



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 19, 2025

Kent Vanderloon
McBride Quality Care Services, Inc.
P.O. Box 387
Mt. Pleasant, MI 48804-0387

RE: License #: AS290404417
Investigation #: 2025A1033054
Woodhaven AFC

Dear Mr. Vanderloon:

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,

A handwritten signature in cursive script that reads "Jana Lipps". The signature is written in a dark ink and is positioned below the word "Sincerely,".

Jana Lipps, 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 #:	AS290404417
Investigation #:	2025A1033054
Complaint Receipt Date:	08/19/2025
Investigation Initiation Date:	08/19/2025
Report Due Date:	10/18/2025
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Kent Vanderloon
Licensee Designee:	Kent Vanderloon
Name of Facility:	Woodhaven AFC
Facility Address:	1015 S. St. John Ithaca, MI 48847
Facility Telephone #:	(989) 388-4029
Original Issuance Date:	11/20/2020
License Status:	REGULAR
Effective Date:	05/20/2025
Expiration Date:	05/19/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided adequate supervision and protection as she never returned to the facility from her evening walk.	Yes

III. METHODOLOGY

08/19/2025	Special Investigation Intake 2025A1033054
08/19/2025	Special Investigation Initiated - Telephone Interview conducted with licensing consultant, Amanda Blasius, via telephone.
08/19/2025	APS Referral- Referral made per protocol.
08/22/2025	Inspection Completed On-site Interviews conducted with direct care staff, Meranda Hunt, direct care staff/home manager, Cindy Robinson, and Resident A. Review of Resident A's resident record initiated.
08/22/2025	Contact - Document Sent Email correspondence sent to direct care staff/home manager, Cindy Robinson, requesting additional documentation.
08/22/2025	Contact - Document Sent Email correspondence sent to licensee designee, Kent Vanderloon.
08/25/2025	Contact – Document Received Email correspondence received from Ms. Robinson.
09/11/2025	Contact – Telephone call made- Attempt to interview Montcalm Care Network case manager, Melissa Bolanos, via telephone. Voicemail message left, awaiting response.
09/11/2025	Contact – Telephone call made Interview conducted with Guardian A1 via telephone.
09/15/2025	Contact – Telephone call made- Interview conducted via telephone with Montcalm Care Network case manager, Melissa Bolanos.

09/15/2025	Contact – Telephone call made- Interview conducted via telephone with Relative A1.
09/19/2025	Exit Conference Conducted via telephone with licensee designee, Kent Vanderloon.

ALLEGATION: Resident A was not provided adequate supervision and protection as she never returned to the facility from her evening walk.

INVESTIGATION:

On 8/19/25 I received an online complaint regarding the Woodhaven AFC, adult foster care facility (the facility). The complaint alleged that Resident A was missing from the facility as she left the facility for a walk and did not return. On 8/19/25 I interviewed adult foster care licensing consultant, Amanda Blasius, via telephone, regarding the allegation. Ms. Blasius reported that she had received an incident report on 8/19/25 that was faxed to her from the facility. Ms. Blasius reported that she is aware of Resident A's history and noted that she was previously in a locked adult foster care facility in the Lansing, MI area. Ms. Blasius reported that she did not have direct knowledge of whether Resident A had a history of elopements and was not certain whether Resident A had returned to the facility yet.

On 8/19/25 I reviewed the document, *AFC Licensing Division – Incident/Accident Report*, for Resident A, dated 8/18/25, completed by Tara Thompson. In each section of the document was the written narrative, "Please see attached sheet". The attached sheet was a document titled, *Montcalm Care Network Incident Report*, for Resident A, dated 8/18/25, and electronically signed by direct care staff, Meranda Hunt and Cindy Robinson. The date of the incident is recorded as 8/17/25, the time 11:00pm. Under the section, *Explain What Happened/Describe Injury (If any)*, it reads, "[Resident A] signed out for her independent walk at 9pm, wearing her dark blue snuggie with a light blue hoodie under it, black leggings, black shoes, and was carrying her green backpack. At 11pm [Resident A] had not returned home. Staff began to drive around Ithaca to look for [Resident A]. At 11pm staff called Gratiot County Sheriff Dept. following [Resident A's] protocol. [Ms. Robinson] called [Montcalm Care Network] on-call, as of 1am there was still no return call from on-call and [Resident A] had not returned home. [Resident A] did not return the entire night." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Staff RE looked for [Resident A], driving down all the side streets, checking the parks, going in open stores to see if anyone had seen a girl with her description but had no luck. [Ms. Hunt] called sheriff department to help look for [Resident A], [Ms. Robinson] reached out to on-call and guardian. Sheriff Department stated they will keep an eye out for her and call Woodhaven if they seen her and if a report is needed to call them in the morning."

