GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 6, 2024

Jeffrey and Julie King
5585 McFall Circle
Montague, MI 49437

RE: License #: AS640270127
Investigation #: 2024A0340028
King Home

Dear King Jeffrey and King Julie:

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 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 (616) 356-0183.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS640270127
Investigation #:	2024A0340028
Complaint Receipt Date:	03/18/2024
Investigation Initiation Date:	03/18/2024
Report Due Date:	05/17/2024
Licensee Name:	Jeffrey King and Julie King
Licensee Address:	5585 McFall Circle Montague, MI 49437
Licensee Telephone #:	(231) 894-3577
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	King Home
Facility Address:	7212 S. Oceana Drive Rothbury, MI 49452
Facility Telephone #:	(231) 894-3577
Original Issuance Date:	10/29/2004
License Status:	REGULAR
Effective Date:	04/28/2023
Expiration Date:	04/27/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the home on 3/7/24 and was found by Oceana County Sheriff's Dept. Staff at the home did not know he was missing.	Yes

III. METHODOLOGY

03/18/2024	Special Investigation Intake 2024A0340028
03/18/2024	APS Referral Received from APS
03/18/2024	Special Investigation Initiated - Telephone
04/26/2024	Inspection Completed On-site
05/06/2024	Exit Conference Julie King

ALLEGATION: Resident A eloped from the home on 3/7/24 and was found by Oceana County Sheriff's Dept. Staff at the home did not know he was missing.

INVESTIGATION: On March 18, 2024, a complaint was filed with the BCAL Online Complaints by Adult Protective Services stating that on March 7th, 2024, at approximately 4:49pm, Resident A was found by Oceana County Sheriff's Dept walking along US-31 attempting to walk to Muskegon, MI. Resident A informed OCSD Deputy that he was a resident of the King Home in Rothbury, MI. Dispatch made contact with the King Home and staff at the King Home did not know Resident A's whereabouts at that time. It was determined that he had been gone for 2-3 hours and had walked approximately 1.5 miles to US 31 from the King Home.

On March 18, 2024, I contacted Licensee Julie King. She was aware of the incident and agreed to send me the IR which I received and reviewed on this day.

The Incident Report (IR) was written on 3/7/24 by staff Hayli Buckhout. It stated that on 3/7/24 at 5:30 pm Resident A was found on US 31 walking to Muskegon. Dispatch had called the home asking if he was missing. The officer said he would bring him back home. Once at the home the officer brought Ms. Buckhout outside and asked her if Resident A was allowed to leave the home. She reportedly informed the officer that Resident A is allowed to leave the home but is required to sign out and let staff know. The officer took Ms. Buckhout to get Resident A out of

the car and let Resident A know that it was a civil infraction to walk along the highway. We then brought Resident A back in the house.

On April 19, 2024, I conducted an unannounced home inspection. I reviewed Resident A's Health Care Appraisal which was signed 10/17/23 by Jennifer White, NP. Under Resident A's diagnosis it stated Dementia.

I reviewed Resident A's Assessment Plan dated 10/31/23, signed by Licensee Julie King. Under Moves Independently in the Community it states that he is able.

There were no other IR's regarding any other elopements for Resident A.

I interviewed staff Kayli Young. She showed me the sign-out list, located in the kitchen. She informed me that Resident A has good cognition. Ms. Young stated she has worked in the home only a few months.

I interviewed Resident A inside the home. He did not present to have adequate cognition to be interviewed. His speech was limited and he did not answer questions posed to him.

On May 6, 2024, I contacted Licensee Julie King and we discussed Resident A. She stated Resident A more recently has had a decreased cognition. He was previously very aware and able to communicate. She stated he does not adhere to requests to let staff know where he goes and can be verbally combative with staff when asked. He recently began to verbalize a strong desire to go to Muskegon to see his family who had recently stopped visiting him which is why he decided to walk there.

The residents living at Ms. Kings home are high functioning and independent and it is not uncommon for them to go for walks on their own. Ms. King stated that Ms. Buckhout did notice Resident A had been gone for quite a while, but this discovery was just before she received the call from Dispatch.

I discussed with Ms. King the contradiction of his dementia diagnosis and his assessment plan allowing for independent access to the community. She stated she will be speaking with his guardian and this will be reassessed. She is also contemplating issuing a 30-day discharge notice to Resident A due to his decrease in cognition since it is not compatible with the rest of the residents.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(2) If an elopement occurs, staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall contact law enforcement.

ANALYSIS:	The allegation was made that Resident A eloped from the home and staff were unaware. Oceana County Sheriff's Dept picked up Resident A walking down US 31. When Dispatch called the King Home, the staff who were working did not know he had left. Police returned Resident A to the home. Resident A's Health Care Appraisal states he has Dementia. Resident A's Assessment Plan states he can be in the community independently. Ms. King stated Resident A's cognition had only recently began to decline. He has a strong desire to visit his family in Muskegon who have recently stopped visiting him.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 6, 2024, I conducted an exit conference with Licensee Julie King. We discussed the incident and I informed her of the violation and request for a Corrective Action Plan which she agreed to send.

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the current license status.

May 6, 2024

Rebecca Piccard Date
Licensing Consultant

Approved By:

May 6, 2024

Jerry Hendrick Date
Area Manager