GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2023

Barry LaPeen & Cynthia Palmateer
456 Leta Ave
Flint, MI 48507

RE: License #: AF250326260
Investigation #: 2023A0582044
Thomas Family Adult AFC

Dear Barry LaPeen & Cynthia Palmateer:

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.
- 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. 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF250326260
Investigation #:	2023A0582044
Complaint Receipt Date:	04/17/2023
Investigation Initiation Date:	04/17/2023
Report Due Date:	06/16/2023
Licensee Name:	Barry LaPeen & Cynthia Palmateer
Licensee Address:	456 Leta Ave Flint, MI 48507
Licensee Telephone #:	(810) 772-3078
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Thomas Family Adult AFC
Facility Address:	5143 Mellwood Dr. Grand Blanc, MI 48507
Facility Telephone #:	(810) 694-4157
Original Issuance Date:	01/15/2013
License Status:	REGULAR
Effective Date:	07/14/2021
Expiration Date:	07/13/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED, ALZHEIMERS

II. ALLEGATION

	Violation Established?
In the late morning on 04/14/2023, Resident A was wandering around lost in the streets of the neighborhood surrounding the AFC home. There is a concern that Resident A continually gets out of the home and becomes lost.	No
Additional Findings	Yes

III. METHODOLOGY

04/17/2023	Special Investigation Intake 2023A0582044
04/17/2023	APS Referral Denied APS referral
04/17/2023	Special Investigation Initiated - Letter With Kathryn Dennis, Adult Protective Services
05/23/2023	Contact - Document Received Email from Cheri Potter, Grand Blanc Police Department
05/24/2023	Inspection Completed On-site
06/02/2023	Exit Conference With Cynthia Palmateer, Licensee
06/06/2023	Exit Conference With Cynthia Palmateer, Licensee

ALLEGATION:

In the late morning on 04/14/2023, Resident A was wandering around lost in the streets of the neighborhood surrounding the AFC home. There is a concern that Resident A continually gets out of the home and becomes lost.

INVESTIGATION:

I received this denied Adult Protective Services referral on 04/17/2023. The referral documents that Resident A is 89 years old and has dementia or severe confusion. The referral documents that on the morning in question while walking in the neighborhood, Resident A did not know his address or how long he had been walking around. When Resident A was asked where he lived, he provided an addressed that turned out to be an old address. Police were contacted and shortly thereafter, and an individual who identified himself as the owner of the AFC home arrived and acknowledged that Resident A is an “escape artist.” The owner did not wait for police to arrive and took Resident A away. Officers did not ultimately respond but are believed to have called the AFC home to verify the situation.

On 04/17/2023, Licensing Consultant Susan Hutchinson emailed Kathryn Dennis, Adult Services Supervisor. Ms. Dennis stated that 3 referrals made in 2023 for Resident A and all were denied. The most recent referral was denied by Centralized Intake with a comment that LARA will investigate.

On 05/23/2023, I received an email from Cheri Potter at the Grand Blanc Township Police Department, which stated that “after a thorough search I was not able to locate a CFS (call for service) for the incident. I checked the officer’s daily reports for 04/14/2023 and did not locate a reference to a phone call being placed to the AFC Home either.”

On 05/24/2023, I conducted an unannounced, onsite inspection at the facility. I observed Resident A, who appeared to be receiving proper care and supervision. Resident A was relaxing in the living room and was cordial. Resident A stated that he feels safe in the home. I interviewed Responsible Person Danielle Mallard. Ms. Mallard stated that Resident A has recently began trying to leave the home and search for his wife, who recently passed away. Ms. Mallard stated that Resident A has only been able to get to the front yard since it became known that he tries to get out of the home. Ms. Mallard stated that cameras and door alarms have been installed to increase safety measures for Resident A. Ms. Mallard stated that she was not aware of an incident in which Resident A was found away from the home without knowledge.