On 8/22/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/home manager, Cindy Robinson. Ms. Robinson reported

that Resident A is 19 years old and was admitted to the facility in November of 2024. She reported that Resident A had eloped from the facility on a previous occasion and the direct care staff had followed her and brought her back to the facility. Ms. Robinson reported that Resident A currently works with the Montcalm Care Network (MCN) Community Mental Health organization for mental health services. She reported that on 8/1/25 MCN updated Resident A's access to the community on her *Person Centered Plan (PCP)* and granted Resident A independent access to the community for one hour twice per day. She reported that once in the early part of the day for an hour Resident A can take an unsupervised walk and once in the later afternoon or evening Resident A can take a walk for an hour. Ms. Robinson reported that things were going well with this plan and Resident A had been following this plan and returning to the facility. Ms. Robinson reported that on the evening of 8/17/25 Resident A took her evening medication and signed out around 9pm to go for her last walk of the day. She reported that Resident A did not return from this walk by 10pm. She reported that the protocol is to send direct care staff to look for the resident and if they cannot find her they are to call Central Dispatch and report her as missing. She reported that direct care staff, Meranda Hunt and Ryan Elenbaas, were working on this shift. Ms. Robinson reported that Mr. Elenbaas went into the community to look for Resident A, could not locate her and then they called Central Dispatch and the police took over searching for Resident A. Ms. Robinson reported that Resident A eventually called Relative A1 several days later, who drove to Chicago, IL to pick up Resident A. Ms. Robinson reported that Resident A had met a man on Facebook dating site and had arranged to have him pick her up at the facility and she went to Chicago with this man. Ms. Robinson reported on 7/25/25 Guardian A1 had taken Resident A's cellular telephone and computer away from her as it was discovered she had been communicating with strange men online and attempting to participate in risky behavior. Ms. Robinson reported that it was later discovered that Resident A had an old cellular telephone that no longer had paid service but could connect to WIFI networks. She reported that Resident A had used this telephone to access the internet and make the connection with this man on Facebook. She reported that no one knew she had access to this device.

During the on-site investigation on 8/22/25 I interviewed Ms. Hunt, regarding the allegation. Ms. Hunt reported she had been working the evening of 8/17/25 when Resident A eloped from the facility. She reported that Resident A asked direct care staff/Assistant Home Manager, Tara Thompson, if she could go for her evening walk, around 8:30pm. She reported that Ms. Thompson told Resident A it was okay for her to go for her walk. Ms. Hunt reported that Resident A signed out around 9pm and left the facility around 9:15pm. Ms. Hunt reported that around 10pm they were expecting Resident A to return and she did not return to the facility. She reported that Mr. Elenbaas left the facility around 10:30pm to go look for Resident A. She reported that Mr. Elenbaas checked with local businesses and drove around looking for Resident A for about two hours. Ms. Hunt reported that she called the police around 11pm, per Resident A's plan of care. Ms. Hunt reported that she then called Ms. Thompson, who in turn called Ms. Robinson. Ms. Hunt reported that both she and Ms. Robinson made attempts to reach the MCN case manager for Resident A and could not get through on their telephone system. Ms. Hunt reported that after contacting Central Dispatch and

making a missing person's report, the police did not come to the facility. She reported that by 8am on 8/18/25 she had still not seen the police. Ms. Hunt reported that Ms. Robinson contacted Guardian A1 the night of 8/17/25. Ms. Hunt reported that Resident A had a history of elopement attempts and had recently had independent walks added to her plan of care. She reported that after the walks were added to her plan, Resident A's elopement attempts decreased significantly. Ms. Hunt reported that Resident A was gone from the facility for two full days. On the third day she Snapchatted her mother and told her she was in Florida and would be back in a couple weeks. Also, on day three Resident A contacted Relative A1 and told her she was in Chicago, IL and needed to be picked up. Ms. Hunt reported that Resident A's sister drove to Chicago and brought her back to the facility. She reported Resident A returned to the facility on 8/21/25. She reported that Resident A admitted that she contacted a man through Facebook and arranged to have him pick her up at the facility on 8/17/25. She reported that Resident A stated the man drove to the end of the driveway of the facility, she got in his car and left. Ms. Hunt reported that Resident A is being guarded about what occurred while she was away from the facility. She reported that Resident A's statement about being with this man was, "I had to get out of there."

