GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2024

Thomas Quakenbush
Community Homes Inc.
3925 Rochester Rd.
Royal Oak, MI 48073

RE: License #: AS630390444
Investigation #: 2024A0465031
Greer Home

Dear Mr. Quakenbush:

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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630390444
Investigation #:	2024A0465031
Complaint Receipt Date:	07/10/2024
Investigation Initiation Date:	07/12/2024
Report Due Date:	09/08/2024
Licensee Name:	Community Homes Inc
Licensee Address:	3925 Rochester Rd. Royal Oak, MI 48073
Licensee Telephone #:	(248) 336-0007
Administrator:	Thomas Quakenbush
Licensee Designee:	Thomas Quakenbush
Name of Facility:	Greer Home
Facility Address:	2035 Lochaven Rd. West Bloomfield, MI 48324
Facility Telephone #:	(248) 336-0007
Original Issuance Date:	12/11/2018
License Status:	REGULAR
Effective Date:	06/11/2023
Expiration Date:	06/10/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 7/9/2024, Resident A eloped from the facility due to lack of proper staff supervision.	Yes

III. METHODOLOGY

07/10/2024	Special Investigation Intake 2024A0465031
07/10/2024	APS Referral Adult Protective Services (APS) referral assigned to Tracey Anderson for investigation
07/12/2024	Special Investigation Initiated - On Site I conducted an onsite investigation, completed a walk-through of the facility, reviewed resident files and interviewed direct care staff, Nichole Fenner
07/16/2024	Contact – Telephone call made I spoke to Officer Scott Engel from the West Bloomfield Township Police Department via telephone
07/16/2024	Contact - Document Received Police Report received from Officer, Scott Engel, via email
07/17/2024	Contact - Document Sent Facility documents received from Nicole Fenner via email
07/18/2024	Contact - Document Received Facility documents received via email
07/22/2024	Contact - Document Sent Email exchange with APS Worker, Ms. Anderson, via email
08/09/2024	Contact - Document Received Documents received from facility via email
08/09/2024	Contact - Document Received Received Discharge Notice document from Tom Quakenbush, via email

08/19/2024	Contact - Document Received Document received via email from Nicole Fenner
08/21/2024	Contact – Telephone call made I spoke to direct care staff, Raynesha Hawkins, via telephone
08/21/2024	Contact - Document Sent Email exchange with staff/home manager, Nicole Fenner
08/21/2024	Contact - Telephone call made I spoke to Guardian A1 via telephone
08/27/2024	Contact - Document Received Email exchange with Ms. Fenner
08/27/2024	Exit Conference I conducted an Exit Conference with Tom Quakenbush, via telephone

ALLEGATION:

On 7/9/2024, Resident A eloped from the facility due to lack of proper staff supervision.

INVESTIGATION:

On 7/10/2024, a complaint was received alleging that on 7/9/2024, Resident A eloped from the facility due to lack of proper staff supervision. The complaint stated that on 7/9/2024, Resident A eloped from the home, walked over two miles on roads and in the grass. The complaint stated that the staff at the facility are unable to properly care for Resident A.

On 7/10/2024 and 7/22/2024, I spoke to Adult Protective Services Worker (APS), Tracey Anderson, via email exchange. Ms. Anderson stated that she has completed an investigation of this complaint and will be substantiating for neglect. Ms. Anderson stated that her investigation is in the process of being closed.

On 7/12/2024, I conducted an onsite investigation at the facility. At the time of my onsite investigation, there were four residents residing in the facility. Resident A was hospitalized at the time of my investigation. I completed a walk-through of the facility, reviewed resident files and interviewed direct care staff, Nichole Fenner.

The *Face Sheet* stated that Resident A was admitted to the facility on 6/19/2015 and has a legal guardian, Guardian A1. The *Health Care Appraisal* lists Resident A's medical diagnosis as Dementia, Autism and Anxiety. The *Assessment Plan for AFC*

Residents stated that Resident A needs mobility assistance in the community with uneven ground and steps, is non-verbal, has a limited alertness and awareness to his surroundings and needs assistance from staff for safety purposes, needs assistance with eating, toileting, bathing, grooming, dressing, personal hygiene and does not use assistive devices. The *Easterseals Crisis Prevention & Safeguard Plan,* dated 7/16/2024, stated the following:

> *Resident attempts to secure staff's attention to take him into the community via use of his sign for lotto ticket, walking towards the door, pacing, etc. Attempting to exit the door may occur when an object of his desire is not immediately available-usually a lottery ticket or coffee. In the past, staff indicate he would exit the door if his previous housemate was teasing him or bothering him. Staff are concerned that Resident A will leave given any opportunity to do so. Resident A walks around in hallway, may decide to change his shirt while looking for an opportunity to exit the home. Make sure approved door alarms are set to alert staff to respond immediately to the elopement. Resident A may exit the home impulsively if he sees the opportunity. Resident A has poor safety skills, does not always dress for the weather and is vulnerable to exploitation by strangers. Make sure staff are aware of Resident A's whereabouts while at the home and in the community. Staff will be in close proximity to Resident A while outside.*