I interviewed Cynthia Palmateer, Licensee. Ms. Palmateer stated that Resident A has dementia. Ms. Palmateer stated that Resident A’s wife recently passed away,

and he can become confused sometimes wanting to go look for her. Ms. Palmateer stated that Resident A only recently began trying to leave the home and has only made it to the front yard with staff following him and redirecting him back inside. Ms. Palmateer stated that they installed cameras in the hallway and a motion alarm at the doors for safety measures. Ms. Palmateer stated that on the day of the allegation, she was downstairs in the basement, and staff was doing laundry. Ms. Palmateer stated that it was only a few minutes later when they discovered that Resident A was no longer in the home. Ms. Palmateer stated that Resident A typically leaves out of the side door when trying to go outside. Ms. Palmateer showed where there was an alarm at the door. Ms. Palmateer stated that her husband Barry LaPeen and Allen Kaczorowski, member of household, immediately went looking for Resident A. Ms. Palmateer stated that Resident A was not far from the home and was brought back in about 10 minutes. Ms. Palmateer stated that they discovered that the door alarm was not loud enough to be heard from the basement with laundry being done and they are looking at getting a louder alarm. Ms. Palmateer stated that staff has increased their supervision of Resident A to ensure his safety. Ms. Palmateer stated that Resident A does not currently have a guardian after his wife's passing.

I reviewed Resident A's *Assessment Plan* dated 06/30/2019, which documented that he is not alert to surroundings and "does not know where he is at." Resident A's *Assessment Plan* documented that he is able to move independently in the community.

APPLICABLE RULE	
R 400.1417	**Absence without notice.**
	Absence without notice. **(1) If a resident is absent without notice, the licensee or responsible person shall do both of the following:** **(a) Make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency.** **(b) Contact the local police authority.** **(2) A licensee shall make a reasonable attempt to pursue other steps in locating the resident.**

ANALYSIS:	Based on interviews and observations at the facility, safety measures such as alarms and cameras have been utilized since it became known that Resident A is an elopement risk. The licensee immediately searched for Resident A when it became known that he was not in the home. Resident A was found and returned to the home within 10 minutes of discovering that he was not in the home, so police were not contacted. The Licensee discussed improving safety measures to include a louder alarm. Resident A was observed in the home to be receiving proper care and supervision during my unannounced, onsite inspection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/24/23, I interviewed Cynthia Palmateer, Licensee. Ms. Palmateer stated that Resident A has dementia. Ms. Palmateer stated that Resident A's wife recently passed away, and he can become confused sometimes wanting to go look for her. Ms. Palmateer stated that Resident A only recently began trying to leave the home and has only made it to the front yard with staff following him and redirecting him back inside. Ms. Palmateer stated that they installed cameras in the hallway and a motion alarm at the doors for safety measures.

I reviewed Resident A's *Assessment Plan* dated 06/30/2019, which documented that he is not alert to surroundings and "does not know where he is at." Resident A's *Assessment Plan* documented that he is able to move independently in the community.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.**

ANALYSIS:	Based on interviews and a review of documentation, Resident A's *Assessment Plan* documents that he is able to move independently in the community and is also not alert to his surroundings. Resident A's current *Assessment Plan* does not reflect his current functioning to address the amount of supervision and protection he requires for elopements. While safety measures have been established to prevent elopements, current documentation does not consider the amount of care necessary for Resident A's safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/02/2023, I conducted an Exit Conference with Cynthia Palmateer, Licensee. I informed Ms. Palmateer of the findings from the investigation. On 06/06/2023, I conducted an Exit Conference with Cynthia Palmateer, Licensee. I informed Ms. Palmateer of the need for a Corrective Action Plan as a result of the additional finding from the investigation.

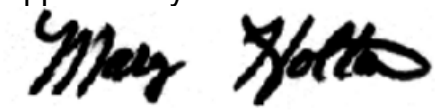
IV. RECOMMENDATION

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

06/09/2023

Derrick Britton Date
Licensing Consultant

Approved By:



06/09/2023

Mary E. Holton Date
Area Manager