GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2025

Timothy Adams
Braintree Management, Inc.
7280 Belding Rd. NE
Rockford, MI 49341

RE: License #: AL340338193
Investigation #: 2025A0577027
Harrison House AFC

Dear Mr. Adams:

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) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AL340338193
Investigation #:	2025A0577027
Complaint Receipt Date:	03/20/2025
Investigation Initiation Date:	03/21/2025
Report Due Date:	05/19/2025
Licensee Name:	Braintree Management, Inc.
Licensee Address:	7280 Belding Rd. NE Rockford, MI 49341
Licensee Telephone #:	(616) 813-5471
Licensee Designee:	Timothy Adams
Administrator:	Jessica Adams
Name of Facility:	Harrison House AFC
Facility Address:	532 Harrison Avenue Belding, MI 48809
Facility Telephone #:	(616) 244-3443
Original Issuance Date:	04/02/2013
License Status:	REGULAR
Effective Date:	10/01/2023
Expiration Date:	09/30/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B have eloped from facility and cannot be in the community unsupervised.	Yes

III. METHODOLOGY

03/20/2025	Special Investigation Intake 2025A0577027
03/21/2025	Special Investigation Initiated – Telephone call made- Interview with Complainant.
03/21/2025	Contact - Document Received- Addt'l Infor for Intake 204800
03/21/2025	APS Referral- Denied for investigation.
03/28/2025	Contact - Telephone call made to Guardian A1.
04/01/2025	Contact - Document Received- Resident Care plan, and case notes.
04/04/2025	Contact - Telephone call made- Thomas Herald, RCC Case Manager.
04/10/2025	Contact - Telephone call made- Jasmine Castillo, Right Door Case Manager.
04/10/2025	Contact - Telephone call made- Guardian B1.
04/15/2025	Contact - Telephone call made- Belding City Police.
04/16/2025	Contact - Face to Face- Belding Police Department.
04/16/2025	Inspection Completed On-site
04/21/2025	Contact - Document Sent- Email to Jessica Adams, LD.
04/22/2025	Exit Conference with licensee designee Jessica Adams.
04/23/2025	Exit Conference with licensee Jessica and Tim Adams.

ALLEGATION: Resident A and Resident B have eloped from facility and cannot be in the community unsupervised.

INVESTIGATION:

On March 21, 2025, a complaint was filed alleging Resident A eloped from the facility on multiple occasions. Previously Resident A was provided a tracking device for the facility to always know her location but the complaint alleged that the device is not currently being used. The complaint reported it is unsafe for Resident A to be in the community unattended due to Resident A's disabilities. The complaint reported of concerns regarding lack of direct care staff and their inability to adequately supervise current residents.

On March 21, 2025, a second complaint was filed alleging both Resident A and Resident B eloped from the facility. The complaint reported specifically that on March 20, 2025, Resident B had eloped from the facility and was located at Family Dollar store. The second complaint also reported concerns regarding the number of staffing, lack of supervision, and safety of residents.

On March 21, 2025, I interviewed Complainant who reported there has been an increase in elopements since there is no longer a live-in direct care staff member. Complainant reported there are only two direct care staff during first shift and many of the residents require hands on assistance with activities of daily living, transfers and supervision. Complainant reported believing two direct care staff cannot meet residents' needs. Complainant reported during a phone conversation on March 20, 2025, direct care staff (DCS) Val Mayer notified Complainant that Resident A and Resident B had eloped. Complainant reported DCS Mayer did not know the exact dates when Resident A and Resident B eloped, but stated, "it has happened a few times over the past couple of weeks and [Resident B] eloped last week." Complainant reported requesting the *AFC Incident-Accident Reports* (IR) regarding the elopements but none could be provided. Complainant reported Resident A and Resident B have guardians, receive services through Reliance Community Care (RCC) Waiver Program, and Resident A receives services through The Right Door Community Mental Health agency.