During the unannounced, on-site investigation on 8/22/25, I interviewed Resident A. Resident A reported that she had access to the internet with an old cellular telephone that no longer had paid service but used a WIFI connection to access the internet. Resident A reported that she had been taking her independent walk time and riding her bike to the local McDonald's to use their WIFI and contact men on the Facebook dating site. She reported that she had been speaking with this man, whose name she cannot recall, for a few days. She reported that he stated he lived in Chicago and offered to drive to the facility and pick her up and take her back to Chicago with him. Resident A reported that she agreed to this plan and told the man to come pick her up. She reported that he picked her up at the end of the driveway of the facility in a taxi and they drove to Chicago. She reported that this man was a taxi driver, and this was his taxi. Resident A reported that once they got on the highway and headed south, the man told her to throw her cellular telephone out the window of the car, which she complied with. She reported that she did not find this an unusual request and felt okay about throwing her phone out the window. Resident A reported that the man took her to his home that he shared with his mother. Resident A reported that during the time she was gone the man did not feed her. She reported that the only thing she had to drink was alcoholic beverages and energy drinks. She reported that she used marijuana edibles with the man and smoked marijuana. Resident A reported that the man worked in Chicago as a taxi driver and while he was gone working, he gave her a handgun for her protection. She reported that she walked around the city with the handgun. She reported that she did not fire the handgun and that the handgun was "heavy." Resident A reported that she would not share any further details of her interaction with this man and refused to discuss whether sexual activity occurred. Resident A reported that she finally broke down a couple days after she left the facility, contacted Relative A1, who came to Chicago and picked her up. She reported that she ate McDonald's at the police station and this was the first food she had since she left the facility on 8/17/25.

During the on-site investigation on 8/22/25, I reviewed the following documentation:

- *Montcalm Care Network, Adult Foster Care Safety Protocol*, for Resident A, dated 3/26/25. Under the section, *Safety Actions*, subsection, *Other*, it reads, “To help promote independence, [Resident A] will be allowed to take one walk independently per day away from town. For the walk AFC staff, should observe from AFC property as she takes walk, checking at least every five minutes. [Resident A] will walk to the south towards Fillmore Road and will turn east on Fillmore Road at the stop sign and come back when she reaches the trees. This is visible from the AFC home. Walks are not to exceed thirty minutes and should begin between 8:00am and 7:00pm. If [Resident A] does not follow this protocol in any way, if she walks to the north instead of the south or if walk exceeds thirty minutes AFC staff should respond with elopement procedure as identified in behavior treatment plan. If [Resident A] makes statements prior to going on walk indicating intent to elope such as “I’m not coming back,” or “I’m running away.” AFC staff should again follow elopement procedure. Following implementation of this protocol, if [Resident A] is able to maintain safety for one week as evidence by AFC and clinical report, no targets behaviors as identified in behavior plan, and following this protocol including returning within expected time frame, she will be able to take two walks per day following this protocol.”
- McBride Quality Care Services Inc., *Attestation Form*, for Resident A, dated 3/26/25. This document identified direct care staff signatures of direct care staff who were trained to the safety protocol dated 3/26/25 instituted by MCN. Mr. Elenbaas, Ms. Hunt, and Ms. Thompson, all signed this document indicating they were trained to this safety protocol.
- *Montcalm Care Network, Adult Foster Care Home Safety Protocol*, for Resident A, dated 4/25/25. Under section, *Safety Actions*, the document indicates the following:
 - Staff to conduct bed checks every 5-15 minutes when Resident A is in her bedroom.
 - All items that could cause self-harm shall be voluntarily removed from Resident A’s bedroom by Resident A.
 - If Resident A elopes, the direct care staff are to follow by foot or in vehicle and encourage resident A to return to the facility. If direct care staff lose sight of Resident A for longer than ten minutes, they shall contact MCN on-call or case manager and follow instructions.
 - “No more walking independently off [The Facility’s] property as [Resident A] has been eloping and threatening to commit suicide.”
- McBride Quality Care Services Inc., *Attestation Form*, for Resident A, dated 4/25/25. This document identified direct care staff who had been trained to this safety protocol dated 4/25/25. Mr. Elenbaas, Ms. Hunt, and Ms. Thompson, all signed this document indicating they were trained to this safety protocol.
- *Montcalm Care Network, Adult Foster Care Home Safety Protocol*, for Resident A, dated 7/30/25. Under section, *Safety Actions*, subsection, *Other*, it reads, “Staff will no longer follow [Resident A] when she elopes; unless she makes statements about harming herself or others, then staff will follow to ensure safety. Guardian is in agreement with this. [Resident A] will have 1 hour in the morning

and 1 hour in the afternoon to walk independently. [Resident A] will sign herself in and out each day. Walks will occur during daylight hours and will not overlap with med time. Staff will start to look for [Resident A] if she does not return in 2 hours. If staff are unable to find her, they should inform Gratiot County Police.”

