RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 4, 2018

Marcia Curtiss
Lifehouse Crystal Manor Operations LLC
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #: AL410302932
Investigation #: 2018A0350010
Crystal Springs Bay Pointe

Dear Mrs. Curtiss:

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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410302932
Investigation #:	2018A0350010
Complaint Receipt Date:	12/26/2017
Investigation Initiation Date:	12/26/2017
Report Due Date:	01/25/2018
Licensee Name:	Lifehouse Crystal Manor Operations LLC
Licensee Address:	Suite 115 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(616) 262-1792
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
Name of Facility:	Crystal Springs Bay Pointe
Facility Address:	1171 68th Street S.E. Grand Rapids, MI 49508
Facility Telephone #:	(616) 281-8054
Original Issuance Date:	04/05/2010
License Status:	REGULAR
Effective Date:	09/26/2016
Expiration Date:	09/25/2018
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
On 12/18/2017, Resident A was found outside in his pajamas at 5:30 am by staff. It is unknown how long Resident A was outside.	Yes

III. METHODOLOGY

12/26/2017	Special Investigation Intake 2018A0350010
12/26/2017	Special Investigation Initiated - Telephone I called and spoke with Relative 1
12/26/2017	Contact - Telephone call made I called and spoke with Kathy Higgins, Executive Director of Crystal Springs
12/27/2017	Contact - Document Received I received an email from Relative 1
12/27/2017	APS Referral
12/28/2017	Contact - Face to Face I spoke with Kathy Higgins, interviewed Resident A, and staff Kyle Garber
12/28/2017	Contact - Telephone call made I made speakerphone calls to several staff members with Zac Blevens, Adult Services Investigator, present
01/03/2018	Exit conference – Held with Marcia Curtiss, Licensee Designee

ALLEGATION: On 12/18/2017, Resident A was found outside in his pajamas at 5:30 am by staff. It is unknown how long Resident A was outside.

INVESTIGATION: On 12/26/2017, I called and spoke with Relative 1.Relative 1 stated that Resident A has only lived there for three weeks (by the time of this phone conversation). Relative 1 told me she wrote a letter with all of her concerns about Resident A's care at this facility, and that she would email me a copy of it. Relative 1 informed me that two staff members were terminated as a result of this incident (door alarms not being on during 3rd shift).

On 12/26/2017, I called and spoke with Kathy Higgins, Executive Director of the Crystal Springs campus. Ms. Higgins stated that Resident A got up at about 5 a.m. and went outside but the door alarm did not go off. Ms. Higgins told me that Resident A was outside in his pajamas for approximately 3 or 4 minutes before he was found, and that he only suffered an abrasion from falling when he was outside. Ms. Higgins reported that after Resident A was brought inside, his vitals were taken, and hospice was called because he is a hospice patient. Ms. Higgins also informed me that Resident A was moved that same day to another facility (Peace Harbor) which requires that a bar be pushed and held for 15 seconds in order to open any of the exit doors. The door alarms at Peace Harbor are also louder than the ones at Bay Pointe, and staff do face-to-face checks of each resident every hour. Ms. Higgins informed me that Resident A was alright after this incident. Ms. Higgins said that an internal investigation was done, and she learned that the two med techs working the 3rd shift on the date of this incident (12/18/2017), knew the alarms were not on, but did nothing to have them turned on; so, Ms. Higgins terminated them both. Ms. Higgins also said that there was a Direct Care Worker (DCW) working during this incident, but this was only her second or third day working, so she gave her a written warning and put a copy in her file. Ms. Higgins stated that all of her staff will be re-educated on the protocol regarding the door alarms. Ms. Higgins further informed me that because of this incident, she had a keypad alarm put on the door Resident A left through, and that this alarm sounds at the door as well as at the work station where staff members can hear it.