On March 28, 2025, I interviewed Guardian A1 who reported not being aware of Resident A eloping recently. Guardian A1 reported Resident A had an incident in Spring 2024, where Resident A was found in a yard during a thunderstorm and at this time it was decided Resident A could not be in the community unsupervised. Guardian A1 reported not having a copy of Resident A's *Assessment Plan for AFC Residents* and could not recall if it was updated to reflect Resident A needing supervision while in the community. Guardian A1 reported Resident A has a *Person Centered Plan* (PCP) with The Right Door, which has recently been updated, but has not been approved and believes the PCP addresses the need for Resident A to be supervised by direct care staff while in the community. Resident A reported to Guardian A1 in February 2025 that Resident A went to the gas station, dollar store and then the police station

independently. Guardian A1 reported not being sure this actually happened because Resident A has delusional thoughts. Guardian A1 reported she asked DCS Val Mayer about Resident A's statement that he went to stores independently and DCS Mayer denied this happened. Guardian A1 confirmed a previous direct care staff member, whose role was home manager, had set up the 360 application, but program was not used due to Resident A breaking her cell phone. Guardian A1 reported the application purpose was able to provide Resident A's location if she eloped from the facility.

On April 04, 2025, I interviewed Thomas Herald, case manager with RCC Medicaid Waiver Program, who reported RCC is the responsible agency for Resident A and Resident B. Mr. Herold reported Resident A also receives services from Ionia County Community Mental Health Agency- The Right Door and her case manager is Jasmine Castillo. Mr. Harold reported he is aware of Resident A and Resident B eloping from the facility but was not provided specific dates regarding the elopements. Mr. Herald reported he has not received *AFC Incident/ Accident Reports (IR)* since the last home manager left over a month ago.

Mr. Herald reported both Resident A and Resident B have *Person Centered Plans* (PCP) through RCC documenting that Resident A and Resident B cannot be in the community unsupervised. Mr. Herald provided this consultant with a copy of Resident A and Resident B's PCP from RCC. Mr. Herald reported due to the recent decrease in the number of direct care staff at the facility, facility administrative staff and Guardian A1 decided to purchase Resident A a cellphone and add the 360 application to it so direct care staff members knew Resident A's location while Resident A was in the community. Mr. Herald stated that by using this application, a direct care staff would not need to provide supervision to Resident A while she was in the community. Mr. Herold reported the thought process would be direct care staff could add the 360 application to their cellphones and monitor Resident A's whereabouts when in the community. Mr. Herald reported resident A's PCP was updated with this information, but Mr. Herald was not sure if Resident A was ever provided a cellphone.

I reviewed Resident A's PCP completed by RCC on January 30, 2025, and it documented Resident A can access the community independently and direct care staff will ensure Resident A signs out when leaving and provides a return time. The PCP documented Resident A was provided a cell phone with the 360 application so direct care staff can track Resident A's location as needed when Resident A leaves the facility. The PCP also documented direct care staff will notify Guardian A1, The Right Door, and RCC when Resident A leaves the home.

I reviewed Resident B's PCP, completed on December 06, 2024, by RCC, which documented Resident B is Vietnamese and speaks minimal English so due to the language barrier requires supervision from direct care staff while in the community. Resident B's PCP documented a goal of no elopements as Resident B has a history of exit seeking even though it has been a few months since Resident B's last elopement. Resident B's PCP documented " a barrier of [Resident B] being placed in a large group home is the inability of direct care staff to monitor Resident B exit seeking." Resident B's

PCP documented when Resident B becomes anxious direct care staff will provide one on one supervision during peak anxiety times to maintain safety. Mr. Herold reported Resident B will exit seek when he becomes anxious.

On April 10, 2025, I interviewed Jasmine Castillo, Case Manager with the Right Door, who reported she visits Resident A two times a month and was aware that Resident A eloped from the facility on multiple occasions, but no specific dates were provided, nor were IR's pertaining to Resident A's elopements received. Ms. Castillo reported during one of her visits she questioned DCS Val Mayer about Resident A leaving the facility unsupervised and was told Resident A has left the facility unsupervised, but DCS Mayer could not provide the specific dates. Ms. Castillo reported Resident A is supposed to be supervised per the Right Door's PCP, which has recently been updated and is waiting to be approved by supervision.

On April 10, 2025, I interviewed Guardian B1 who reported Resident B required supervision while in the community due to a language barrier. Guardian B1 reported she was not aware of Resident B being in the community unsupervised over the last few months. Guardian B1 reported she was not aware of the incident that happened on March 20, 2025, and did not receive an IR notifying Guardian B1 that Resident B was found at Family Dollar without direct care staff supervision.

