. In the narrative section it stated, "Client goes to the store in the company of other clients. Taken to all appointments." In the "assistive device" section of the report it stated, "Uses cane only when outside the facility." In the "physical exercise" section of the report it stated, "walking."

I reviewed the facilities in and out log which documented, "Friday 6 at 11:45," Resident A signed out and in the "destination" portion of the log it stated, "raidos." [sic] The log documented that Resident A returned at "3:45."

I interviewed direct care worker (DCW) Kathleen Finlayson who was on duty on 01/11/2023. DCW Finlayson reported Resident A does not go into the community alone because he has had instances of getting lost, falling and getting tired because he walks too far. DCW Finlayson reported Resident A typically goes into the community with Resident B so that Resident B can watch over Resident A. DCW

Finlayson reported Resident A does not have a history of signing out alone, wandering off alone or eloping from the facility. DCW Finlayson reported that Resident A did not show any signs of wanting to the leave the facility, he did not talk about wanting to leave nor did he ask to go anywhere. DCW Finlayson reported Resident A was acting like himself and gave no signs that he was thinking about eloping. DCW Finlayson reported since the elopement occurred the direct care workers on duty have been checking on Resident A hourly to ensure his whereabouts. DCW Finlayson reported she was not on duty on 01/06/2023.

I interviewed Resident A who reported he does not remember being at Panda Express on 01/06/2023 but reported someone brought him home. Resident A could not remember what time of day it was when he was brought home. Resident A could not recall if he was wearing a coat on 01/06/2023 or what the weather was. Resident A reported that he likes to watch television and walk but he could not recall the last time he went for a walk, nor did he know what his favorite restaurant was.

I interviewed licensee designee Agonor who reported DCW Francisca Farris was on duty on 01/06/2023. Licensee designee Agonor reported DCW Farris was newly hired and she was downstairs doing laundry when Resident A signed out and left the facility. Licensee designee Agonor reported DCW Farris contacted her on 01/06/2023 and reported the East Lansing Police were with Resident A at Panda Express which is located about 5.2 miles from the facility. Licensee designee Agonor reported Resident A would have had to take the bus or gotten a ride as he could not have walked that far. Licensee designee Agonor reported Resident A does get confused sometimes when in the community when he wants to come home and he cannot always remember how to get back to the facility. Licensee designee Agonor reported that Resident A does not have a history of leaving the facility alone, wandering off while in the community, or eloping from the facility. Licensee designee Agonor reported she provided Resident A's case manager, Heather McClelland, with a written 30-day notice on 01/10/2023 by email. Licensee designee Agonor reported that she had not had a chance to put a copy of the 30-day notice in Resident A's record at the facility. Licensee designee Agonor reported direct care workers on duty have been checking on Resident A hourly since the incident occurred to ensure his whereabouts. Licensee designee Agonor reported Resident A's written assessment plan documents that Resident A can be in the community if someone else goes with him to provide assistance. Licensee designee Agonor reported that typically Resident B goes with Resident A when he is in the community to provide assistance to him. Licensee designee Agonor reported Resident A is 74 and although he does not have a formal diagnosis of dementia there have been other instances when he has been confused, combative, angry and irritable. Licensee designee Agonor reported that there have been two to three incidents in the neighborhood where he has gone walking and could not find his way home therefore, he does not go into the community alone.

On 01/12/2023, I interviewed Taylor Knickerbocker, social worker with the East Lansing Police Department, who reported she was contacted by dispatch when an

employee at Panda Express called the emergency response number due to a disoriented man sitting in the lobby. Social worker Knickerbocker reported she went to Panda Express and Resident A had identification and told her that he took the bus to Panda Express on 01/06/2023 but that he did not like Chinese food. Social worker Knickerbocker reported Resident A had a card in his wallet that had the facility name and phone number on it. Social Worker Knickerbocker confirmed the direct care worker, name unknown, who answered believed Resident A was napping in his bedroom. Social worker Knickerbocker reported Resident A was not oriented to time and place and Resident A stated he wanted to go home but he did not know how to get there.