On 12/27/2017, I received an email from Relative 1, who stated:

“We spoke on the phone today regarding the complaint I made Dec. 21, 2017 against Crystal Springs Assisted Living Center. I believe you are going to the facility tomorrow to start your investigation. I'm attaching the letter we intend to give to Crystal Springs tomorrow.
I'm including (Relative 2) in this email as she is also Resident A's Power of Attorney.

Feel free to contact Jessica, head of nursing, at Crystal Springs as well as (Resident A’s) Spectrum Hospice team at 616-391-4200, Rachelle is his Hospice nurse and Shandra is his social worker. All three of them have observed (Resident A) since this incident and can possibly assist you in determining the scope of neglect.

I would like to add that on Christmas Eve., Dec. 24, while visiting (Resident A) in Peace Harbor wing at approx. 1 p.m., I couldn't find an aid so I waited by the entryway when someone went through the door so that an employee would have to come to the central area to turn the alarm off. An older gentlemen came over to me and asked who I was looking for and turned the alarm off himself. He told me the aids were busy helping his wife who is a resident. Even though there is a sign by the alarm system asking visitors to not turn the alarm off, there is obviously some major issues that need to be fixed. At the end of the two hallways in Peace Harbor there are doors that have simple locks on them. We were told

(Resident A) did go outside one of them Friday, Dec. 22 in the early evening. Apparently the alarm did sound and an aid brought him back to his room. These doors and the one in the dining room do not have a keypad on them. The alarm that would sound when these are used would not be the louder security alarm like the front door (when the alarm is engaged and the code isn't inputted into the keypad), but the same alarm heard repeatedly that is routinely turned off."

Relative 1 also attached the letter her family plans on submitting to Kathy Higgins to her email to me on 12/27/2017. The letter states:

"Dear Marcia,

As you are aware, our Dad, (Resident A), was found outside the Bay Point building by staff Monday, December 18, 2017 at 5:25 a.m. Tammy was called later that morning and we came later that morning to see Dad.

Staff was moving the things from Dad's room to Peace Harbor all day and had him transferred to a new room in that unit around noon. (Resident A's) face was red and chapped, both knees and both elbows had abrasions. His right elbow was bandaged and had bled through the bandaging. He was non communicative all Monday and so weak he needed two people to assist him from the wheelchair to the bed. He was also now incontinent. Tuesday he was more communicative but still needs more help than he ever had before. He has noticeable chest congestion and was put on antibiotic by Hospice on Thursday. He was shivering uncontrollably for periods of time on Tuesday when we were there with his hospice nurse and social worker. He complains about being very sore especially his left hip. His finger tips are painful and numb when he touches things and his toes are scraped.

(Resident A) remembers being outside and slipping on the ice and realized he shouldn't have gone out that door. He called for help and tried to pick up chunks of ice to throw at the building to get someone's attention. He doesn't know how long he was out there but says he was scared. When we asked for management to come to his room Monday to tell us what happened, you were one of the ladies who came to talk to us. You told us you were investigating and needed to hear back from some of the employees who were working on third shift. What you knew so far was he was outside between 25 minutes or up to an hour and a half.

We had not heard an update from anyone so Thursday afternoon we went to Kathy Higgins' office to find out how the investigation was going. You were in Kathy's office along with Zach from Waldon Woods but didn't provide any input. Kathy didn't know who we were and said she has been out of the office sick but was just finishing filing her incident report on Dad. She told us two employees were fired after admitting to disarming the alarm and/or knowing it was turned off but didn't correct it. Kathy said staff is being retrained to follow protocol and a keypad was being put on the door (Resident A) went out with no alarm sounding. If we understand correctly, anyone can still go through this door but the alarm will be louder if you don't input the code. Too little, too late. Your system is still only as good as any employee who has the

time and desire to silence the alarm after checking on every entryway when anyone uses any of the doors.
Kathy said she determined Dad was outside five minutes because his pajamas were not wet. He doesn't wear pajamas and was presumably out there in shorts and tee shirt. Lying in the melting snow would have made his clothes wet instantly.