On April 15, 2025, I contacted Belding City Police and left a message for Sergeant Hummel. On April 16, 2025, I interviewed Jennifer McNinch, Belding Police Department Clerk, who reported she is familiar with Resident A and Resident B and based on her memory has not heard anything about either resident eloping or needing assistance from the police. Ms. McNinch looked at the police system and reported the last known contact with Resident A or Resident B was in the spring and summer of 2024.

On April 16, 2025, I completed an unannounced onsite investigation and interviewed DCS Val Mayer who reported she has worked at the facility for about seven months and since working at the facility Resident A has not eloped. DCS Mayer reported per Resident A's *Assessment Plan for AFC Residents*, Resident A can be in the community unsupervised. DCS Mayer reported per Resident B's *Assessment Plan for AFC Residents,* Resident B needs to be supervised in the community due to Resident B not speaking English. DCS Mayer reported she is aware that Resident B eloped from the facility back in February or March of 2025 but did not know the exact date. DCS Mayer reported at the time of Resident B's elopement, she just had left the facility due to her shift ending and she received a phone call from direct care staff asking her to return to assist in looking for Resident B, who was missing from the facility. DCS Mayer reported within five minutes of returning to the facility, Resident B was found at a store downtown. DCS Mayer reported she unsure if an IR was completed.

On April 16, 2025, I interviewed Resident A who denied leaving the facility without direct care staffs' knowledge. Resident A reported she can leave the facility unsupervised and does take public transportation into the community by herself. Resident A reported her health has recently declined significantly leaving her barely able to walk to the end of

the driveway without being out of breath, so she no longer walks to town. Resident A reported she does not have a cell phone because it is broken. Resident A reported she was not sure if it had the application 360 on it. Resident A reported she is not aware of Resident B leaving unsupervised.

I attempted to interview Resident B but was unsuccessful due to the language barrier. During the onsite investigation on April 16, 2025, I reviewed Resident A and Resident B's *Assessment Plans for AFC Residents.* Resident A's *Assessment Plans for AFC Residents* was completed on May 01, 2024, and documented Resident A can move independently in the community. Resident B's *Assessment Plans for AFC Residents* was completed on June 11, 2024, and documented Resident B cannot move independently in the community, "[Resident A] needs assistance by staff when going into the community." Upon review of Resident A and Resident B's resident file, I did not find any IR's completed referring to the elopements of Resident A and Resident B.

On April 21, 2025, I contacted licensee designee/administrator Jessica Adams via email requesting direct care staff names and numbers who were working when Resident B eloped from the facility as well as any completed IRs. Ms. Adams reported she completed a staff meeting on March 14, 2025, and it was noticed Resident B was carrying around a piece of paper, which is a signal that Resident B wants to go to the store. Ms. Adams reported she advised direct care staff that Resident B wanted to go to the store and that he needs to be closely monitored, or he will walk to the store himself without direct care staff supervision. Ms. Adams reported with all the commotion, Resident B left the facility and walked to the store unsupervised. Ms. Adams reported this has been the only time Resident B a has left the property unsupervised in almost a year. Ms. Adam provided a copy of the IR completed on March 14, 2025, by licensee designee/administrator Jesicca Adams which documented that after a staff meeting, fire drill, and shift change, Resident B left the property unsupervised. The IR reported after about 20 minutes of searching, Resident B was located at the store by licensee designee Tim Adams and returned to the facility. Ms. Adams reported since this incident, one-hour checks were put in place when Resident B is not in the line of sight of direct care staff during waking hours.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on the information gathered during the investigation, Resident B eloped or left the facility without direct care staff supervision on March 14, 2025, even after displaying eloping behavior. Resident B was not provided supervision according to Resident B's written assessment plan which documents Resident B requires supervision in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

On April 22, 2025, exit conference and consultation was provided to Licensee Designee, Jessica Adams, to ensure a safety plan and proper supervision has been established to ensure the safety and supervision of Resident B, with a known history of elopements, is being provided.

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, It is recommended that the current status of the license remains unchanged.

Bridget Vermeesch

04/24/2025

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 04/24/2025

_____

Dawn N. Timm Date
Area Manager