I reviewed the *West Bloomfield Township Police Department Case Report*, dated 7/9/2024, which stated:

> *On 7/9/2024 at approximately 5:44pm, Officer Peruzzi and Officer Engel were dispatched to the facility regarding a vulnerable adult walking away from the group home. Resident A, a non-verbal male suffering from dementia and Alzheimer's wearing a red collared Red Wings shirt, khaki pants and grey sketchers shoes. Enroute, we advised Officer Szybisty to begin checking north of the facility as we observed multiple reports of Resident A leaving the facility in this direction. Upon arrival, we spoke with the singular employee on scene, identified as Raynesha Hawkins. Ms. Hawkins stated she last observed Resident A at 5:20pm, shortly after the began cooking dinner for the residents. She stated that Resident A likes to lay down in the driveway and has not walked away from the facility in the year that she has worked here. Ms. Hawkins stated she has expressed to the facility manager, Nicole Loafman (Fenner), that she is unable to handle Resident A. Ms. Hawkins was concerned that Resident A may be at risk due to her inability to provide constant supervision to him and manage the day-to-day of the facility and care of the other residents simultaneously. Ms. Hawkins stated she attempted to reach Ms. Loafman (Fenner) via telephone several times after Resident A disappeared today and was unable to reach her. We also attempted to reach Ms. Loafman (Fenner) via telephone at approximately 8:30pm today and were sent to voicemail. I left a message. Officer Peruzzi and I began searching the home and property for Resident A, reasoning that he may be hiding. While doing so, Officer Szybisty advised he located Resident A at Cooley Lake Rd. and Mercedes St. Officer Szybisty transported Resident A back to the residence, and Ms. Hawkins was able to coax him out of the vehicle and back into*

the facility. Officer Frost documented similar circumstances in his report (#22-15037) from 08/15/2022. Per the report, Ms. Loafman was concerned the facility was unable to meet Resident A's needs. Jim Stark was identified as Resident A's legal guardian.

I reviewed the *Incident/Accident Reports* for Resident A, which documented the following:

7/9/2024 at 6:15pm; Completed by staff, Raynesha Hawkins: Today, Resident A went and sat outside while I went and prepared dinner. I came back to do my 10-minute engagement and Resident A was gone. He went outside at 5:30pm. I went around the house and neighbor houses. After 10 minutes of looking, couldn't find. Got a hold of police at about 6:00pm. They arrived at the house about 6:15pm/6:20pm. Resident A was located five minutes later, and police brought him home. Corrective Action: Will re-train the team on closer engagement with Resident A. Work with legal guardian and coordinate to determine a plan.

7/11/2024 at 4:00pm: Completed by staff, Jessica McLaughlin: When staff were walking with Resident A in driveway to come into the house after workshop, Resident A refused to come into the house and sat in a chair in the front yard by front door.

8/8/2024 at 3:40pm; Completed by staff, Jessica McLaughlin and Ray Hawkins: When Resident came home from workshop, he refused to come into the house. Staff called other staff for help as Resident A started walking down the side of the road. Staff called 911. Before cops arrived, Resident A was prompted to the house. The cops arrived shortly after and made a phone call out in their car to ask for advice on the situation and Resident A walked out the front door. The cops ended up taking Resident A to the hospital because he was a risk to himself. Corrective Action: Continue to try and keep Resident A safe. Resident A is currently on emergency placement list for a place that can better meet his needs.

8/13/2024 at 3:45pm; Completed by Jessica McLaughlin: Resident A was helped off van after day program. Staff used hand-over-hand to steady him to prevent falling. Resident A walked toward the house then stopped. Staff continued to encourage him. Resident A turned and started heading for the street. Staff continued to encourage Resident A to go in for a snack, coffee, etc. Resident A continued his effort to go into street. Took hand of Resident A and were able to get him in to go in house. Lots of praise once inside.

8/15/2024 at 5:20pm; Completed by staff, Jessica McLaughlin and Ray Hawkins: Resident A walked out the front door and started walking towards the road as staff tried to redirect him. Resident A was still walking towards the road. Staff then called 911 and the dire department came and picked up Resident A and took him to the hospital.

8/21/2024 at 9:00am; Completed by staff, Nicole Fenner: I received a phone call that Resident A was discharged from the hospital and transferred to a nursing home facility that specializes in dementia care. I spoke to Guardian A1, and he said this would be a long-term placement for Resident A. Resident A discharged from our care.