- *Montcalm Care Network, Adult Foster Care Home Safety Protocol*, for Resident A, dated 8/21/25. Under section, *Safety Actions*, the document identifies the following information:
 - Items that could be used to self-harm should be voluntarily removed from Resident A’s bedroom by Resident A.
 - If Resident A elopes from the facility, the direct care staff are to follow by foot or in vehicle and encourage her to return to the facility. If direct care staff lose site of Resident A for more than ten minutes, they are to contact MCN on-call or case manager and follow instructions per MCN.
 - The document reads, “[Resident A] left from the home after meeting a man on Facebook Dating 24 hours prior. He picked her up and brought her back to Chicago where she stayed in his home during the night and sat outside the hotel where he worked in the daytime. [Resident A] attempted to leave the hotel when she heard Relative A1 was coming to pick her up. The police had to stay with [Resident A] until Relative A1 arrived. [Resident A] reported the man she called “Bae” had a gun. She was not given much food while she was in Chicago. [Resident A] will use the home phone 3 times a day for 15 minutes calling Relative A1s, mom, grandma and MYOI worker. (MCN, Clergy, Lawyer and guardian are exempt from plan). [Resident A] will have a staff person present to ensure she is not making plans to leave the home. Phone calls can occur in private away from other residents with staff present. [Resident A] will have supervision from AFC staff whenever she leaves the home. She will not have outings from AFC staff until this weekend.”
- *The Montcalm Center for Behavioral Health, Behavior Treatment Program*, document for Resident A, dated August 2025. This document tracks Resident A’s behaviors at the facility. She had one documented incident of elopement on 8/17/25.
- *The Montcalm Center for Behavioral Health, Behavior Treatment Program*, document for Resident A, dated July 2025. This document recorded 11 incidents of elopement for Resident A during the month of July 2025.

On 8/25/25 I received email correspondence from Ms. Robinson, regarding the allegation. I reviewed the following documentation provided by Ms. Robinson:

- *AFC – Resident Care Agreement*, for Resident A, dated 1/1/25.
- *Health Care Appraisal*, for Resident A, dated 11/19/24. Under section, 7. *Diagnoses*, it reads, “Major depressive disorder, Recur; Severe IDD, PTSD, BPD, OSA, Overweight, nocturnal enuresis.” Under section, 11. *Mental/Physical Status and Limitations*, it reads, “As tolerated”. This document was completed by Shelly Springsteen, RN.
- *Assessment Plan for AFC Residents*, for Resident A, dated 1/1/25. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves*

Independently in Community, the document is marked, “No”, with the following narrative, “Follow BTP, Follow safety plan, intermittent checks while shopping.” Under subsection, *J. Controls Sexual Behavior*, the document is marked, “No”, with a narrative, “History of sexual abuse, history of sexual promiscuity and sexual trauma.” Under subsection, *L. Exhibits Self Injurious Behavior*, the document is marked, “Yes”, with the following narrative, “Inserting screws or tampons and swallowing batteries. Glued eye lids shut with nail glue.”