To say we as a family are very disappointed is an understatement. Your lack of communication and treatment of what happened as just paperwork and seemingly not even interested in (Resident A)'s condition and state of being is disturbing. We were hoping for honesty from management.

(Resident A) moved to Crystal Springs Dec. 4 because of his mild dementia and his fear of going outside without knowing where he was. Two weeks later he walked out a door during the night and no alarm went off and nobody knew it for an undetermined amount of time. Why were the security issues not fixed before this especially in light of the woman dying last October in the very same manner? Had it been colder outside we would be in the exact same situation. Alarms being on as promised and security cameras would be the minimal safeguards.

We told Kathy Higgins on Thursday the care he's getting at Peace Harbor is lacking. We've arrived to find him lying in a wet bed more than once. We understand the aides are short staffed. We also told Kathy when Karri visited Dad in Peace Harbor this Wednesday, Dec. 20, from approximately 5 p.m. to 7 p.m. the alarm did not sound either time. There was no staff around the entryway to see who was coming or going. This was two days after he "wandered" out of Bay Point and now in the Peace Harbor unit you claim to be most secure.

As of Thursday, December 21 we have filed a complaint with the State of Michigan Licensing Bureau. We are not confident your report is accurate. It is our intent to get the best care for our Dad as well as the other residents."

This letter is addressed to Marcia (Curtiss), the Licensee Designee for the Crystal Springs facilities.

On 12/27/2017, I referred this complaint to Central Intake (Adult Protective Services), and added a note to the complaint stating that I was going to Crystal Springs Bay Pointe the following morning, 12/28/2017, at 10 a.m.

On 12/28/2017, I made an onsite inspection and met first with Ms. Higgins. Zac Blevens, Adult Services Investigator, was also present. I asked Ms. Higgins for copies of a variety of documents, and she provided them to me and Mr. Blevens. I also asked Ms. Higgins to show Mr. Blevens and me the door Resident A went out of that morning and the alarm system. Ms. Higgins explained that the door alarms are supposed to be on 24/7; however, for some reason they were not activated the morning of 12/18/2017 when Resident A went outside. When tripped, the alarm sounds and a light flashes on a panel near the center of the

building where staff can hear and see it; the panel also indicates which of the exit four doors was opened. Ms. Higgins showed Mr. Blevens and me that a keypad had been added after this incident, and explained how it works. When a door is opened, an alarm sounds throughout the building much louder than before, and can only be turned off with the keypad that is right next to the door on the inside of the building. Ms. Higgins also showed Mr. Blevens and me where Resident A was found, which was just outside the door. He was found lying down partially on the lawn and partially on the sidewalk. She said that Resident A had abrasions on his elbows and knees. Ms. Higgins reported that a Hospice nurse was called out, and she had no concerns regarding Resident A's health as a result of this incident. I requested a copy of the nurse's notes, and Ms. Higgins said she would try to get them and send them to me. Ms. Higgins stated that the alarm was somehow turned off and not turned back on during third shift on that day. Ms. Higgins showed Mr. Blevens and me where Resident A's bedroom was; which was two doors away from the exit. She told us he was moved to a more secured building the same day this happened. Ms. Higgins stated that Resident A was found lying outside by the dietician, Diane Treece, as she was coming into to work, and that Ms. Treece told kitchen staff member, Kyle Garber, who was in his car before his shift started. Mr. Garber assisted Ms. Treece with Resident A. As Mr. Treece was present during my onsite inspection, Mr. Blevens and I interviewed him.

On 12/28/2017, Mr. Blevens and I interviewed Kyle Garber, kitchen employee at this facility. Mr. Garber stated that Ms. Treece got his attention while he was waiting in his car in the parking lot before his shift started. He said that Ms. Treece told him that Resident A was outside, lying in the snow. Mr. Garber reported that he ran to get a blanket, then helped get Resident A up, and then wrapped a blanket around him and assisted in getting him back into the building. Mr. Garber said that he suggested that an ambulance be called, but instead the hospice nurse who has been working with him was called and came out. Mr. Garber told Mr. Blevens and me that he observed that some of the snow was bloodstained, and he noticed abrasions on Resident A's elbows. Mr. Garber stated that Resident A did not appear to be excessively cold during this incident.