On 01/12/2023, I interviewed Officer Harrison with the East Lansing Police Department who reported she was dispatched to Panda Express when a call came in by an employee at Panda Express stating that there was a disoriented man sitting in the lobby. Officer Harrison reported Resident A admitted that he did not know where he was and that he wanted to go home but he did not know how to get there. Officer Harrison reported Resident A stated that he took the bus to Panda Express. Officer Harrison reported Resident A was dressed appropriately for the weather. Officer Harrison reported Resident A did not know his name but he did provide identification and had a card with the address of where he lived in his wallet. Officer Harrison reported social worker Knickerbocker called the facility and drove Resident A back to the facility after providing him with McDonalds.

On 02/28/2023, I interviewed Resident A's case manager Heather McClelland with Community Mental Health (CMH) of Clinton, Eaton and Ingham (CEI) who reported that on 01/06/2023 the direct care worker (name unknown) on duty was in the basement stocking food when Resident A signed out and left the facility. Case manager McClelland reported Resident A does not have a history of going into the community alone and/or wandering off. Case manager McClelland reported Resident A likes to sit and watch television and or be in his room. Case manager McClelland reported Resident A will go into the community with Resident B so that Resident B can assist him. Case manager McClelland reported she was provided a 30-day notice from licensee designee Agonor and Resident A has been moved to a secured living arrangement. Case manager McClelland reported direct care staff members conducted hourly checks on Resident A after this incident occurred and that there were no other elopements while Resident A resided at the facility.

On 03/01/2023, I reviewed a Michigan Workforce Background Clearance for DCW Farris that was dated 01/05/2023 and documented that DCW Farris was eligible for employment at an adult foster care facility.

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: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Licensee designee Agonor, DCW Finlayson and case manager McClelland all reported Resident A did not have a history of elopement from the facility prior to this incident. There is evidence to support that this was an isolated incident and after this elopement incident, licensee designee Agonor implemented hourly checks were immediately, and Resident A did not have any other elopements. Additionally, a written 30-day notice was completed by licensee designee Agonor on 01/10/2023 and provided to case manager McClelland. Resident A has since been moved to a secure setting. Resident A also gave no prior indication he wanted to leave the facility or was acting unusual.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 01/11/2023, I conducted an unannounced investigation and DCW Finlayson was on duty. DCW Finlayson could not provide me with a *Staff Schedule* to review as there was not one posted or available in the facility. DCW Finlayson reported everyone knows what days they work and licensee designee Agonor contacts them is there is any schedule changes.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.**

	(c) Hours or shifts worked. **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	At the time of the unannounced investigation on 01/11/2023 a staff schedule was not available for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 01/11/2023, I conducted an unannounced investigation and I interviewed DCW Finlayson and licensee designee Agonor who both reported Resident A does not go into the community alone because he has had instances of getting lost, falling and getting tired because he walks too far. DCW Finlayson and licensee designee Agonor reported that Resident A typically goes into the community with Resident B so that Resident B can watch over or provide supervision to Resident A. DCW Finlayson and licensee designee Agonor both reported that there is one direct care worker on duty per shift.

I reviewed Resident A's record which contained an *Assessment Plan for AFC Residents* completed on 10/19/2022. In the "Moves independently in Community" section of the report both yes and no were marked. In the narrative section it stated, "Client goes to the store in the company of other clients. Taken to all appointments."

On 02/28/2023, I interviewed case manager McClelland who reported Resident A will go into the community with Resident B so that Resident B can assist him as Resident A has been lost and confused in the community previously. Case manager McClelland reported that the facility has one direct care worker on duty per shift.

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:	Licensee designee Agonor, DCW Finlayson and case manager McClelland all reported that there is only one direct care worker on duty per shit therefore, the facility did not have sufficient direct care staff available to assist Resident A with supervision, protection and personal care while he was out in the community. Instead licensee designee Agonor utilized another resident/vulnerable adult to provide Resident A with supervision while out in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
ANALYSIS:	Resident A's record contained an *Assessment Plan for AFC Residents* completed on 10/19/2022. In the "Moves independently in Community" section of the report both yes and no were marked. In the narrative section it stated, "Client goes to the store in the company of other clients. Taken to all appointments." Licensee designee Agonor, DCW Finlayson and case manager McClelland all reported Resident A does not go into the community alone as Resident A requires someone else to go with him to provide assistance and typically that person is another resident, Resident B. A violation has been established as Resident A's safety, well-being and supervision is being managed in the community by Resident B who is also a vulnerable adult. By having another vulnerable adult provide Resident A with supervision, protection and personal care while out in the community, Resident A's needs were not being met per his written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/01/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

03/03/2023

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Dawn N. Timm Date
Area Manager