- *[Resident A’s] Independent Walks*. This document is used as a sign in and sign out sheet for Resident A when she takes her independent walks twice per day. On the date 8/17/25 she signed out for her second independent walk at 9:00pm. This document identified that Resident A did not take walks every day and sometimes only took one walk per day on the days she chose to walk. On the date 8/17/25 this was the only time Resident A had taken a walk this late in the day. All previous afternoon/evening walks had been completed prior to 8pm.
- *Montcalm Care Network PCP Meeting*, for Resident A, dated 12/2/24, with expiration date of 12/1/25. This document refers to the *Behavior Treatment Plan (BTP)* in multiple areas in terms of direct care staff responsibilities for Resident A. It is identified on this document on page 3, “[Resident A] is line of sight in the community”. This statement is also referencing Resident A’s BTP. On page 4 under the section, *Health and Safety Modifications*, it reads, “[Resident A] is a young woman with a traumatic background including having resided in approximately 28 placements since 2015 when she and her two older sisters were removed from the mother’s care due to neglect, chronic unstable housing, and mother’s drug use. Records further indicate a history of sexual victimization. [Resident A] has an extensive history of emotional and behavioral difficulties, including mood dysregulation, impulsivity, verbal and physical aggression, property destruction, suicidal ideation, self-harming behavior, and elopement. A behavior treatment program was in place for [Resident A] at Hawthorn Center, while a “special behavior program for safety” was in place at Vista Maria. A behavior program continues to be warranted and will address issues that that have been displaced during the past year.” On page 4 it is also identified that the only current “*restrictive technique*” utilized for Resident A is the “*line of sight*” monitoring in the community and noted this technique is reviewed quarterly.

On 9/11/25 I sent email correspondence to Ms. Robinson requesting a copy of the BTP that was in effect for Resident A on 8/17/25. Ms. Robinson responded and provided the following document:

- *Behavior Treatment Program*, for Resident A, dated 5/29/24.
 - Under the section, *Target Behaviors*, the document lists
 - Provoking Peers
 - Verbal Aggression
 - Physical Aggression
 - Self-harm behavior
 - Eloping: “includes any episode of leaving the immediate area surrounding her AFC home without obtaining permission”.
 - Compliance with a non-preferred task

- The document identifies that the goal for reducing eloping behaviors as, “to 0 episodes per month for three consecutive months by May, 2025”.
- The document identifies *Interventions for Targeted Behavior*, addressing the interventions for *Eloping* as follows, “If [Resident A] threatens to run away, remain calm toward her. If the trigger to her threats is a denial of something that she wants, it is very important to remain consistent in not giving in to this request. She must not learn that threatening behavior will result in others giving into her regarding the things that she wants. In a matter-of-fact manner, attempt to gain her involvement in acceptable activity.” The intervention further states that direct care staff should immediately follow after Resident A should she elope. Noting, “You should stay with her and should assure her safety until you are able to verbally redirect her back to the home.” The final intervention for *Eloping* reads, “If [Resident A] elopes from the home and goes to any area that is outside of your view of “line of sight” monitoring, or you are otherwise unable to follow after her, you should follow the home’s protocol on how to address this.”
- The document provides the following definition for *Line of Sight Monitoring while in the community*: “When in the community, [Resident A] must have “line of sight” monitoring at all times. This means that a staff member must maintain an unobstructed view of her at all times throughout the outing.”

On 9/11/25 I sent a follow-up email correspondence to Ms. Robinson to confirm that this BTP was the one in place and active for Resident A on 8/17/25. I have not received a response to this inquiry.

On 9/11/25 I interviewed Guardian A1, via telephone, regarding the allegation. Guardian A1 reported that Resident A eloped from the facility on 8/17/25. She reported that Resident A has since moved to live with Relative A1 in Clinton County, Michigan and no longer resides at the facility. She reported that Resident A moved because she continued to elope from the facility after she returned. Guardian A1 reported that she feels direct care staff did everything they were supposed to do in terms of following the recommendations from MCN, but she was concerned that Resident A was allowed to take an independent walk on 8/17/25, after sunset. She reported that she was under the understanding that Resident A could only take her independent walks during daylight hours. She reported that she was informed by direct care staff that Resident A left the facility at 9:15pm on 8/17/25 to begin her walk for the evening. Guardian A1 reported that if she left at 9:15pm and walked for an hour, it would be at least 10:15pm before she returned, which is well past daylight hours. Guardian A1 reported that she had been in agreement with the MCN safety plan for Resident A. She reported that she was not certain whether the BTP for Resident A, dated 5/29/24 was the most current BTP available for Resident A. Guardian A1 reported that Resident A had an increase in the number of elopements she attempted at the facility during the month of July 2025. She further reported that she had to take Resident A’s laptop and cellular telephone away from her on 7/25/25 due to Resident A engaging with strange men through dating

websites on her phone and computer. Guardian A1 reported that despite the increased elopements and Resident A engaging in dangerous online activities, MCN still modified her safety plan on 8/1/25 to allow her to have one-hour, unsupervised walks, twice per day. Guardian A1 reported that Resident A is not disclosing all the details related to her elopement and she does not know which details to believe as Resident A has a history of fabricating stories. Guardian A1 reported that the direct care staff notified her of Resident A's elopement on 8/17/25 around 11pm. She reported that she and Resident A's sister worked together in efforts to find Resident A. Guardian A1 reported that the police were never in contact with her regarding Resident A's elopement, but she is aware that the police were working with Resident A's sister in efforts to find Resident A.