I reviewed the Community Homes, Inc. *Emergency Discharge Notice*, dated 8/9/2024, which stated the following:

Please accept this letter as emergency discharge notice for Resident A. Due to recent behavior displayed by Resident A, we believe there is substantial risk to the resident due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home. Further, we believe the amount of personal care, supervision, and protection that is required by the resident is no longer available in the home; and we cannot provide the kinds of services, skills, and physical accommodation. Resident A has displayed an abrupt decline in cognitive response and awareness. He no longer responds to redirection and has wandered from the home and/or refused to enter the home. Yesterday afternoon he declined to enter the home and instead pushed the staff away and continued to leave the premises. Police were called to assist. He has a previous diagnosis of Dementia that may be causing the increase in challenging behavior. He is presently at the hospital after being transported by police, due to leaving the home without staff. We are requesting emergency placement in a home/location that can better meet his needs. Thank you, Tom Quakenbush

I spoke to direct care staff and home manager, Nichole Fenner. Ms. Fenner stated that she has worked at the facility for five years. Ms. Fenner stated, “Resident A has a medical diagnosis of Dementia, and he has eloped from the home in the past. He hasn’t had an elopement in over a year. Over the last several months, Resident A has been attempting to elope more often. We also live off of a bust street with no sidewalks, so this is also a safety concern for Resident A. Last year, we updated our door alarm chime system for the exit doors. We also are not supposed to allow Resident A to be out of our sight or outside unsupervised. Staff are supposed to provide line-of-sight supervision to Resident A at all times. But is has been a struggle for staff to provide direct care to the other residents due to all the attempted elopements by Resident A. Staff have been vocalizing that a lot of their work time is spent keeping Resident A safe and it is taking away their ability to provide proper care to the other residents in the home.”

On 7/16/2024, I spoke to Officer Scott Engel from the West Bloomfield Township Police Department. Officer Engel stated, “We are concerned that Resident A is not safe at the current home. When we interviewed the staff on duty, Raynesha Hawkins, she stated that she could not keep line of sight of Resident A and care for the other residents at the same time. Resident A was able to leave the home unsupervised, without staff knowledge, and travel over 2½ miles before we found him. There are concerns that this home cannot provide proper care for him.”

On 8/21/2024, I spoke to direct care staff, Raynesha Hawkins, via telephone. Ms. Hawkins stated, “Resident A has a history of eloping. But he hadn’t eloped in a long time. So, I didn’t know he was going to elope. It’s hard to keep an eye on him, and also do my job and care for the other residents. I do my best, but I have told management that Resident A needs more care than we can offer. On 7/9/2024, I was inside making dinner for everyone. When I gave Resident A his dinner, he got up and went outside but I didn’t realize he was gone until a little while later. I went back outside and saw him in the driveway. I tried to re-direct him into the home, and he refused. He then took off down the road and I couldn’t go after him due to other residents being in the home. I then called the home manager Nicole Fenner, but she didn’t answer. So, I called 911. And they came to the house. Shortly after they got here, they found him wandering the streets and they brough him home.”

On 8/21/2024, I spoke to Guardian A1 via telephone. Guardian A1 stated, “Resident A has been moved to a more secured placement. He no longer resides at this facility. He is now in a placement that allows him to move independently without concern of elopement.”

On 8/27/2024, I conducted an exit conference with Tom Quakenbush, via telephone. Mr. Quakenbush is in agreement with the findings in this report.

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:	According to the *Easterseals Crisis Prevention & Safeguard Plan,* direct care staff must maintain line of sight of Resident A and know his whereabouts at all times due to his elopement history. According to the *West Bloomfield Township Police Department Case Report* and *Incident/Accident Report*, Ms. Hawkins intentionally left Resident A alone outside, unsupervised for approximately 10 minutes before realizing he had eloped from the facility. Ms. Hawkins acknowledged that she was not supposed to leave Resident A unsupervised. According to Ms. Hawkins, on 7/9/2024, she observed Resident A elope from the facility and she was unable to follow him to ensure his safety and protection needs were met. Ms. Hawkins

	acknowledged that she was supposed to maintain line of sight of Resident A and know his whereabouts at all times. During the months of July 2024 and August 2024, Resident A attempted to elope from the facility 7/11/2024, 8/8/2024, 8/13/2024 and 8/15/2024. On 7/9/2024, Resident A successfully eloped from the facility. On 8/15/2024, Resident A was transported by police to the hospital due to continued attempts of elopement from the facility. Based on the information above, the facility has not attended to Resident A's personal needs, including protection and safety, at all times.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED:** **Reference Special Investigation Report 2022A0465043, dated 9/29/2022; CAP dated 10/11/2022**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend this special investigation be closed with no change to the status of the license.

Stephanie Gonzalez 9/13/2024

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn 09/16/2024

Denise Y. Nunn Date
Area Manager