On 12/28/2018, Mr. Blevens and I also interviewed Resident A. Resident A said that he saw a trailer outside and thought it was going to be used for a parade, so he went outside to check it out. He reported that he slipped and fell in the snow, and that he was only wearing a t-shirt and a pair of track pants; he had no shoes, socks, or slippers on. Resident A guessed that he may have been outside for up to 45 minutes, and that when he began yelling for help, it took about 20 minutes for someone to come help him. Resident A reported that when he was lying in the snow, he threw snowballs at the building to try to get someone's attention. Resident A told Mr. Blevens and me that he liked living at this facility, and that the staff usually provide him with good service.

On 12/28/2017, I asked Ms. Higgins if Mr. Blevens and I could use her office to do speakerphone interviews with the staff members who worked at the time of this incident, and she allowed us to do so. Ms. Higgins informed me that she interviewed staff member Sharon Walker, Med Tech, who worked from 3:00 p.m. to 11:00 p.m. on 12/17/2017, and Ms. Walker told her that the alarms were “on and functioning” when she left the building at the end of her shift.

On 12/28/2017, I called Diane Treece, got her on speakerphone with Mr. Blevens present and asked her questions. Mr. Treece explained that she arrived at Crystal Springs at about 5 a.m. on 12/18/2017 and waited in her car until about 5:25 a.m. before going into Bay Pointe, where she usually works. While in her car, she heard someone yelling for help three times, and she went to see what was happening. She found Resident A lying in the snow and she ran to Mr. Garber, who was in his car, and he assisted her with Resident A. Ms. Treece stated Resident A’s body from the waist down was on the cement, the rest was on the snow. Ms. Treece reported that Mr. Garber ran to get a blanket, and another Direct Care Worker also joined them in helping get Resident A up and back into the building. Ms. Treece told Mr. Blevens and me that Resident A was only wearing a pajama bottom. They got him into a wheelchair and put him back in his room. A staff member stayed with Resident A while the hospice nurse was being called. Ms. Treece said she also observed some blood in the snow and looked Resident A over, finding abrasions on his elbows and knees, but no other injuries. The Med Tech on duty at the time, Jasmine Washington, received directions of what to do over the phone from the nurse.

On 12/28/2017, I called Jasmine Washington, Medication Technician (Med Tech), and got her on speakerphone in Mr. Blevens presence. Ms. Washington stated that she was in the medication area when Mr. Garber came to her and told her what happened with Resident A. She reported that the alarm did not go off. Ms. Washington said that she went to Resident A to make sure he was responsive, check his range of motion, and to take his vitals. Ms. Washington told Mr. Blevens and me that Resident A was responsive and his vitals were normal, and that she only observed the scrapes on his elbows and knees. Ms. Washington stated that she called the supervisor and the hospice nurse, and it was determined that 9-1-1 did not need to be called.

On 12/28/2017, I called Yahntea Weaver, Direct Care Worker who worked the third shift on 12/17-12/88/2017. Ms. Weaver said this shift was her third day of training, and no one had told her how the alarm system worked yet. Ms. Weaver reported that she made rounds hourly during her shift and that she observed Resident A in bed at 4:30 a.m. She reported that at about 5:30 a.m. a kitchen staff member came in the building and told the other staff members that Resident A was found lying outside in the snow. Ms. Weaver told Mr. Blevens and me that the alarm did not go off during her entire shift. Ms. Weaver stated that she helped with Resident A and rubbed his hands to warm them up. Ms. Weaver said that

Resident A was only wearing pajama bottoms or track pants, and an adult brief (diaper).