On 9/15/25 I interviewed MCN, case manager, Melissa Bolanos, via telephone. Ms. Bolanos reported that she is the case manager for Resident A. She reported that prior to Resident A's elopement on 8/17/25, MCN had changed Resident A's safety protocol in order to give her more independence in the community with two unsupervised walks per day for an hour each. She reported that prior to this Resident A had been eloping from the facility frequently and making a "game" out of it, as she enjoyed having the direct care staff follow after her. She reported that they tried the unsupervised walks to see if Resident A could manage this expectation and reducing her elopement. Ms. Bolanos reported that Resident A's episodes of elopement did decrease with this plan until 8/17/25 when Resident A eloped and went with a strange man she had met on the internet, to Chicago. Ms. Bolanos reported that she feels the direct care staff were following the safety protocol and did follow the elopement instructions provided to them when they realized she was not returning from her walk. Ms. Bolanos reported that the direct care staff allowed Resident A to leave the facility around 9pm and she questioned whether this was too late in the evening according to Resident A's safety protocol which states Resident A's independent walks should take place during daylight hours. Ms. Bolanos reported that Resident A no longer resides at the facility as Relative A1 has agreed to have Resident A move into her home. She reported that she is unaware whether any criminal charges will be pressed against the gentleman who picked up Resident A and reported she does not know this individual's name. Ms. Bolanos was asked about the BTP that was reviewed for Resident A during this investigation. Ms. Bolanos reported that if the BTP was dated 5/19/24 and stated the name of another adult foster care facility then this document is outdated and there should have been a more current version for the direct care staff to utilize for Resident A. She reported that the BTP must be updated at least annually and when an individual moves to a new placement. She reported that she is not aware if this document has an updated version as she was not near her files during this conversation. Ms. Bolanos reported that the safety protocol documents supersede the BTP document if they are dated after the creation of the BTP.

On 9/15/25 I interviewed Relative A1, via telephone, regarding the allegation. Relative A1 reported that Resident A is now residing in her home due to continued attempts of elopement since Resident A returned to the facility. She reported that she is concerned why direct care staff allowed Resident A to go for an independent walk at 9pm on 8/17/25 when her safety protocol indicates her walks should be taken during daylight

hours. Relative A1 reported that she feels this was poor judgement on the part of the direct care staff and the elopement could have been prevented if they had not allowed Resident A to take this walk past sunset. Relative A1 reported that she worked to return Resident A to the facility, independently. She reported that besides contacting the police and driving around the night of the elopement, she is unaware what the direct care staff did in efforts to find Resident A. Relative A1 reported that she has spoken with the police officer in Chicago and they are trying to press charges against the individual who picked up Resident A at the facility but they do not even know his name, which is making this difficult.

APPLICABLE RULE	
R 400.14303	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 upon interviews conducted and documentation reviewed it can be determined that there is adequate evidence to note that the direct care staff did not provide for Resident A's supervision and protection on 8/17/25 as they did not follow her written assessment plan. The <i>Assessment Plan for AFC Residents</i> document dated 1/1/25, identified, "Follow BTP, Follow safety plan, intermittent checks while shopping," regarding Resident A's access to the community. Resident A's <i>Adult Foster Care Home Safety Protocol</i> , dated 7/30/25 identified that Resident A's independent walks must occur within daylight hours. The document, <i>[Resident A's] Independent Walks</i> , identified that Resident A signed out of the facility at 9pm for her independent walk on 8/17/25. Ms. Hunt reported that Resident A left the facility around 9:15pm. Ms. Robinson, Guardian A1, Ms. Bolanos, Relative A1 and the incident report reviewed identified that Resident A left the facility at 9pm on 8/17/25. If Resident A left the facility between 9pm and 9:15pm and took a one-hour walk, as allowed by her safety protocol, she would not have returned to the facility until 10pm to 10:15pm which is not within daylight hours for this time of year in the state of Michigan. Therefore, a violation has been established as Resident A should not have been permitted to take this independent walk at this time of day, which put her safety and protection in danger.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

Jana Lipps

9/15/25

Jana Lipps
Licensing Consultant

Date

Approved By:

Dawn Timm

09/18/2025

Dawn N. Timm
Area Manager

Date