On 12/28/2017, I called Summer Lodewyk, DCW, and got her on speakerphone with Mr. Blevens present. Ms. Lodewyk stated that she worked 14 hours between 12/17 and 12/18/2017, starting at the Peace Harbor building, then working at Bay Pointe from 3:30 p.m. to 5:30 p.m., then went back to Peace Harbor. Ms. Lodewyk stated that when she left for the day at 9:00 p.m., she went back through the door of the Bay Point building to go outside but the alarm did not go off.

On 01/02/2018, I reviewed the documents Ms. Higgins faxed to me on 12/26/2017 and the ones she gave me in person on 12/28/2017. These documents include: Resident A's Health Appraisal, the Incident Report pertaining to this incident, an internal plan of correction dated 12/19/2017, a timeline of events, an internal investigation narrative, the Security Rounds checklist for 12/17 and 12/18/2017, the workers' schedule for this time period, Resident A's Elopement Risk Assessment, his Fall Risk Assessment, a copied photograph of the bloodstained snow, a blank copy of a General Orientation Checklist, a copy of their Security Check Training Module, Resident A's one-page information check sheet, and the Alarm Check sheet for 12/17 to 12/18/2017.

Resident A's Health Appraisal shows his diagnosis as Arteriosclerotic Cardiovascular Disease; and reports that he can ambulate short distances, but has an unsteady gait. The Incident Report filled out on 12/18/2017 states that "Dietary staff observed (Resident A) outside, approx. 5 feet from the door, outside bay pointe unit. Resident A was lying on his left side, and yelling for help. Abrasion to right elbow, and bilateral knees. Staff wrapped (Resident A) in blanket, lifted him in to wheelchair, and brought him in to her (his) room. VS (vital signs) stable. Hospice called and nurse came to assist. RCM, ed, POA notified. Wounds bandaged. Full staff investigation, resident moved to secure unit [sic]." Resident A scored a 7 on his Elopement Risk Assessment; a score of 9 or higher being considered an elopement risk. Resident A scored a 17 on his Fall Risk; a score of 10 or greater being considered "High Risk." Resident A's information check sheet (my term, as the document is not labeled) has "Fall Risk" checked off, as well as boxes stating he requires one-person assistance for mobility and uses a wheelchair. The Security Check Training Module that is provided to new staff members states that "All alarmed security doors will be checked hourly. The security alarm check will include all doors with alarms." The hourly Alarm Check sheet shows that the door alarms were checked every hour from 7:00 a.m. to 11:00 p.m. on 12/17/2017, but were not checked after 11:00 p.m. all the way to 6:00 a.m. on 12/18/2017.

On 01/03/2018, I checked the website timeanddate.com and discovered that the recorded temperature for Grand Rapids, Michigan on December 18, 2017 at the time Resident A was discovered was approximately 36° F.

On 01/03/2018, I called and held an exit conference with Marcia Curtiss, Licensee Designee. I informed Ms. Curtiss that I was citing a violation of this rule as the responsible staff member did not check to make sure the door alarms were on, which allowed Resident A to go outside unnoticed. Ms. Curtiss stated that she has re-educated the staff on the correct procedures of the door alarms and had them sign a document stating they know how to use them. Ms. Curtiss also confirmed that a lockable cabinet will be attached to the wall over the buttons that operate the door alarms. Ms. Curtiss thanked me and had no further comments.

APPLICABLE RULE	
R 400.15305	**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:	Staff failed to ensure that the door alarms were turned on. As a result, Resident A was able to wander outside in the cold improperly dressed, where he fell and received minor injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

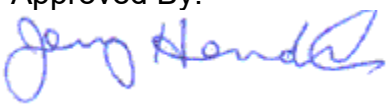
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this facility's license remain unchanged, and that this special investigation be closed.

January 3, 2018

Ian Tschirhart — Date
Licensing Consultant

Approved By:



January 4, 2018

Jerry Hendrick — Date
Area Manager